STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105792	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Winter Haven	1510 Cypress Gardens Blvd Winter Haven, FL 33884

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were provided dining services and resident care with dignity for four residents (#63, #2, #26, and #72) out of eight sampled residents. Findings Include: 1. During an observation made on 02/17/25 at 1:03 pm., Resident #63 was sitting up in bed with her lunch tray placed in front of her. She was observed having a hard time picking up her food using a specialized spoon. At 1:42 p.m., Staff D, Certified Nursing Assistance, CNA was observed standing over Resident #63 assisting her with her meal. During an observation made on 02/19/2025 at 1:29 pm, Resident #63 was observed sitting up in her bed with her lunch tray in front of her. Staff D, CNA was observed standing over her assisting Resident #63 with her meal. Review of an admission Record dated 02/20/2025 showed Resident #63 was admitted to the facility originally on 7/1/2024 and readmitted on [DATE] with diagnoses to include but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, abnormal posture, other feeding difficulties. During an interview conducted on 2/17/2025 at 2:00 p.m. with Staff D, she stated she was trained to sit down whenever she was assisting residents with their meals. Staff D stated she stood whenever she was assisting Resident #63 because she had to assist both residents in the room at the same time with their meal. During an interview conducted on 2/17/2025 at 2:15 p.m. with Staff B, License Practical Nurse (LPN), she stated she was never informed of how staff were supposed to be positioned when assisting residents with their meals. Staff B stated she had to find out if staff should sit down or stand up. During an interview conducted on 2/17/2025 at 2:30 p.m. with Staff F, License Practical Nurse LPN/ Unit Manager, she stated whenever staff were assisting residents with their meals, they were supposed to sit down at eye level facing the residents while assisting them. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 02/19/2025 at 4:00 p.m. with the Director of Nurses (DON), she stated residents who required assistance with their meals should have staff sitting down next to their bed, with the residents at eye level when they are assisting a resident with their meal. 2. On 2/17/25 at 12:08 p.m., an unknown staff member was observed in the Golden unit dayroom placing clothing protectors on unknown residents, including Resident #2, awaiting meal service. On 2/17/25 at 12:54 p.m., Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM) was heard saying you took your bib off to an unknown female resident sitting in the day room. On 2/19/25 at 1:08 p.m., Resident #2 was observed sitting in the Golden unit dayroom awaiting meal service. The observation revealed Staff Q, Master Social Work (MSW) entered the day room and placed a meal tray in front of the resident. The staff member removed a white sheer napkin from the tray and tucked it into the neckline of the resident's shirt. The staff member continued to set up the resident by peeling a banana with bare hands and placed the unpeeled fruit in front of the resident's plate directly onto the meal tray. During an interview on 2/20/25 at 3:18 p.m., the DON stated residents had a choice for wearing clothing protectors, If oriented, the resident would be asked and for non-oriented residents, the family members would be asked for permission. She stated it would be a personal preference to use a napkin for a protector. The DON stated the resident would be asked prior to putting on the protector and if non-oriented, a staff member would still ask the resident and the clothing protector would be added to the care plan. Review of a quarterly Minimum Data Set (MDS) with a target date of 1/20/25 revealed Resident #2's was not interviewed for a Brief Interview of Mental Status (BIMS) as the resident was rarely/never understood. The staff assessment of the resident showed the resident had short and long-term memory problems, and the cognitive skills for daily decision making was severely impaired. Review of Resident #2's electronic bedside care record, active as of 2/20/25, instructed staff regarding the residents' Eating/Nutrition needs: - To eat in an upright position, to eat slowly, and to chew each bite thoroughly. - Provide Nutrition - Snacks. - Occupational Therapy (OT) and Speech Language Pathologist (SLP) to screen as needed. Provide adaptive equipment as recommended. - Provide extensive tray set up during meal times and assist as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The review did not include care instructions to place a clothing protector or tuck napkin into neckline during meals. Review of Resident #2's care plan included the following focuses and associated interventions: - Resident had a incapacity (statement) and a family member was healthcare surrogate (HCS) and durable power of attorney. (DPOA). - Resident had actual preferences related to hair styling and napping locations. The one intervention showed the resident wished hair to bed washed as tolerated and uncut or styled. - Resident had potential risk for Activities of Daily Living (ADL) self-care performance deficits related to (R/T) multiple listed diagnoses. The interventions included did not show the resident's or HCS's choice was for the resident to wear a clothing protector or a napkin to be placed in neckline during mealtime. Review of the care plan for Resident #2 did not include the resident or family member's choice for the resident to wear a clothing protector or for a napkin to be placed in the neckline of the resident's shirt during meals. Review of the facility policy titled, Feeding a Resident, Revised dated 8/24/2023 showed Policy: This facility will ensure that 1. Properly trained personnel supervised by nursing assist residents as needed with meals and snacks and feed residents who are unable to feed themselves. Procedure 3. Sit to assist resident with eating. 3. On 2/17/25 at 1:02 p.m., Resident #26 reported feeling abused by staff who spoke French during care and when realized the resident also spoke French the staff would switch to Creole. The resident stated she had not informed anyone about feeling staff were abusive by speaking another language during care. Review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #26 was readmitted on [DATE], with a preferred spoken language of English. The resident's Brief Interview for Mental Status (BIMS) score was 15 of 15, which indicated intact cognition. The functional assessment revealed the resident had range of motion impairment on one side of upper extremity and one side of lower extremity and required substantial/maximal assistance with toileting hygiene, bathing/showering and dressing. Review of the Resident Council minutes, dated 12/5/24, revealed Resident #26 had attended the meeting. The minutes discussed the council reported Residents feel Certified Nursing Assistants (CNAs) should not be talking to each other during care. The minutes revealed a staff education was attached which showed staff were to Focus on resident when providing care, engage resident in discussion if resident likes to talk. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 2:31 p.m. with the Executive Director (ED). The ED stated Resident #26's allegations were reported to state agencies and law enforcement. The ED stated the resident reported some aides (identified two) spoke in a language other than English while providing care and made the resident feel uncomfortable at times with the most recent episode this past weekend. The NHA reported she interviewed residents on Resident #26's hallway and no other resident reported having heard any staff speaking other languages during care. 4. On 2/17/25 at 11:07 a.m., Resident #72 reported staff would talk in a different language when inside the resident's room and spoke a different language while providing resident care for most of the weekend. On 2/17/25 at 11:47 a.m. Resident #72 reported the incident of staff speaking different languages was the same incident already mentioned in resident council (resident was not listed as an attendee on 12/5/24). The resident stated staff speak different languages to each other during resident care, mostly recently occurring this past weekend. Review of Resident #72's admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to unspecified peripheral vascular disease and type 2 diabetes mellitus with diabetic polyneuropathy. Review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #72's preferred language was English. The resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Review of Resident #72's electronic bedside care record showed staff were to honor resident wishes daily each shift. Review of the facility's corporate website, located at lcca.com/about/mission, revealed: - We believe our residents are our highest priority. - We believe in the preservation of dignity, self-respect and resident rights in a loving and caring environment. - We believe in the resident-centered approach to care in which the total needs of the residents are met. The resident's family is encouraged to become closely involved with the center in meeting the resident's needs.