STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105324	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Center	301 S Bay St Eustis, FL 32726

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observation, interview, and record review, the facility failed to provide a safe, clean and homelike environment. (Photographic evidence obtained). Findings include: 1) During observations on 12/9/2024 at 9:33 AM, 12/10/2024 at 8:56 AM, and 12/11/2024 at 7:40 AM, on the 200 Unit East Wing, there was dirt, debris, and dried layers of red liquid and red stains on the floor tiles of the resident hallway outside the dining room and along the dining room wall. On the bottom corners of the left and right sides of the two door frames to the dining room, there was a buildup of dirt, chipped tiles on the floor, and chipped paint along the door frame and the door into the dining room. There were dried layers of dirt built up along the edges of resident rooms along the left and right side of the door frames and along the floor. There were large amounts of hair wrapped around each of the four wheels on the medication cart. There was dark dried liquid streaking down the backside of the medication cart. During an interview on 12/11/2024 at 7:40 AM, the Director of Environmental Services (EVS) confirmed the buildup of dirt and debris in the corners of the resident room door frames and two doors leading into the resident dining room, the red staining and buildup of dried red liquid and dirt along the hallway floors outside of the resident dining room, large amounts of hair wrapped in the wheels of the medication cart, and dried liquid spills down back of the medication cart observed on the East Wing of the residential unit. The Director of EVS stated, It's pretty dirty up here. I expect the floor techs [technicians] to be cleaning the spills off the floor and walls and cleaning the buildup of dirt and debris from the corners of the resident room doors and floors daily. The floor techs should be wiping down the medication cart daily and the wheels should not look like that [pointing to the hair wrapped around all four wheels of the medication cart]. This is not acceptable. During an interview on 12/12/2024 at 2:28 PM, when asked about the dirt, debris, and dried spilled red liquid on the floors, hair in the wheels of the medication cart in the hallways to resident rooms, the Administrator stated, They should be cleaning the floors and equipment daily. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an observation on 12/9/2024 at 10:30 AM, Staff K, Certified Nursing Assistant (CNA), was standing beside Resident #13's bed, that was unmade exposing the bare mattress, wearing a pair of gloves and getting a clean fitted bottom sheet for the resident's bed out of a clear plastic bag of linen on the bedside table. The bare blue foam mattress was worn, with the blue color fading, and there were several cracks in the mattress surface. There was a large indentation and sagging in the middle center of the mattress approximately one to one and a half inches deep and extended to the sides of the mattress and approximately 12 to 18 inches from the top to the bottom of the mattress. There was a darker wet-like appearance where the mattress was indented and sagging toward the center of the mattress covering the 12-to-18-inch perimeter. There was a very strong foul urine odor noted coming from the mattress. During an interview on 12/9/2024 at 10:31 AM, Staff K, CNA, stated, It looks wet right here [setting her gloved hand down in the center of the indented and sagging part of the mattress]. It smells bad too. I know it's not this linen, because the linen is not wet, it's clean. I was just starting to make the bed with this linen. The mattress is very bad. It's been that way for a long time. They know it's like this. During an observation on 12/11/2024 at 3:50 PM, the Director of Nursing (DON) entered Resident #13's room, approached the resident's clean made bed, and pulled the bedding down to expose Resident #13's bare mattress, and the large indentation and sagging in the middle. During an interview on 12/11/2024 at 3:50 PM, the DON confirmed the poor condition of the mattress, the sagging, indentations, fading color, cracks, and the foul urine smell coming from the mattress. The DON stated, I'm aware of the bad condition of [Resident #13's name] mattress. I see where it looks wet. I'm not going to touch it without gloves. I think maintenance was informed, but I'm not sure. With the mattress in this condition, it could cause issues like skin breakdown for the resident. During an interview on 12/12/2024 at 9:37 AM, the Director of Environmental Services provided a printed copy of the work order sheet [an electronic work order form used for building and furniture maintenance repair notification] for 12/1/2024 through 12/12/2024 and stated, There was no [name of work order platform] initiated for [Resident #13's name] for a mattress needed. I was not aware the mattress needed to be replaced. All staff can access the [name of work order platform] online and put in an order for repairs. 