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure two (#49 and #141) of fifty- four sampled residents were assessed for self-administration of medications and failed to ensure physician orders had been obtained for medications observed on over-bed table of one (#141) of two residents observed. Findings included: 1. On 2/17/25 at 12:12 p.m., Resident #49 was observed speaking with a visitor while holding onto a nebulizer device. The observation showed the visitor leave the resident's room on 2/17/25 at 12:14 p.m. Resident #49 leaned over, turned on the nebulizer machine located on the bedside dresser, and put the nebulizer device to her mouth. The observation showed an aerosol-like mist coming from the end of the device. Review of Resident #49's admission Record revealed the resident was admitted on [DATE] and re-admitted on [DATE]. The record included diagnoses not limited to unspecified dementia unspecified severity without behavioral disturbance and chronic obstructive pulmonary disease (COPD) with (acute) exacerbation. Review of Resident #49's Medication Review Report, dated 2/18/25 at 3:42 p.m., did not reveal the resident had a physician order allowing for the self-administration of any medications. The orders showed an order for Ipratropium-Albuterol Solution 0.5-2.5 milligram (mg)/3 milliliter (mL) - 3 mL inhale orally via nebulizer every 6 hours as needed for shortness of breath. Lung sounds (LS) = C-clear, W-wheezing, R-rhonchi, CR-crackles, (or) D-diminished. Review of Resident #49's care plan included the following focuses with interventions: - Has altered cardiovascular status related to (r/t) diagnoses (dx) of A-fib, hypertension (HTN), (and) heart failure. The associated interventions instructed staff to assess for shortness of breath and cyanosis, and to observe and report as needed any changes in lung sounds on auscultation, edema, and changes in weight. - Has diagnosis (dx) of COPD. The interventions included to elevate head of bed in or out of bed during episodes of difficulty breathing, observe for difficulty breathing on exertion, and observe for signs/symptoms of acute respiratory insufficiency. The care plan did not include a focus or intervention showing the resident had been assessed for the self-administration of any medication. The facility did not provide the requested Self-Administration assessment for Resident #49. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 2/17/25 at 10:31 a.m., Resident #141 was observed lying in bed with an over-bed table within reach of the resident. A bottle of sore throat spray containing a green liquid was observed on the table. On 2/18/25 at 10:38 a.m., Resident #141 was observed lying in bed with the over-bed table within reach, the observation revealed a bottle of throat spray with the top off containing green liquid sitting on top of the table. On 2/18/25 at 10:40 a.m., the resident confirmed it was a bottle of [name brand] throat spray that was used when the resident feels something coming on. The observation showed a jar of mentholated topical ointment on the over-bed table next to the bottle of throat spray. During the interview Staff A, Licensed Practical Nurse (LPN)/Unit Manager (UM), entered the room and stated the resident's call light was on. The staff member shut the light off at the head of the resident's bed and informed the resident she would send staff in to assist the resident. On 2/18/25 at 10:44 a.m. an unknown Certified Nursing Assistant (CNA) was observed entering the resident's room with clean linens. On 2/20/25 at 8:57 a.m., Resident #141 was observed lying in bed. The observation revealed the bottle of throat spray and mentholated topical ointment continued to sit on top of the resident's over-bed table and within reach of the resident. The observation revealed another jar of what appeared to be mentholated topical ointment on the bedside dresser. The resident reported using the throat spray 1-2 times a month when feeling something coming on and puts the ointment up her nose. She said, There's a lot of sickness in here. On 2/20/25 at 9:06 a.m., Staff A observed the throat spray and mentholated topical ointment on top of Resident #141's over-bed table. Staff A reported not knowing about the throat spray or ointment at the resident's bedside. The staff member informed the resident the items would have to removed and a physician order would have to be obtained for their use. Review of Resident #141's Order Summary Report, active as of 2/20/25 at 4:44 p.m. did not reveal a physician order for the self-administration of any medication. The report did not reveal the resident had an order for any type of throat spray or mentholated topical ointment. The facility reported 0 residents self-administered (medications). During an interview on 2/20/25 at 3:09 p.m., the Director of Nursing reported the facility had started working on allowing certain residents to self-administer medication. Review of the policy - Self-Administration of Medications, revised 6/1/24, revealed the applicability, This policy 2.1 sets forth procedures relating to resident self-administration of medications. The procedure included: 1. The so they should comply with the facility policy, applicable law in the state operations manual with respect to resident self-administration of medications. 2. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the residence functionality and health condition. 5. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer. 6. Facility staff should order new and refill medications from pharmacy for residents who self-administer medications to provide access to inadequate supplies of medications. 9. Facility should document in the residence care plan whether the resident or facility staff is responsible for the storage of the resident's medications. If the resident is responsible for the storage of his/ her medications, for sale they should provide a secure compartment for storage of such medications in accordance with facility policy, applicable law, the state operations manual and as follows: - 9.1 The medication storage compartment should be located in the residence room so that another resident is not able to access the medications. - 9.2 The storage compartment should be locked when not in use. 10. Facility staff should document the self-administration of medications on the resident's medication administration record (MAR) according to the medication administration schedule. 11. Facility should document the self-administration and self-storage of medications in the residence care plan.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to file a grievance related to missing clothes for one resident (#57) out of eight residents sampled. Findings include: During an observation on 2/17/2025 at 9:00 a.m., and 12:00 p.m., Resident #57 was observed sitting on the side of her bed, fully dressed. She stated she had complained to the facility about her missing clothes, and nothing had been done about it. Resident #57 stated no one at the facility told her about the grievance process. Review of an admission Record dated 2/20/2025 showed Resident #57 was admitted to the facility originally on 5/3/2024 and readmitted on [DATE] with diagnoses to include but not limited to other specified fractures of left pubis, subsequent encounter for fracture with routine healing, pain in left hip. Review of a Minimum Data Set, dated [DATE] showed Section C, Cognitive Patterns, Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. During an interview conducted on 2/20/2025 at 12:30 p.m. with Staff E, Director of Housekeeping, Staff E stated Resident #57 reported to her that she was missing clothes. Staff E stated she was not able to find the clothing items Resident #57 reported and she did not assist Resident # 57 with filing a grievance. During an interview conducted on 2/20/2025 at 1:00 pm. with the Nursing Home Administrator (NHA), the NHA stated as soon as a complaint was brought to the staff's attention, she expected a grievance should be filed. The NHA stated for example, if a resident came to her about missing pajamas, she would expect a grievance to be filed, she would look at the inventory sheets to see if the items were inventoried, and they would come up with a resolution. Review of the facility policy titled, Grievance Program (Concern and Comment) Revised date 1/7/2025 showed Policy: 1. Residents and their families have the right to file a complaint without fear of reprisal. Upon request, the facility must give a copy of the grievance policy to the residents. Procedure 1. The facility will post in a prominent location throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously. 8. Following up with the residents and family to communicate resolutions or explanations and ensure that the issue was handled to the resident and family's satisfaction.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on record review and interview the facility failed to provide written notification to the resident and resident representative prior to an emergency transfer for one (#49) of two residents sampled for transfer and discharge rights. Findings included: Review of Resident #49's admission record revealed an initial admission date of 1/24/24, a transfer to the hospital on 1/30/25 and a readmission to the facility on 2/5/25. The admission record showed the resident was his own responsible party, and a family member was listed as the first emergency contact. A change in condition evaluation, dated 2/18/25, showed the resident had a large abscess to the left neck area and was having a slight issue with swallowing. An electronic transfer form dated 2/18/25 at 2:19 p.m. showed the resident was transferred to an acute care facility/hospital. Review of Resident #49's electronic record on 2/19/25 revealed no evidence of a written notice of transfer/discharge to the hospital to the resident for the 2/18/25 emergency hospitalization. An interview on 2/19/25 at 12:40 p.m. with the Executive Director (ED) confirmed Resident #49 was discharged to the hospital on 2/18/25, and it was a facility-initiated discharge. An interview was conducted on 2/19/25 at approximately 1:00 p.m. with the Social Service Director (SSD). The SSD reviewed electronic records and a stack of paperwork on his desk before reporting the written notice for the 2/18/25 transfer could not be found. An interview was conducted with Staff A, Licensed Practical Nurse (LPN)/Unit Manager (UM) on 2/19/25 at 1:23 p.m. The staff member stated during a transfer, staff complete a change in condition evaluation, a transfer form, an infection control evaluation, obtain a physician order to send to the hospital, and normally take the resident off the facility census. Staff A, LPN/UM stated she was present for Resident #49's transfer on 2/18/25. Staff A, LPN UM confirmed she did not provide a written notice of transfer/discharge to the resident prior to the transfer. On 2/19/25 at 1:36 p.m., the Director of Nursing (DON) brought Resident #49's hard chart and stated the SSD was making a copy of the transfer form. The DON stated the facility had 24 hours to provide a written notice of transfer/discharge to the resident. On 2/19/25 at 1:45 p.m., the SSD provided a Nursing Home Transfer and Discharge Notice (AHCA Form 3120) dated 2/18/25 for Resident #49. The SSD reported it was from the DON today (2/19/25), and per policy they have 24 hours to complete the form to allow for flex time. Review of the nursing home transfer form revealed the notice was documented as given to the resident on 2/18/25 with an effective date of 3/21/25. The reason for discharge or transfer was Your needs cannot be met in this facility with a brief explanation of MD [Medical Doctor] order to send to hospital for evaluation. The section marked Notice presented by: was signed and dated 2/19/25 by the SSD (as designee for the Nursing Home Administrator). The section marked Notice received by was documented verbal verification provided. Review of the signature line for the resident or representative name revealed the signature of the DON and Staff A, LPN/UM with a date of 2/18/25. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted with Staff A, LPN on 2/20/25 at 9:15 a.m. Staff A, LPN/UM reviewed the transfer notice signed and dated by her on 2/18/25 for Resident #49. Staff A, LPN/UM stated the reason the resident did not sign the form was because the resident had already left the facility, and it required the signature of two nurses after the resident left. Review of the facility policy titled Notice of Transfers and Discharges, revised on 10/29/24, revealed: Policy: The facility will provide notice to the resident and/or resident representative in situations where the facility initiates a transfer or discharge . Timing of the Notice: (ii). Notice must be made as soon as practicable before transfer or discharge when - An immediate transfer or discharge is required by the resident's urgent medical needs. Procedure: The facility ensures that systems are implemented to provide written notification to the resident and resident representative prior to transfer or discharge for facility-initiated transfers/discharges. This written notification is provided on the notice of resident discharge or transfer form. a. Florida facilities should utilize the Transfer Discharge Notice Form (AHCA Form 3120-0002). Emergency Transfers: -When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable before the transfer. During the interview with the SSD on 2/19/25 at 1:45 p.m. he stated the facility has a Quality Assurance and Performance Improvement (QAPI) plan on this. The SSD was asked to provide a copy of the QAPI plan at the time of interview. No documentation was provided prior to exiting the facility on 2/20/25.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10. Review of Resident #18's admission Record showed the resident was admitted on [DATE]. The record revealed the principal diagnosis was unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with additional diagnoses of cognitive communication deficit, other Alzheimer's disease, unspecified mood [affective disorder], and moderate recurrent major depressive disorder. Review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #18 had active diagnoses of Alzheimer's disease, non-Alzheimer's dementia, depression other than bipolar, cognitive communication deficit, and unspecified mood [affective] disorder. Review of Resident #18's Pre-admission Screening and Resident Review (PASRR) completed by Staff Q, Master Social Worker (MSW) on 2/16/25, did not show the resident had a primary diagnosis of dementia or a related neurocognitive disorder (including Alzheimer's disease). The screening revealed the resident had no diagnosis or suspicion of Serious Mental Illness or Intellectual disability and a Level II PASRR evaluation was not required. 11. Review of Resident #49's admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed diagnoses of unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified epilepsy not intractable without status epilepticus, unspecified altered mental status, unspecified recurrent major depressive disorder, adjustment disorder with anxiety, cognitive communication deficit, unspecified dementia unspecified severity with psychotic disturbance, unspecified insomnia, and unspecified convulsions. Review of Resident #49's Level 1 PASRR completed by Staff Q on 6/20/24, revealed the resident did not have either a depressive disorder or Epilepsy per documented history and medications. The screening completion showed the resident did not have a diagnosis or suspicion of serious mental illness or intellectual disability and a Level II PASRR was not required. Review of Resident #49's Minimum Data Set (MDS) dated [DATE] included active diagnoses of non-Alzheimer's disease, seizure disorder or epilepsy, and adjustment disorder with anxiety. The assessment did not include the resident's diagnosis of unspecified recurrent major depressive disorder. An interview on 2/19/25 at 10:46 a.m. was conducted with Staff Q and the Social Service Director (SSD). Staff Q acknowledged she did the PASSR assessments by looking at hospital records, diagnoses, and medications. Staff Q reported seeing the residents before the facility's attending physicians. Staff Q stated when the resident had a new diagnosis, the physician was spoken with, notes were reviewed, and a new document (PASRR) was generated, also the facility had a psych meeting every Tuesday and changes in diagnoses and medications were discussed during the meetings. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy - Pre-admission Screening and Resident Review, (PASARR) reviewed on 9/26/24 revealed the facility will ensure that potential admissions are to be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre screening is referred to as PASSAR level I, and is completed prior to admission to a nursing facility. A negative level I screen permits admission to proceed in ends the PASSAR process unless a possible serious mental disorder or intellectual disability arises later. A positive level I screen necessitates an in depth evaluation of the individual by the state designated authority, known as PASSAR level II, which must be conducted prior to admission to a nursing facility. 1. Ensure level 1 PASSAR screening has been completed on potential admissions prior to admission. 2. A negative level 1 screen permits admission to proceed and ends the PASSAR process unless a possible serious mental disorder or intellectual disability arises later. 3. A record of the prescreening should be retained in the residence medical record. 4. A positive level 1 screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASSAR level 2, which must be conducted prior to admission to a nursing facility. 5. When a level 2 PASSAR screening is warranted it must be obtained as well as determination letter prior to admission. The level II PASSAR cannot be conducted by the nursing facility. 6. With respect to the responsibilities under PASSAR program, the state is responsible for conducting the screens preparing the PASSAR report, in providing or arranging the specialized services that are needed as a result of conducting the screens. a. The state is required to provide a copy of the past our report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the state to provide. All other needed services are the responsibility of that facility to provide. 7. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The level II PASSAR determination and evaluation report specifies services to be provided by the facility and/ or specialized services defined by the state. 8. Recommendations from PASSAR level II determination and PASSAR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care. 9. As part of the PASSAR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder (MD) or intellectual disability (ID) has a significant change in their physical or mental condition. This will ensure the residents with a mental disorder or intellectual disability continue to receive the care and services they need in the most appropriate setting. 11. Facilities should look to their state PASSAR program requirements for specific procedures. PASSAR contact information for the SMH/ ID authorities and the state Medicaid agency. 13. Any resident with newly evident or possible serious mental disorder, ID or a related condition must be referred by the facility to the appropriate state designated mental health or intellectual disability authority for review. 14. Referral for a level 2 resident's review evaluation is required for individuals previously identified by PASSAR to have a mental disorder, intellectual disability, or a related condition who experiences significant change. 4. Review of the admission record for Resident #12 showed she was admitted to the facility on [DATE] with diagnoses to include dementia - 5/13/24, major depressive disorder - 5/13/24, and anxiety disorder - 5/13/24. Review of the level I PASRR for Resident #12 dated 5/14/24, revealed a qualifying secondary diagnosis of dementia was not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following the qualifying diagnoses. 