51447 3) During an observation on 12/9/2024 at 9:43 AM, Resident #79 was attempting to enter a housekeeping storage room door. The door had a keypad on the outside of the door. Resident #79 was opening the door without entering a code on the keypad. A facility staff member was heard saying, [Resident #79's name], you're not supposed to go in there. Resident #79 closed the door without entering the room. During an observation on 12/9/2024 at 9:45 AM, the housekeeping storage door was able to be opened without entering a code on the keypad to unlock the door. There was one bottle of [NAME] Neutral cleaner, one bottle of Reston heavy duty restroom cleaner, and one bottle of Greenex concentrated glass cleaner. There was also one aerosol can of stainless-steel cleaner in the left corner of the room on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/2024 at 9:49 AM, Staff L, Licensed Practical Nurse (LPN), stated, That door should not be unlocked. During an interview on 12/9/2024 at 9:50 AM, the Director of Nursing (DON) stated, I was not aware of the door lock being broken. My expectation would be that the doors are locked. During an interview on 12/9/2024 at 10:01 AM, the Assistant Maintenance Director stated, I was not aware of the lock being broken. During an observation on 12/10/2024 at 8:55 AM, a compartment located on the housekeeping cart was open, and the locking mechanism was not engaged. The compartment contained one bottle of Reston heavy duty restroom cleaner, one spray bottle with Reston heavy duty restroom cleaner, one bottle of Pro-Con Gold and one spray bottle with Pro-Con Gold inside, one bottle of concentrated glass cleaner and one spray bottle with the concentrated glass cleaner, one bottle of [NAME] Neutral cleaner and one spray bottle of Sani-Chem odor eliminator. During an observation on 12/10/2024 at 8:56 AM, Resident #97 and Resident #256 were sitting in the TV common area facing the housekeeping cart. There were no staff present within eyesight of the cart for two minutes. During an interview on 12/10/2024 at 9:32 AM, Staff M, Housekeeper, stated, The lock has been broken for about two months. When it initially broke, I told the Housekeeping Supervisor about it. During an interview on 12/10/2024 at 9:40 AM, the Housekeeping Supervisor stated, I was not aware of the lock on the cart being broken. During an interview on 12/12/2024 at 10:56 AM, the Maintenance Director stated he had no knowledge of locks being broken until the other day [12/10/2024]. 4) During an observation on 12/11/2024 at 9:32 AM, Resident #8's wheelchair cushion had a large rip in the front center. The wheelchair armrest on the right side was missing and the armrest on the left side was ripped on the edge. During an interview on 12/12/2024 at 8:43 AM, Staff L, Licensed Practical Nurse (LPN), stated that she was not notified of Resident #8's wheelchair condition, and the ripped portions would make sanitizing the cushion not possible. During an interview on 12/12/2024 at 3:20 PM, Staff N, CNA, stated, A resident can get hurt and you can't clean it properly. During an interview on 12/12/2024 at 1:40 PM, the Assistant Maintenance Director stated that he had not received any notification or work orders about [Resident #8's name] wheelchair armrests. Review of the facility policy and procedure titled Maintenance & Repair Policies with an effective date of 10/1/2024 read, The facility is maintained in good repair and kept free from hazards such as those created by any damaged or defective parts or equipment . Walls and flooring coverings are to be maintained in accordance with state and federal codes and regulations. Resident room furniture and mattresses are to be maintained in accordance with state and federal requirements.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41334 Based on observation, interview, and record review, the facility failed to ensure residents received oxygen as per physician order for 1 of 3 residents reviewed for respiratory care, Resident #94. Findings include: Review of Resident #94's admission record showed the resident was admitted on [DATE] with the diagnoses that include unspecified cardiomyopathy (a disease of the heart that makes it hard for the heart to pump blood), hypertensive heart disease with heart failure, old myocardial infarction (a heart attack), and chronic systolic (congestive) heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). Review of Resident #94's physician orders showed an order dated 12/6/2024 for administration of oxygen at 2 liters per minute as needed for shortness of breath. During an observation on 12/10/2024 at 9:10 AM, Resident #94 was in bed, receiving oxygen via nasal cannula. The oxygen concentrator was set a 4 liters per minute. During an observation on 12/10/2024 at 2:15 PM, Resident #94 was in bed, receiving oxygen via nasal cannula. The oxygen concentrator was set at 4 liters per minute. During an interview on 12/10/2024 at 4:20 PM, Staff H, Licensed Practical Nurse (LPN), stated, We will usually just check the oxygen when we give meds to make sure its running right. His is ordered for 2 liters not 4 liters. During an interview on 12/12/2024 at 8:47 AM, the Director of Nursing (DON) stated, I do expect staff to check oxygen and make sure they follow orders. When they do hand off, they should do that. Review of the facility policy and procedure titled Standards and Guidelines: Physician Orders with the last approval date of 11/25/2024 read, Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing. Procedure . 9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during the shift. The physician should be notified and the responsible party if indicated.