5. Review of the admission record for Resident #126 showed she was admitted to the facility on [DATE] with diagnoses to include dementia - 7/9/24, Alzheimer's disease - 9/1/23, adjustment disorder - 11/29/23, and anxiety disorder - 9/13/23. Review of the level I PASRR for Resident #126 dated 3/22/24, revealed a qualifying diagnosis of Alzheimer's Disease was not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 6. Review of the admission record for Resident #140, showed she was admitted to the facility on [DATE] with diagnoses to include dementia - 9/4/24, Alzheimer's disease - 9/4/24, major depressive disorder - 9/4/24, and anxiety disorder - 9/4/24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the level I PASRR for Resident #140 dated 6/12/24, showed qualifying diagnoses of Alzheimer's Disease and dementia were not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 7. Review of the admission record showed Resident #130 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include dementia - 8/16/23, Alzheimer's disease - 11/8/22, mood disorder - 1/10/23, adjustment disorder - 1/10/23 and anxiety disorder - 4/16/24. Review of the level I PASRR for Resident #130 dated 6/20/24, showed qualifying diagnoses of Alzheimer's Disease and dementia were not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 8. Review of the admission record for Resident #23 showed she was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include dementia - 9/25/23, Alzheimer's disease - 7/26/21, mood disorder -11/30/22, adjustment disorder - 4/16/24, major depressive disorder - 7/26/21 and anxiety disorder - 4/16/24. Review of the level I PASRR for Resident #23 dated 6/21/24, showed qualifying diagnoses of Alzheimer's Disease and dementia were not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 9. Review of the admission record for Resident #54 showed she was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include psychosis - 8/8/13, mood disorder -7/24/24, dementia - 9/20/23, adjustment disorder with anxiety - 9/20/23, major depressive disorder - 8/8/13, and anxiety disorder - 7/1/24. Review of the level II PASRR for Resident #54 dated 3/22/24, showed Resident #54 was not rescreened after a new qualifying diagnosis in July 2024 for mood and anxiety disorders. The review showed a follow up Level I PASRR was not completed, and a level II was not resubmitted for consideration following qualifying diagnoses. Based on interview and record review, the facility failed to ensure Preadmission Screening and Record Review (PASSR) was completed accurately for eleven residents (#112, #144, #21, #12, #126, #140, #130, #23, #54, #18, and #49) out of 33 residents sampled. Findings included: 1. Review of the admission Record for Resident #112 showed the resident was admitted to the facility on [DATE] with diagnoses including major depressive disorder, generalized anxiety disorder, altered mental status (unspecified), and cognitive communication deficit. Review of Resident #112's most current Level 1 PASRR was dated 02/14/2023 revealed the PASRR did not show a diagnosis of dementia. Review of a physician progress noted dated 08/11/2024 revealed Resident #112 had a diagnosis of dementia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician progress noted dated 11/22/2024 revealed Resident #112 had a diagnosis of dementia. Review of a physician progress noted dated 02/10/2025 revealed Resident #112 had a diagnosis of dementia. Review of Resident #112's electronic medical record (EMR) and the resident's paper chart revealed no updated PASRR to reflect the dementia diagnosis. 2. Review of the admission Record showed Resident #144 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, adjustment disorder with depressed mood, dementia and altered mental status. Review of Resident #144's most recent PASRR, dated 02/16/2025, revealed Section 1: PASRR Screen Decision-Making, Section A and Section B did not have the diagnosis of Cognitive Communication Deficit noted. Section II Other Indications for PASRR Screen Decision-Making questions #5, #6 and #7 related to dementia were all answered no. 3. Review of the admission Record showed Resident #21 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder bipolar type, depression, anxiety disorder and seizures. Review of Resident #21's most current Level 1 PASRR dated 10/30/2024, revealed the PASRR did not show the diagnoses of epilepsy and dementia. Review of Resident #21 Minimum Date Set (MDS) Quarterly Assessment, dated 02/16/2025, revealed Section I - Active Diagnoses under the Neurological section Seizure Disorder or Epilepsy was checked as an active diagnosis. Review of a physician progress noted dated 07/14/2024 revealed Resident #21 had a diagnosis of dementia. Review of a physician progress noted dated 10/14/2024 revealed Resident #21 had a diagnosis of dementia. Review of a physician progress noted dated 11/19/2024 revealed Resident #21 had a diagnosis of dementia. Review of a physician progress noted dated 02/10/2025 revealed Resident #21 had a diagnosis of dementia. Review of Resident #21's electronic medical record (EMR) and the resident's paper chart revealed no updated PASRR to reflect the dementia and epilepsy diagnoses. During an interview on 02/19/2025 at 10:54 a.m., Staff Q, Social Worker (SW) said she was not aware of the diagnoses not listed on Resident's #21, #144 and #112 PASRR's. She said she would have to review the records. Staff Q said the facility did not do any dementia testing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide wound care in accordance with professional standards of practice and as ordered by the physician for one resident (#54) of two residents reviewed. Findings included: On 2/17/25 at 2:15 p.m., Staff H, Registered Nurse (RN) removed Resident #54's left foot covering. There were no dressings covering the medial and lateral foot wounds. Staff H checked the resident's footwear for bandages, none were found and said the dressings would be replaced immediately. Review of the admission record showed Resident #54 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include diabetes mellitus, and disorder of the skin and subcutaneous tissue. Review of care plan for Resident #54, initiated 12/18/18 showed: Focus-A diagnosis of Diabetes Mellitus; Goal- no complications related to diabetes; Interventions to include- check all of body for skin breaks and treat promptly as ordered by the doctor. Another care plan initiated 11/29/24: Focus-potential for impairment to skin integrity and discoloration related to age, thin fragile skin, impaired mobility, incontinence .; Goal-free of injury through review date; Interventions to include follow facility protocols for treatment of injury, weekly treatment documentation to include measurement of each area of skin breakdown . Review of Resident #54's Minimum Data Set (MDS) dated [DATE], Section GG, functional abilities showed for lower body dressing, substantial or maximal staff assistance was needed. Review of Resident #54's physician orders, titled active orders as of 2/19/25, showed orders dated 1/21/25 to include, 1. cleanse open wound on left lateral foot gently with normal saline and pat dry. Then apply Santyl ointment (nickel-thickness) over wound bed only. Then cover with calcium alginate wound dressing and secure with dry absorbent dressing as needed for wound healing. 2) cleanse open wound on left medial foot gently with normal saline and pat dry. Then apply Santyl ointment (nickel-thickness) over wound bed only. Then cover with calcium alginate wound dressing and secure with dry absorbent dressing as needed for wound healing. Order dated 2/18/25, verify placement of wound dressing on left lateral and medial foot on 7 a.m.- 3 p.m. and 3 p.m.-11 p.m. shifts. Dressing change performed by 11 p.m.- 7 a.m. nurse. If the dressing is absent, please redress these wounds. During an interview on 2/17/25 at 2:34 p.m., Staff I, Registered Nurse (RN), Unit Manager (UM) said Resident #54's wounds were expected to have dressings as ordered by the physician. During an interview on 2/19/25 at 3:28 p.m., Staff G, Licensed Practical Nurse (LPN), Wound Care nurse said Resident #54 had diabetic wounds on the medial and lateral left foot. Resident #54 often removed wound dressings. A rolled gauze was used to help with dressing securement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Treatment Orders, revised 7/9/24 showed the following: Policy-treatment orders are written per physician's orders. Procedure-1) after observation/ evaluation of the affected skin area the physician is notified. 2) The physician writes a treatment order 3) the physician order is followed, as are the manufacturer's instructions for use for each product ordered .