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47275 Based on observation, interview, and record review, the facility failed to utilize the Quality Assessment and Performance Improvement (QAPI) process for staff identified quality deficiencies of water intrusion in the kitchen and failed to fully implement a quality improvement plan for the stripping and waxing of the floors to include resident areas, and the replacement of a soiled and damaged mattress. Findings include: 1) During an observation while conducting the initial tour of the kitchen on 12/9/2024 at 9:49 AM, water was dripping from the kitchen ceiling into two plastic bins located on top of a two-door convection oven that was in use at the time. There was a third plastic bin half full of water located on the floor to the right of the oven, that was catching dripping water from the ceiling. The convection oven was plugged into an electrical outlet, a toaster was plugged into the lower wall electrical outlet, both appliances were in use at the time of observations. Water was dripping out of the exit sign in front of the convection oven hood. About one-half inch of water standing from the back wall of the kitchen under the convection oven, leading to the double doors exiting to the main dining room of the facility. There was no Caution Wet Floor signs. There were four staff members working in the kitchen at the time of the observations. Staff D, Dietary Cook, and Staff E, Dietary Cook, were gathering supplies from the walk-in cooler bringing them to the prep line. Staff D and Staff E were walking through puddles of standing water. Staff F, Dietary Aide, and Staff G, Dietary Cook, were in the dishwashing room cleaning up from the morning meal service. During an interview on 12/9/2024 at 10:00 AM, the Director of Dietary Services stated, There was a small leak that started on Friday [12/6/2024]. Maintenance was working on it, but it has gotten worse since this morning. During an interview on 12/9/2024 at 10:10 AM, Staff E, Dietary Cook, stated, The leak started around 8:00 AM to 8:30 AM on Friday. I was here when it started. I notified maintenance when they arrived Friday morning, and the Maintenance Director started working on it. During an observation on 12/9/2024 at 10:15 AM, upon entry to the kitchen, there was standing water intrusion over the entire surface of the kitchen floor, from an eighth of an inch to one half of an inch, with the water depth being greater surrounding the convection oven, toaster, and steamer area. The convection oven was on and there were two trays of food being cooked. There was one plastic bin on the floor, and two plastic bins on the top of the convection oven. Each contained approximately three to four inches of standing water. The exhaust oven hood over the convection oven had a continuous flow of water coming down from the ceiling to the right side and front of the exhaust hood dripping into the bins. There was water dripping in a continuous moderate flow from the exhaust duct falling directly onto the top of the convection oven. Water was flowing down the right side of the convection oven onto the floor. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/9/2024 at 10:16 AM, water was actively dripping out of the exit sign in the ceiling in front of the convection oven hood. There were seven employees in the kitchen. Two employees were exiting the refrigerator area, walking through the standing water to the front of the kitchen. Three employees were on the food service hot line and two employees were observed in the office. All the utilities and water were on, and the staff were cooking using electrical appliance that were plugged into electrical outlets in the areas of the water intrusion. During an observation of kitchen area on 12/9/2024 at 10:17 AM, the ceiling tiles were removed, and water was running into an open electrical junction box located in the ceiling. The lid to the junction box was open and the wires were exposed. More ceiling tiles were removed exposing numerous patch attempts on all four copper lines. These patches consisted of hose clamps and rubber material. The water was flowing continuously over the exposed wires and along the air conditioning duct work. During an interview on 12/9/2024 at 11:40 AM, Staff D, Dietary Cook, stated, I became aware of the leak Friday between 8 AM and 9 AM in the morning. Maintenance was notified about 15-20 minutes after the leak started. During an interview on 12/9/2024 at 1:15 PM, the Senior Regional Maintenance Director stated, I was notified this morning by [Regional Maintenance Director's name] that there was a leak in the kitchen area this morning. To the best of my knowledge, there has been no maintenance performed to prevent the spraying of water within the kitchen area. During an interview on 12/9/2024 at 1:51 PM, the Regional Maintenance Director stated, There was no prior notification made in reference to a water leak in the kitchen. Upon arrival at the facility on December 9, 2024, at 10:40 AM, this was the first time the incident had been reported. There is nothing recorded in the electronic maintenance record keeping program in reference to the leak happening on Friday December 6, 2024. During an interview on 12/9/2024 at 2:02 PM, the Administrator stated, I was made aware of the situation this morning when I arrived at the facility. I was on paid time off last week. The Director of Nursing was on duty in my absence as the facility's point of contact person. During an interview on 12/9/2024 at 2:11 PM, the Director of Nursing (DON) stated, I was not made aware of a water leak in the kitchen area. I am aware the kitchen area has had several leaks in the past and they have been reported to the maintenance department. On Friday [12/6/2024], I was not aware of the leak that the kitchen staff reported to the Maintenance Director occurring approximately 7:00 AM to 8:00 AM. The Maintenance Director, who's been employed with the facility for three to four months has always been aware of past water leaks within the kitchen area. I was made aware of the hazard at 9:00 AM [12/9/2024] in the morning meeting that the administrative staff has. During an interview on 12/9/2024 at 2:44 PM, the Maintenance Director stated, I have been at this facility for about three months. I was notified of the water leaking on top of the appliances on Friday December 6. I notified [the Senior Regional Maintenance Director's name] on Friday December 6, 2024. I put a patch on Friday on another water leak, and the leak over the appliances was something new. I did not advise the DON of the water leak over the kitchen appliances on Friday [December 6, 2024]. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/2024 at 2:53 PM, the Plumber stated, When I got here, the water was shut off. I came here yesterday [12/9/2024] around 2-2:30. I was notified around 1 o'clock. I needed to remove all the copper [pipes]. There were three copper lines that were badly corroded. One had numerous rubbers [patches], clamps and rubber on it. This was a quick fix. We don't like using them at all [these types of repairs]. It's a quick fix, you still have a pinhole [leak], you are not fixing the actual pipe, you are just stopping it from leaking temporarily. There were four copper lines; one was the circulating pump, another line fed the bathrooms and the laundry room, and the other two lines fed the kitchen. I just replaced everything in the kitchen area. I looked into the kitchen area. I don't think these ones in the dining area needed to be changed [the pipes]. The water wasn't getting into the food per se, but the water was getting into the electrical. It is a hazard. I didn't see how bad they were leaking, but the pipes were in pretty bad shape. They needed to be replaced. Maintenance needs to check the electrical and the ceilings. An AC [air conditioning] guy, they should be looking at everything up in there. What they had was wire hangers, I put it above the supports and strapped it to that. They had bailing wire [ceiling tile wire]. There were two, one-inch lines that fed the kitchen. The water should have been shut off and the lines repaired, the rubber and clamps were a temporary fix. When it began to leak again the water should have been shut off. I saw signs that water had been dripping onto the electrical appliances, the ovens, and steamers. There were bins of water and water was still on the floors when I arrived. In some spots the water was maybe one half to one-inch, other areas had just a little water. There were signs that water had been coming from the vent onto the walls and the electrical sockets. There was a good amount of damage to the ceiling tiles. The ceiling tiles could have fallen in around the areas of the leaks. It all needs to be replaced. During an interview on 12/11/2024 at 1:25 PM, the Maintenance Director stated, I thought that I had fixed the leak on Friday after it was patched. The kitchen staff did not tell me about any other problems. I am on call and would have come in if they let me know. I was not on call on the weekend, [the Assistant Maintenance Director's name] was. The kitchen staff should have called us, they know they can call us. We should have known about this before Monday [12/9/2024]. During an interview on 12/11/2024 at 1:40 PM, the Assistant Maintenance Director stated, I was the admin [Administrator on call] this weekend. I was in the building over the weekend. I did rounds like I should. I wasn't told about any other leaks in the kitchen. I don't remember if I went into the kitchen or not. I did do some repairs to the leak; I think that was on Friday. The staff should have let me know there was a problem. I have known about leaks before, but they were patched up. I'm not sure why they didn't let us know about this. We should have known. During an interview on 12/11/2024 at 1:50 PM, the DON stated, I was aware that there are leaks in the kitchen, they have been leaking for a while. I think we have a QAPI on that. Well, that would be something we should QAPI if it's a problem. I am the administrator on call when [the Administrator's name] is out, not working. It would be my responsibility to do an ad hoc QAPI if we find a problem. All problems should be reported when [the Administrator's name] is away. I just wasn't told. I should have been told. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During observations on 12/9/2024 at 9:33 AM, 12/10/2024 at 8:56 AM, and 12/11/2024 at 7:40 AM, on the 200 Unit East Wing, there was dirt, debris, and dried layers of red liquid and red stains on the floor tiles of the resident hallway outside the dining room and along the dining room wall. On the bottom corners of the left and right sides of the two door frames to the dining room, there was a buildup of dirt, chipped tiles on the floor, and chipped paint along the door frame and the door into the dining room. There were dried layers of dirt built up along the edges of resident rooms along the left and right side of the door frames and along the floor. There were large amounts of hair wrapped around each of the four wheels on the medication cart. There was dark dried liquid streaking down the backside of the medication cart. During an interview on 12/12/2024 at 12:45 PM, the Administrator stated, I have an ongoing PIP for homelike environment for the second floor that I started on November 13, 2024. When asked the time necessary to clean the hallway the Administrator stated, Probably about a week. Review of the facility's Performance Improvement Plan dated 11/13/2024, read, Initiative/Goal: To ensure all residents are provided with a homelike environment. Initiative: Bolster home-like environment throughout [the facility name]. Action Steps: Strip and wax all VCT tile throughout the facility - Hallways/Resident rooms. Title DON [Director of Nursing], IDT [Interdisciplinary Team], Nursing Staff, Role [blank], Person Assigned [blank], Signature [blank]. During an interview on 12/12/2024 at 2:28 PM the Administrator confirmed the staining and the floors were in need of cleaning and stated, We have a plan and have not done the 200 East Hall yet. You have to strip down the layers of wax and replace it to create a barrier against spills and dirt build up. Spills happen all the time up there and it would be hard to keep it clean constantly. They should be cleaning the floors and equipment daily. 3) During an observation on 12/9/2024 at 10:30 AM, Staff K, Certified Nursing Assistant (CNA), was standing beside Resident #13's bed, that was unmade exposing the bare mattress, wearing a pair of gloves and getting a clean fitted bottom sheet for the resident's bed out of a clear plastic bag of linen on the bedside table. The bare blue foam mattress was worn, with the blue color fading, and there were several cracks in the mattress surface. There was a large indentation and sagging in the middle center of the mattress approximately one to one and a half inches deep and extended to the sides of the mattress and approximately 12 to 18 inches from the top to the bottom of the mattress. There was a darker wet-like appearance where the mattress was indented and sagging toward the center of the mattress covering the 12-to-18-inch perimeter. There was a very strong foul urine odor noted coming from the mattress. During an observation on 12/11/2024 at 3:50 PM, the Director of Nursing (DON) entered Resident #13's room, approached the resident's clean made bed, and pulled the bedding down to expose Resident #13's bare mattress, which had a large indentation and sagging in the middle. During an interview on 12/11/2024 at 3:50 PM, the DON confirmed the poor condition of the mattress, sagging, indentation, fading color, cracks, and a foul urine smell coming from the mattress. The DON stated, I'm aware of the bad condition of [Resident #13's name] mattress. I see where it looks wet. I'm not going to touch it without gloves. I think maintenance was informed, but I'm not sure. With the mattress in this condition, it could cause issues like skin breakdown for the resident. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 9:37 AM, the Director of Environmental Services provided a printed copy of the work order sheet [an electronic work order form used for building and furniture maintenance repair notification] for 12/1/2024 through 12/12/2024 and stated, There was no [name of work order platform] initiated for [Resident #13's name] for a mattress needed. I was not aware she needed a mattress replaced. All staff can access the [name of work order platform] online and put in an order for repairs. Review of the facility's Performance Improvement Plan (PIP) dated 11/25/2024 read, Initiative/Goal: Identify mattresses that need to be replaced. Initiative: 1. Room rounds were conducted and each mattress inspected for damage/wear and tear that need to be replaced. Action Steps . Order mattresses as need; maintenance to replace mattresses as needed. Review of the document attached to the PIP titled Mattress needs to be replaced dated 11/25/2024 read, Updates: 12/10 - mattress in [Resident #13's room number] replaced. Review of the facility policy and procedure titled Maintenance and Repair Policies with an effective date of 10/1/2024 read, The facility is maintained in good repair and kept free from hazards such as those created by any damaged or defective parts or equipment. Operating systems such as plumbing, electrical, communications, heating and cooling are maintained in compliance with state and federal codes and regulations . Walls and flooring coverings are to be maintained in accordance with state and federal codes and regulations. Resident room furniture and mattresses are to be maintained in accordance with state and federal requirements . Emergency repairs will be addressed immediately. The use of an electronic maintenance system is used to assist in the maintenance department in staying up with areas of concern. Review of the facility policy and procedure titled Quality Assurance and Performance improvement (QAPI) Program read, Policy Statement: This facility shall develop, implement, and maintain an ongoing, facility-wide data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Policy Interpretation and Implementation: The objectives of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and processes related to the delivery of quality of care and services. 