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide proper foot care and treatment to maintain good foot health according to professional standards of practice for three residents (#134, #141, and #140) out of fifty-three residents sampled. Findings Include: 1. During an observation on 02/17/2025 at 9:20 a.m., Resident #134 was observed lying down in bed dressed in his night clothes. Resident #134's great toe was observed with the toe nail sticking out of a hole on his left sock. Resident #134 stated he really needed his toenails cut because they were causing his feet to hurt. He stated he had asked staff repeatedly to cut his toenails, but no one would listen to him. Resident # 134 gave consent to take a picture of his toenails. Photographic evidence obtained. During an observation on 02/18/2025 at 3:00 p.m., Resident #134 was observed lying down in bed dressed in his night gown. He stated he had requested to have his toenails and his fingernails cut but staff would not assist him. Review of an admission Record dated 2/20/2025 revealed Resident #134 was admitted to the facility originally on 12/2/2024 and readmitted on [DATE] with diagnoses to include but not limited to Type 2 Diabetes Mellitus without Complications, Difficulty in Walking, Not Elsewhere Classified. Review of an Active Order Summary Report dated 02/20/2025, showed an active prescriber written podiatry consult dated 1/29/2025. Further review of the same order summary report showed another Podiatry Consult was obtained on 2/19/2025. Review of a Minimum Data Set (MDS) dated [DATE], showed Section C- Cognitive Patterns, Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Further review of the MDS Section GG- Functional Abilities showed Resident #134 had functional limitation in range of motion due to impairment on one side on his lower extremity. Review of Resident #134 Care Plan created and revised on 12/5/2024, showed a focus for Resident #134 diagnoses of Diabetes Mellitus. Review of the same care plan showed the goal for Resident #134 will have no complications related to diabetes through the review date- date initiated 12/03/2024, revision on 12/31/2024, target date 03/04/2025. Review of the same care plan showed an intervention to refer Resident #134 to podiatrist/foot care as needed - date initiated 12/12/2024. During an interview conducted on 02/18/2025 at 2:00 p.m with Staff D, Certified Nursing Assistant (CNA), Staff D stated she did everything for Resident #134 related to his care. Staff D stated Resident #134 refused to take a shower, so she gave him bed baths. Staff D stated Resident #134's fingernails were dirty because he played with his bottom. She stated Resident #134 accused her of hitting him whenever she tried to clean his fingernails. Staff D stated Resident #134 had asked her to cut his toenails, but she told him she was not allowed to cut his toenail because the facility had special people to cut his nails. Staff D stated she could not remember if she reported to the nurse that Resident #134 needed his toenails cut. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 2/18/2025 at 2:30 p.m. with Staff C, Register Nurse (RN), Staff C stated he had worked at the facility for a year, and he was familiar with Resident #134. Staff C stated he checked the resident's skin every day and Resident #134's skin looked great. Staff C stated when he did skin checks he looked to see if there were changes in the resident's skin. Staff C stated during his skin check he looked at Resident #134's fingernails and toenails to see if there were any changes. Staff C stated Resident #134 had some dirt under his fingernails yesterday, but his toenails looked good when he did his skin check. Staff C stated nurses, and the podiatrist were responsible for making sure the residents' nails were kept cut and maintained. The unit managers and the wound care nurse were responsible for adding residents on the list to be seen by the podiatrist. Staff C later stated while looking at Resident #134's feet that he did not look at the resident's feet when he did his skin check yesterday. He stated he did not know that his toenails were in the condition they were, if he had seen Resident #134's toenails, he would have notified the unit manager so the resident could have been added to the list to be seen by the podiatrist. During an interview conducted on 02/18/2025 at 3:00 p.m. with Staff F, License Practical Nurse/ Unit Manager, Staff F stated the expectations were that resident's fingernails and toenails should be maintained. Staff F stated staff were not allowed to cut the resident's toenails at the facility. If a resident needed their toenails cut, and they were a diabetic, they would get a podiatry consult and refer them to the podiatrist. Staff F stated Resident #134's nurse should have reported to him the condition of the resident's toenail so he could have obtained a podiatry consult. During an interview conducted on 02/18/2025 at 4:00 p.m. with the Director of Nurses (DON), the DON stated all residents' skin should be assessed, once a week, and more often when staff were providing care. The DON stated not all residents were seen by podiatry, only the ones that had a problem with their toenails, for example, if a resident had long nails, pain or anything abnormal, then those were the ones that would get a podiatry consult. The DON stated Resident #134 should have been referred to be seen by the podiatrist. 2. On 2/20/25 at 8:57 a.m., Resident #141 was observed with an brown adhesive dressing on her thumb and ring finger of her left hand. The thumbnail extended approximately ½-3/4 inches past the fingertip and had a yellowish-orange substance built up underneath the nail. The fingernail of the ring finger appeared to be cut short and was covered by the adhesive dressing. The resident reported having a nail fungus and wished the facility would cut the nails but had not offered to do so. Resident #141 stated the toenails had not been cut since coming to the facility. On 2/20/25 at 9:06 a.m. Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM) stated she was unaware of the thumbnail and fingernail and informed Resident #141 she would cut them. The resident moved the blankets off her bilateral feet and showed the toenails bilaterally extended approximately ¼ past the end of toes and were thickened. The staff member asked if the resident was diabetic when the resident affirmed. The staff member stated the resident had been referred to podiatry last night, 2/19/25, after the toenails were observed and Staff A was unable to clip the toenails. Review of Resident #141's admission Record showed the resident had been admitted on [DATE]. The record revealed diagnoses not limited to Type 2 Diabetes Mellitus without complications and unspecified heart failure. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #141's February Treatment Administration Record (TAR) showed an order had been obtained at 11:09 a.m. and discontinued at 5:30 p.m. on 2/20/25 for staff to clean nail bed of the first and fourth finger of the left hand, cover with dry bandage until podiatry/derm(atology) gave different orders every evening shift every 3 day(s) for wound bed. An order had been obtained on 2/20/25 at 5:30 p.m. instructing staff to cleanse 4th finger on left hand with normal saline and cover with dry clean dressing every evening shift every 7 day(s) for cracked nail, to start on 2/21/25. The TAR did not show staff had obtained an order to place adhesive dressings on thumb or ring finger of left hand as observed on 2/20/25 at 8:57 a.m. Review of Resident #141's Weekly Skin Integrity Data collection dated 2/18/25 at 5:29 p.m., showed the resident had dry skin. The evaluation did not mention fingernails or toenails were to be assessed. Review of Resident #141's Nursing (NRSG) Monthly Summary dated 2/5/24 showed fingernails were cut as needed (PRN) by staff and toenails were cut by podiatrist. The summary did not have comments made regarding the condition of the residents fingernails or toenails. Review of Resident #141's Order Summary Report dated 2/20/25 at 4:44 p.m., revealed an order for a podiatry consultation was made on 2/19/25. 3. On 2/20/25 at 11:20 a.m., during an interview and observation assisted by Staff L, CNA, Resident #140's toenails were between 1/8 to 1/4 inch in length from the nailbed. The great toenails appeared thick and curving at the tip of the nail. All nails were pale yellow. On 2/20/25 at 11:20 a.m., during an interview Staff L said she did not cut Resident #140's toenails because the resident had diabetes. Review of admission record showed Resident #140 was admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus. Review of monthly nursing summary dated 2/3/25 showed Resident #140's toenails were cut as needed (PRN) by the nursing staff. Review of Resident #140's care plan showed the following: Focus: the resident has diabetes, initiated 9/9/24. The goal is the resident will have no complications related to diabetes. The interventions include refer to podiatrist for foot care as needed. Review of the policy - Nail Care, reviewed 9/10/24 revealed the resident will receive assistance as needed to complete activities of daily living (ADLs). Any concerns with skin or nails identified during completion of nail care should be reported to the nurse who will document and report to the practitioner as needed. The policy acknowledged foot care regulation to ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) provide foot care and treatment, in accordance with professional standards of practice, and including to prevent complications from the residents medical condition(s) and (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(ii) if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. For general fingernail care for most residents, the following procedure will be followed: 1. ensure your fingernails are clean and trimmed to avoid injury and infection. 2. Explain the importance of fingernail care to the resident. 3. Assemble all necessary equipment, which may include fingernail Clipper, nail file or [NAME] board, orange sticks, wash basin, towel, and any other necessary equipment. 4. Provide privacy and perform nail care. 5. Do not trim the nail below the skin line and not to cut the skin or cuticle. 6. Report any abnormalities to the nurse. Special care must be given to resident with certain underlying conditions such as Diabetes, Raynaud's Disease, and certain vascular disease. For this group of residents, the procedure for fingernail care will be modified as listed below: 1. ensure fingernails are clean and trimmed to avoid injury and infection. 2. Explain the importance of fingernail care to the resident. 3. Assemble all necessary equipment, which may include fingernail Clipper, nail file or [NAME] board, orange sticks, wash basin, towel, and any other necessary equipment. (continued on next page)