4. Establish systems through which to monitor an evaluate corrective actions. Authority: 1. The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI program. 2. The governing board/owner evaluates the effectiveness of its QAPI Program at least annually and presents findings to the QAPI Committee. 3. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. 4. The QAPI Committee reports directly to the Administrator. Implementation: 1. The QAPI Committee oversees implementation of our QAPI Plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI Committee. 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance; b. Establishing goals and thresholds for performance measurement; c. Identifying and prioritizing quality deficiencies; d. Systematically analyzing underlying causes of systemic quality deficiencies; e. Developing and implementing corrective action or performance improvement activities; and f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.

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Bayview Center	301 S Bay St Eustis, FL 32726

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47275 Based on observation, interview, and record review, the facility failed to ensure the kitchen equipment utilized by staff was used under safe conditions and failed to maintain a safe working environment when a water leak had been identified in the ceiling and was not repaired causing standing water on the floor of the kitchen and on electrical equipment putting staff who enter and/or work in the kitchen at risk of possible electrocution and/or falls. Findings include: During an observation while conducting the initial tour of the kitchen on 12/9/2024 at 9:49 AM, water was dripping from the kitchen ceiling into two plastic bins located on top of a two-door convection oven that was in use at the time. There was a third plastic bin half full of water located on the floor to the right of the oven, that was catching dripping water from the ceiling. The convection oven was plugged into an electrical outlet, a toaster was plugged into the lower wall electrical outlet, both appliances were in use at the time of observations. Water was dripping out of the exit sign in front of the convection oven hood. About one-half inch of water standing from the back wall of the kitchen under the convection oven, leading to the double doors exiting to the main dining room of the facility. There was no Caution Wet Floor signs. There were four staff members working in the kitchen at the time of the observations. Staff D, Dietary Cook, and Staff E, Dietary Cook, were gathering supplies from the walk-in cooler bringing them to the prep line. Staff D and Staff E were walking through puddles of standing water. Staff F, Dietary Aide, and Staff G, Dietary Cook, were in the dishwashing room cleaning up from the morning meal service. During an interview on 12/9/2024 at 10:00 AM, the Director of Dietary Services stated, There was a small leak that started on Friday [12/6/2024]. Maintenance was working on it, but it has gotten worse since this morning. When asked if this was a safe environment for staff to be working in, the Director of Dietary Services stated, No. Not really. During an interview on 12/9/2024 at 10:10 AM, Staff E, Dietary Cook, stated, The leak started around 8:00 AM to 8:30 AM on Friday. I was here when it started. I notified maintenance when they arrived Friday morning, and the Maintenance Director started working on it. When asked if it is safe working around leaking water and electricity, she stated, No, I don't think it's safe to work around water and electricity. During an observation on 12/9/2024 at 10:15 AM, upon entry to the kitchen, there was standing water intrusion over the entire surface of the kitchen floor, from an eighth of an inch to one half of an inch, with the water depth being greater surrounding the convection oven, toaster, and steamer area. The convection oven was on and there were two trays of food being cooked. There was one plastic bin on the floor, and two plastic bins on the top of the convection oven. Each contained approximately three to four inches of standing water. The exhaust oven hood over the convection oven had a continuous flow of water coming down from the ceiling to the right side and front of the exhaust hood dripping into the bins. There was water dripping in a continuous moderate flow from the exhaust duct falling directly onto the top of the convection oven. Water was flowing down the right side of the convection oven onto the floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/9/2024 at 10:16 AM, water was actively dripping out of the exit sign in the ceiling in front of the convection oven hood. There were seven employees in the kitchen. Two employees were exiting the refrigerator area, walking through the standing water to the front of the kitchen. Three employees were on the food service hot line and two employees were observed in the office. All the utilities and water were on, and the staff were cooking using electrical appliance that were plugged into electrical outlets in the areas of the water intrusion. During an observation of kitchen area on 12/9/2024 at 10:17 AM, the ceiling tiles were removed, and water was running into an open electrical junction box located in the ceiling. The lid to the junction box was