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	105792	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Winter Haven	1510 Cypress Gardens Blvd Winter Haven, FL 33884

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Provide privacy and perform nail care - Only licensed nurses are allowed to trim nails of residents in this group. Certified nursing assistants (CNAs) should file the nails. 5. Do not trim the nail below the skin line and not to cut the skin or cuticle. 6. Report any abnormalities to the nurse or practitioner as needed. For general toenail care for most residents, the following procedure will be followed, if after evaluation by the licensed nurse no contradictions are identified. Special care must be given to the resident with certain underlying conditions such as diabetes, Raynaud's disease, peripheral vascular disease, and other vascular disease. For this group of residents, the procedure for two nil care will be modified as listed below: 1. in general, residents that fall into this category should only have their toenails filed and not trimmed by the staff at the facility. 2. The staff should arrange for the resident to be seen by a podiatrist that either visits the facility periodically to provide services or sent to an independent Podiatry office for the evaluation and treatment. If during assessment by a licensed nurse, it is determined the residents nails need trimming prior to being seen by intermediate risk, a physician or licensed independent practitioner should evaluate and oversee the nail trimming process by a registered nurse. The physician or licensed independent practitioner will need to attest that prior to nail trimming, they have evaluated and determined the need for the toenails to be trimmed in the facility outweighs the risk of performing the trimming by a registered nurse. The registered nurse will follow the procedure below: 1. ensure toenails are clean and trim to avoid injury and infection. 2. Explain the importance of toenail care to the resident. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Assemble all necessary equipment, which may include fingernail Clipper, nail file or [NAME] board, orange sticks, wash basin, towel, and any other necessary equipment. 4. Provide privacy and perform nail care. 5. Do not trim the nail below the skin line and not to cut the skin or cuticle. 6. Report any abnormalities to the practitioner and/ or podiatrist.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, review, and interview, the facility failed to ensure the medication error rate was less than 5.00%. Thirty-three medication administration opportunities were observed, and fourteen errors were identified for six (#143, #37, #218, #117, #120, and #106) of eight residents observed. These errors constituted a 42.42% medication error rate. Findings included: 1. On 2/18/25 at 9:54 a.m. Staff B, Licensed Practical Nurse (LPN) obtained a blood pressure of 115/49 from Resident #143 and informed the resident that the blood pressure medication Hydralazine was going to be held for a while. On 2/18/25 at 9:58 a.m., an observation was made of Staff B dispensing the following medications for Resident #143: - Aspirin Enteric coated 81 milligram (mg) over-the-counter (otc) tablet - Magnesium oxide 400 mg otc tablet - Ferrous Sulfate 325 mg otc tablet The staff member confirmed dispensing 3 tablets for Resident #143, placed the tablets into a plastic envelope and crushed the tablets before placing the remnants into chocolate pudding. Staff B entered the resident's room and placed two individual spoonfuls of the pudding into the resident's mouth, followed by a nutritional supplement drink. The resident complained of a headache, rating the pain 8 of 10, and was offered Tylenol. The staff member returned to the medication cart and dispensed 2 tablets of Acetaminophen 325 mg, confirming the two tablets prior to the administration of the requested medication. An interview was conducted with Staff B on 2/18/25 at 10:09 a.m. The staff member stated some enteric coated medications can be crushed. Review of Resident #143's February Medication Administration Record (MAR) revealed the following issues with the resident observed administration: - Aspirin Tablet Chewable 81 mg - Give 81 mg by mouth one time a day for coronary artery disease (CAD). The staff member crushed an enteric coated Aspirin instead of the physician ordered chewable tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-

Docusate Sodium capsule 100 mg - Give 1 capsule by mouth two times a day for constipation. Continue until stools are soften. This medication was not observed, however Staff B documented it was given.

-

Hydralazine oral tablet 10 mg - Give 1 tablet by mouth three times a day for hypertension. The observation revealed Hydralazine was not administered and Staff B stated Hydralazine was to be held due to blood pressure. The MAR showed the medication was administered with a documented blood pressure of 115/49. The progress notes for the resident showed the staff member had documented on 2/18/25 at 9:57 a.m. Hydralazine 10 mg tablet was held due to low blood pressure (BP). The physician order did not include parameters in which staff were to hold for blood pressure readings.

Review of #143's Medication Admin Audit Report for 2/18/25 showed Staff B had documented hydralazine was administered on 2/18/25 at 9:57 a.m. and on 2/18/25 at 10:03 a.m. docusate sodium and aspirin 81 mg chewable was administered.

2. On 2/18/25 at 10:13 a.m., an observation was made of Staff M, Registered Nurse (RN) dispensing the following medications for Resident #37, the medication profile was colored red showing the medications were late:

-

Ferosol Iron 325 mg otc tablet

-

Multivitamin with mineral otc tablet

-

Eliquis 2.5 mg tablet

-

Nitrofurantoin Mcr 50 mg capsule

-

Sertraline HCl 25 mg tablet

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff member poured approximately 90 milliliters (mL) of a nutritional supplement liquid into a blue plastic cup. The staff member confirmed dispensing of 5 oral tablets (Sertraline had broken in half during the dispensing) then a half tablet of Sertraline fell out of medication cup. Staff M removed the other half from the cup, threw both halves away, and dispensed another 25 mg tablet of Sertraline. Resident #37 refused the nutritional supplement stating makes me throw up. The staff member administered the oral medications and on 2/18/25 at 10:21 a.m. documented the medications were given. Review of Resident #37's February Medication Administration Record (MAR) showed the psychotropic medication Sertraline, the antibiotic Nitrofurantoin, the multivitamin, and iron tablets were scheduled to be administered at 9:00 a.m. and the anticoagulant medication Eliquis was scheduled to be administered twice daily at 9:00 a.m. and 5 p.m. Review of Resident #37's progress notes for 2/18/25 did not show the physician was notified of the resident's scheduled medications had been administered late. 3. On 2/18/25 at 8:25 a.m., Staff N, LPN removed a wrist blood pressure cuff from the bottom drawer of the cart. The staff member dispensed the following medications for Resident #218: - Ferrous sulfate 325 mg otc tablet - Baclofen 5 mg tablet - Losartan potassium 25 mg tablet (placed in separate medication cup) The staff member entered the resident room and placed the blood pressure cuff on the resident's left wrist. The blood pressure obtained was 120/57. Staff N informed the resident the blood pressure was a little low for the Losartan and recommended the resident not take it. Staff N left the room and placed the Losartan tablet in the sharps container attached to the medication cart. Review of Resident #218's February Medication Administration Record (MAR) included the following physician orders: - Ferrous Gluconate oral tablet 324 (38 Fe) mg (Ferrous Gluconate) - Give 1 tablet orally two times a day for prophylaxis with meals. Scheduled times 7:30 a.m. and 4:30 p.m. - (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Losartan Potassium oral tablet 25 mg (Losartan Potassium) - Give 1 tablet by mouth one time a day for hypertension (htn). The MAR did not include parameters for the blood pressure medication to be held and the showed Staff N had documented the medication had been given. 4. On 2/19/25 at 8:51 a.m., an observation was made of Staff O, Registered Nurse (RN) dispensing the following medications for Resident #117: - Famotidine 20 mg tablet - Isosorbide Dinitrate 30 mg tablet - Labetalol 200 mg tablet - Clopidogrel 75 mg tablet - Amlodipine 10 mg tablet - Potassium chloride extended release (ER) 10 milliequivalents (meq) tablet - Metformin 1000 mg tablet - Divalproex delayed release (DR) 125 mg capsule - Aspirin enteric coated (EC) 81 mg otc tablet - Simethicone 125 mg otc tablet - placed in separate medication cup - Fish Oil 1000 mg otc capsule The staff member reported the resident was to receive Clonidine but had to check blood pressure prior to the administration. Staff O confirmed dispensing 11 tablets prior to entering the resident's room. The staff member obtained a blood pressure of 131/80 and a pulse of 90 from the resident's right arm. Staff O placed the 10 medications in the residents mouth with encouragement then placed the Simethicone tablet in the resident's mouth informing them to chew it. The staff member left the room (after verification the resident had swallowed the tablet) and reported Clonidine would be held due to the resident's blood pressure. Review of Resident #117's February MAR revealed the following issues: - Antacid Oral tablet chewable 500 mg (Calcium carbonate (Antacid)) - Give 1 tablet by mouth three times a day for upset stomach and heartburns. The MAR showed Staff O had documented this medication had been administered. - (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Loratadine 10 mg - Give 1 tablet by mouth one time a day for allergy symptoms. This medication was scheduled for 9:00 a.m. and not observed as administered. The review showed the resident did not have a scheduled or as needed (prn) order for Simethicone 125 mg chewable tablet. The resident did have an order for Simethicone suspension 40 mg/0.6 milliliter (mL) - Give 40 milligrams by mouth every 4 hours as needed for gas prn every bedtime (qHS), put in 8 ounces (oz) water. 5. On 2/19/25 at 8:39 a.m., an observation was made of Staff O, RN dispensing the following medications for Resident #120: - Amlodipine 2.5 mg tablet - Magnesium oxide 400 mg otc tablet The staff member stated the resident was to receive potassium but had to remove it from the machine due to it was not being here yet. Staff O went to the electronic medication dispenser and reported having to call the pharmacy as the potassium was not available. Staff O returned to the medication cart parked outside Resident #120's room, the resident was not in the room, the staff member searched the therapy departments without locating the resident. Staff O stated the 11 p.m. - 7 a.m. nurse had reported calling pharmacy (regarding the potassium) and she (Staff O) had called pharmacy yesterday and was told the potassium would be sent on the second round. The staff member placed the medication cup containing Resident #120's Amlodipine and Magnesium oxide on top of medication cart next to the insulated cooler containing pitcher of water then began the process of dispensing and administering medications for another resident. On 2/19/25 at approximately 9:08 a.m. Resident #120 returned to the room and Staff O administered the previously dispensed medications. The staff member stated therapy had informed her earlier that the resident's blood pressure was okay, normally would have taken it. Review of Resident #120's February MAR revealed the following Potassium order: Potassium Chloride (cl) tablet Extended Release (ER) 20 milliequivalents (meq) - Give 2 tablets by mouth one time a day for hypokalemia for 14 days. The MAR revealed Staff O documented Potassium was hold/see progress notes (7). Review of the electronic Medication dispenser showed the facility had Potassium Cl ER 10 meq capsules available. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 2/19/25 at 11:25 a.m., an observation was made of Staff P, Licensed Practical Nurse (LPN) obtaining a blood glucose level from Resident #106. The staff member cleaned the left pointer finger with alcohol pad, lanced it and obtained a sample from the first drop of blood. The glucometer measured a blood glucose level of 256. The staff member returned to the medication cart, removing the resident's insulin lispro 100 unit/milliliter pen. The staff member wiped the end of the pen with an alcohol pad before screwing on a needle. The staff member returned to the resident room, sanitized hands, placed the pen on a paper towel laid upon the over-bed table, and donned gloves. The staff member dialed the pen to 6 units and injected the insulin into the back of the resident's right arm, unscrewed the needle and placed it into the rooms sharp box. An interview was conducted with Staff P on 2/19/25 at 11:35 a.m. The staff member reported normally does prime the insulin pen with 2 units but today she had not. Staff P stated she knows she was supposed to. Review of Resident #106's MAR revealed the resident was to receive Insulin Lispro per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus (DM). The sliding scale showed the resident was to be administered 6 units for a blood glucose level of 256. During an interview on 2/19/25 at 5:12 p.m. the Director of Nursing (DON) stated the record should reflect what we are doing, late medications are medication errors and the process was to notify the physician, pharmacist, and family member, and to monitor the resident. She stated the physician was to be notified prior to administering late medications. The DON stated nurses are able to make nursing judgements related to holding the blood pressure medications. The DON reported staff were to prime insulin pens, crushing enteric coated medications are contraindicated, holding blood pressure medication would be specific to the resident condition, physician's would order blood pressure to be taken and (staff obtain) at least weekly blood pressures for residents. Review of the policy - Administration of Medications, reviewed 9/16/2024 revealed The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnosis in signs and symptoms. The facility must ensure that its medication error rates are not 5% or greater; and the facility must ensure that its residents are free from any significant medication errors. The policy defined medication error as This means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: 1. The prescriber's order; 2. Manufacturer's specifications (not recommendations) regarding the preparation in administration of medication or biological; or 3. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. The procedure revealed: 1. Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medications any skilled nursing facility. 2. Staff who are responsible for medication administration will adhere to the 10 rights of Medication Administration: a. Right drug. Every drug administered must have an order from the provider. Compare the order with the medication administration record (MAR) for accuracy. b. Right resident. c. Right dose. Check the MAR (medication administration record) and the doctor's order before medicating. Use standard measuring devices such as syringes, graduated cups, or scaled droppers. If there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering. d. Right route. e. Right time and frequency Check the order for when it would be given and when the last time it was given. f. Right documentation. Make sure to write the time and any remarks on the chart correctly. Medication administrations should be documented timely following the administration to the resident. g. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Right assessment. Note the resident's history in any parameters during Drug Administration. h. Right to refuse. i. Right evaluation/ response. j. Right education and information. 3. A physician order that includes dosage, route, frequency, duration, and other required considerations including the purpose, diagnosis or indication for use is required for administration of medication. 10. The facility should refer to their pharmacy manual for additional guidance and resources on medication administration common in conjunction with state-specific guidelines regarding the administration of medications. Review of the policy - Blood Glucose Monitoring, reviewed 9/23/24, revealed associate to obtain capillary blood glucose specimens will do so in accordance with their scope of practice and in accordance with all applicable local, state, and federal guidelines. Specimens will be collected in a manner that adheres to current standards of practice in infection control standards. Review of the pharmacy - Guidance for Using Insulin Products, copyrighted 2023, revealed: 7. Prime pen-like devices prior to each and every injection to minimize air bubbles. Dial units as per below guidance in push into a drop of insulin is seen at the top of the needle. If it does not appear after multiple attempts (i.e., 2-8 attempts - refer to prescribing an information for precise number), change the needle. The documentation revealed Insulin lispro pens should be primed with 2 units.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to obtain physician ordered laboratory testing for one (#141) of fifty-four sampled residents. Findings included: On 2/17/25 at 10:31 a.m. Resident #141 was observed lying in bed. The resident reported being woken up at 4 a.m. to give pills. Review of Resident #141's admission Record showed the resident was admitted on [DATE] with a diagnosis of unspecified hypothyroidism. Review of Resident #141's January and February Medication Administration Records (MAR) revealed the resident was receiving Levothyroxine sodium 100 microgram (mcg) daily for hypothyroidism. The medication was scheduled for 6:00 a.m. daily. Review of Resident #141's January Treatment Administration Record (TAR) revealed an order dated 1/6/25 for Thyroid-Stimulating Hormone (TSH), Free T4, and Parathyroid Hormone (PTH) to be drawn every night shift. This order was discontinued on 1/21/25. The TAR showed the laboratory testing had been administered (per chart code of checkmark) on 1/6 - 1/14, 1/18, and 1/19/25. Staff members documented 10 = Other/See progress note on 1/15-1/17/25. Review of laboratory requisitions for Resident #141's hallway showed the resident had an Albumin, Basic Metabolic Panel (BMP), Complete Blood Count (CBC) with differential, and Magnesium drawn on 1/6/25 and a Complete Blood Count (CBC) with differential on 1/15/25. Review of medline.gov revealed a CBC with differential measured the different sizes, numbers and types of cells including white blood cells, red blood cells, platelets, hemoglobin, hematocrit, and mean corpuscular volume (MCV). The website revealed a BMP measured glucose, calcium, sodium, potassium, carbon dioxide, chloride, blood urea nitrogen (BUN), and creatinine. The review showed neither CBC or BMP measured thyroid hormones. Review of Resident #141's provider's note dated 1/6/25 showed the plan was to check PTH (corresponding with the resident's January TAR). Review of Resident #141's progress notes related to the order for TSH, Free T4, (and) PTH showed the following: - 1/12/25 at 8:34 a.m. - Called Lab for a weekend STAT draw. I was told that order does not meet requirements. - 1/16/25 at 2:02 a.m. - order need clarification, it's has been on since 01/7. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/17/25 at 6:07 a.m. - order need clarification it's has been on since 01/7. - 1/18/25 at 12:07 a.m. - order need clarification it's has been on since 01/7. Review of Resident #141's available laboratory results from 1/20 to 2/19/25 revealed results had been obtained for a T3 uptake, T4 (thyroxine), and TSH on 2/19/25, approximately 30 days after the January order was discontinued. The facility was unable to provide any thyroid panel results from 1/6 to 1/19/25, the time in which staff had documented on January TAR the panel had been completed. During an interview on 2/20/25 at 3:21 p.m., the Director of Nursing stated the expectation was to get labs as soon as possible. She reported the process was to put the ordered tests into the lab portal. She said the laboratory vendor came to the facility every day except for Sunday.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, and interview, the facility failed to ensure direct care equipment was cleaned in between two (#149 and #218) of eight residents observed during the administration of medications. Findings included: On 2/19/25 at 8:17 a.m., an observation was conducted with Staff N, Licensed Practical Nurse (LPN) of the medication administration for Resident #149. The staff member removed a blood pressure wrist cuff from the bottom drawer of the medication cart and dispensed one 81 milligram (mg) chewable tablet of Aspirin, a half tablet of 20 mg Furosemide, and one 5 mg tablet of Lisinopril. Staff N placed the Lisinopril tablet in a separate medication cup then entered the resident's room. Staff N placed the blood pressure cuff on the resident's left wrist and informed the resident to lay arm on stomach. The staff member reported the first attempt to obtain blood pressure the cuff had registered an error. A second attempt was made with results of 101/48 and the staff member held the resident's Lisinopril. After administering the Aspirin and Furosemide, Staff N left the resident room, replacing the blood pressure cuff into the bottom drawer of med cart. On 2/19/25 at 8:25 a.m., a continued observation was conducted with Staff N of medication administration with Resident #218. The staff member opened the bottom drawer of med cart and extracted the wrist blood pressure cuff. Staff N dispensed the resident's medications, placing a 25 mg tablet of Losartan in a separate medication cup. The staff member entered the resident room and placed the blood pressure cuff on the left wrist, obtaining a blood pressure of 120/57. The staff member administered medications, holding the resident's Losartan before returning to the medication cart. An interview was conducted with Staff N on 2/19/25 at 8:35 a.m. The staff member reported having two blood pressure cuffs in the bottom drawer and one was observed in a fitted container, while the one used was sitting on med cart. Staff N confirmed using the same blood pressure cuff for Resident #149 and #218 and had not cleaned the cuff in between the residents. The staff member reported the cuff should have been cleaned between residents.