open and the wires were exposed. More ceiling tiles were removed exposing numerous patch attempts on all four copper lines. These patches consisted of hose clamps and rubber material. The water was flowing continuously over the exposed wires and along the air conditioning duct work. During an interview on 12/9/2024 at 11:40 AM, Staff D, Dietary Cook, stated, I became aware of the leak Friday between 8 AM and 9 AM in the morning. Maintenance was notified about 15-20 minutes after the leak started. I do not feel safe working around water and electricity. During an interview on 12/9/2024 at 12:39 PM, Staff F, Dietary Aide, stated, On Saturday [12/7/2024] morning when I came in at 11:30 AM, I was told it [the leaks] started on Friday. There were buckets to catch the leaks. They were drying the floors. They [maintenance] got their ladders and tools and were looking up in the ceiling when I was here on Saturday. We have continued to operate accordingly. During an interview on 12/9/2024 at 12:40 PM, Staff A, Dietary Aide, stated, The leak started on Friday. I'm not sure when they [maintenance] were notified. The water has been dripping on my head. It is not a comfortable feeling. I don't feel comfortable working around the water and electricity. Maintenance has been trying to fix it since Friday. During an interview on 12/9/2024 at 12:43 PM, Staff B, Dietary Aide, stated, I became aware of the leak in the kitchen on last Friday. I don't remember the time. I saw maintenance in the kitchen that day opening tiles on the ceiling. During an interview on 12/9/2024 at 12:49 PM, Staff G, Dietary Cook, stated, I worked Friday after 11 AM. The leak was occurring when I got here. [the Assistant Maintenance Director 's name] was checking it out. They said it started early that morning. I saw water dripping down by the oven, on the side to the front. There were buckets to catch the drips. I don't remember seeing any wet floor signs. I haven't been here since Friday. I came in at 11. I saw that the leak was still there, didn't look as steady a drip but still dripping [as of Friday]. There are buckets in place. I think there is one wet floor sign. I wasn't made aware of the electrical panel getting sprayed with water. When asked if you feel safe, Staff G stated, Yes and no. I'm not comfortable with the idea. During an interview on 12/9/2024 at 12:50 PM, Staff C, Certified Nursing Assistant (CNA), stated, I don't work directly in the kitchen, but I do go in and out when I am in the dining room assisting the residents. I knew about the leak last Thursday. I witnessed maintenance in the kitchen trying to work on it Friday. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/9/2024 at 1:15 PM, the Senior Regional Maintenance Director stated, I was notified this morning by [Regional Maintenance Director's name] that there was a leak in the kitchen area this morning. To the best of my knowledge, there has been no maintenance performed to prevent the spraying of water within the kitchen area. I recognize the hazard of potential slip and fall and possible electrocution as the water is running on top of a conventional oven and toaster. During an interview on 12/9/2024 at 1:51 PM, the Regional Maintenance Director stated, There was no prior notification made in reference to a water leak in the kitchen. Upon arrival at the facility on December 9, 2024, at 10:40 AM, this was the first time the incident had been reported. There is nothing recorded in the electronic maintenance record keeping program in reference to the leak happening on Friday December 6, 2024. During an interview on 12/9/2024 at 2:02 PM, the Administrator stated, I was made aware of the situation this morning when I arrived at the facility. I was on paid time off last week. The Director of Nursing was on duty in my absence as the facility's point of contact person. I do not believe that it is a safe environment for the employees to be working in the hazardous area. During an interview on 12/9/2024 at 2:11 PM, the Director of Nursing (DON) stated, I was not made aware of a water leak in the kitchen area. I am aware the kitchen area has had several leaks in the past and they have been reported to the maintenance department. On Friday [12/6/2024], I was not aware of the leak that the kitchen staff reported to the Maintenance Director occurring approximately 7:00 AM to 8:00 AM. The Maintenance Director, who's been employed with the facility for three to four months has always been aware of past water leaks within the kitchen area. I was made aware of the hazard at 9:00 AM [12/9/2024] in the morning meeting that the administrative staff has. During an interview on 12/9/2024 at 2:44 PM, the Maintenance Director stated, I have been at this facility for about three months. I was notified of the water leaking on top of the appliances on Friday December 6. I notified [the Senior Regional Maintenance Director's name] on Friday December 6, 2024. I put a patch on Friday on another water leak, and the leak over the appliances was something new. I did not advise the DON of the water leak over the kitchen appliances on Friday [December 6, 2024]. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/2024 at 2:53 PM, the Plumber stated, When I got here, the water was shut off. I came here yesterday [12/9/2024] around 2-2:30. I was notified around 1 o'clock. I needed to remove all the copper [pipes]. There were three copper lines that were badly corroded. One had numerous rubbers [patches], clamps and rubber on it. This was a quick fix. We don't like using them at all [these types of repairs]. It's a quick fix, you still have a pinhole [leak], you are not fixing the actual pipe, you are just stopping it from leaking temporarily. There were four copper lines; one was the circulating pump, another line fed the bathrooms and the laundry room, and the other two lines fed the kitchen. I just replaced everything in the kitchen area. I looked into the kitchen area. I don't think these ones in the dining area needed to be changed [the pipes]. The water wasn't getting into the food per se, but the water was getting into the electrical. It is a hazard. I didn't see how bad they were leaking, but the pipes were in pretty bad shape. They needed to be replaced. Maintenance needs to check the electrical and the ceilings. An AC [air conditioning] guy, they should be looking at everything up in there. What they had was wire hangers, I put it above the supports and strapped it to that. They had bailing wire [ceiling tile wire]. There were two, one-inch lines that fed the kitchen. The water should have been shut off and the lines repaired, the rubber and clamps were a temporary fix. When it began to leak again the water should have been shut off. I saw signs that water had been dripping onto the electrical appliances, the ovens, and steamers. There were bins of water and water was still on the floors when I arrived. In some spots the water was maybe one half to one-inch, other areas had just a little water. There were signs that water had been coming from the vent onto the walls and the electrical sockets. There was a good amount of damage to the ceiling tiles. The ceiling tiles could have fallen in around the areas of the leaks. It all needs to be replaced. During a telephone interview on 12/10/2024 at 3:17 PM, the Electrician stated, When I first arrived [12/9/2024], I spoke with [the Maintenance Director's name]. He walked me to the kitchen where there was the busted pipe above the oven and the grill. He pointed to a junction box on the ceiling above the range hood. It had water intrusion, once it received water, it arched out, it created a short an electrical grounding hazard at that location. The one junction box was fully submerged in the a/c duct work and was surrounded with water. I relocated the junction box. I blew it out, removed all the debris, made the proper repairs, then checked all the electrical areas running from there. It looked like water was splashed on them but not inside of them. I kept tracing the junctions that followed the pipes. It looked like the lights were dry. I checked connections on all of them. I put a marker with today's date on everything I looked at, so you would know where I went through the ceiling. The exit light was damaged, where it was no longer working. Other lights next to it had water damage and water around them, but no internal damage. There was water around the edges but not within the light. I would say, the circuit only blew up/blew out. Once I walked in, it was semi-dangerous with that exposed junction and the water. I moved it over, so it was no longer a danger. It possibly could have been an electrocution risk, being on top of the air duct. It can carry a conduction of electricity with the water. Prior to my arriving, there could have been a possibility of electrocution. There would have been no way [for staff] to safely move it [the junction box] before I arrived because the connections between the junction and the electrical box were touching and there was water. There was a risk of both fire and electrocution. It would not be safe to have people working in that area or have use of the electrical appliances during that time. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 1:25 PM, the Maintenance Director stated, I thought that I had fixed the leak on Friday after it was patched. The kitchen staff did not tell me about any other problems. I am on call and would have come in if they let me know. I was not on call on the weekend, [the Assistant Maintenance Director's name] was. The kitchen staff should have called us, they know they can call us. We should have known about this before Monday [12/9/2024]. During an interview on 12/11/2024 at 1:40 PM, the Assistant Maintenance Director stated, I was the admin [Administrator on call] this weekend. I was in the building over the weekend. I did rounds like I should. I wasn't told about any other leaks in the kitchen. I don't remember if I went into the kitchen or not. I did do some repairs to the leak; I think that was on Friday. The staff should have let me know there was a problem. I have known about leaks before, but they were patched up. I'm not sure why they didn't let us know about this. We should have known. Review of the facility policy and procedure titled Maintenance and Repair Policies with an effective date of 10/1/2024 read, The facility is maintained in good repair and kept free from hazards such as those created by any damaged or defective parts or equipment. Operating systems such as plumbing, electrical, communications, heating and cooling are maintained in compliance with state and federal codes and regulations . Emergency repairs will be addressed immediately. The use of an electronic maintenance system is used to assist in the maintenance department in staying up with areas of concern.