STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105455	A. Building B. Wing	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Placid Health and Rehabilitation Center	125 Tomoka Blvd S Lake Placid, FL 33852

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36678 Based on record review, interviews, observation, and policy review the facility did not ensure a care plan was developed for wandering for one (#65) of 40 sampled residents, and the facility failed to implement the plan of care for seizure precautions for one (#49) of 40 sampled residents. Findings included: 1. On 6/02/21 at 8:55 AM, an interview was conducted with Resident #7. Resident #7 reported that Resident #65 goes in everybody's rooms, takes things, puts the items in her room, and the staff get the items back. Resident #7 said he has found Resident #65 laying in his bed. The staff just let her do whatever she wants. Resident #7 had not talked to anyone in the facility about it because he didn't know who to talk to. Resident #7 stated the staff all know about it, but he thinks they don't watch Resident #65 good enough because there is not enough staff. A review of Resident #65's admission record revealed a diagnosis of Alzheimer's disease. A review of the quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment. Further review of the MDS, section E, behaviors, revealed wandering behaviors had occurred one to three days in the 7 day look back period. A review of Resident #65's care plan dated 3/15/21 revealed no evidence that a care plan for wandering behaviors had been developed. On 6/03/21 at 9:32 AM, Staff D, LPN (licensed practical nurse) MDS coordinator said, I don't see a wandering care plan. Social Services does the wandering care plans. I am not sure they do a care plan for the locked unit. On 6/03/21 at 9:42 AM, an observation was conducted on the Happy Trails secure unit. Resident #65 was not found in her room and could not be found anywhere in the hallway or common areas. Further observation revealed Resident #65 was in Resident #82's bed covered in blankets wearing her pajamas. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/21 at 9:47 AM, an observation and interview was conducted with Staff C, CNA (certified nursing assistant). Staff C, CNA said she has worked on the secure unit for five years. Staff C, CNA indicated Resident #65's room was not where Resident #65 was found by the surveyor. Staff C, CNA confirmed Resident #65 does wander. She said Resident #65 does have a wandering care plan, but she doesn't know what it is. Staff C, CNA also confirmed Resident #65 was in Resident #82's room in Resident #82's bed. Staff C, CNA said Resident #65 does it all the time. She wanders. Resident #65 also takes other residents' things sometimes. Staff C, CNA said, we try to redirect her. She takes shoes or blankets. None of the other residents have complained that she knows of. Staff redirect Resident #65 out of the room and show her where her room is. Staff C, CNA went into Resident #82's room and asked Resident #65 to come with her so she could show her where her room was. On 6/03/21 at 9:53 AM, an interview was conducted with Staff A, CNA. Staff A, CNA said she has worked on the secure unit about five years. Staff A, CNA said Oh yes, she wanders. Staff A, CNA also said Resident #65 has been found in other residents' beds. Staff redirect Resident #65 to her room and change the linens on the other resident's bed. Staff A, CNA said, we try to watch her very closely; try to redirect her. We try to keep a close eye on her. Other residents have told staff Resident #65 was in their room. If we see her we'll go get her. On 6/03/21 at 9:55 AM, an observation was conducted. Resident #65 was observed wandering through the hallway. She began following the nurse down the hall. On 6/03/21 at 9:57 AM, an interview was conducted with Staff B, LPN. Staff B, LPN said Resident #65 wanders a lot. She does wander into other residents' rooms. We have tried activities. She doesn't like them. We try redirection. Staff B, LPN said other residents have complained including Resident #7 and Resident #153. I have seen her come out with clothing items. She will give it to me. Staff B, LPN confirmed Resident #65 has been found in other residents' beds before. There are quite a few who get confused about their room. We coax her to come out. Sometimes we can talk to her and get her distracted, and sometimes she won't come out so we wait a little bit and try again. On 6/03/21 at 10:07 AM, another observation was conducted. Resident #65 was observed exiting room [ROOM NUMBER], which was not her room. Staff B, LPN invited Resident #65 to go to her room with her to change her clothes. On 6/03/21 at 10:24 AM, an interview was conducted with the Social Services Assistant (SSA). He said there used to be three social service staff members, but currently it was down to just himself. The SSA said he was definitively behind. The SSA said he does do the wandering care plans. We discuss it. We put them on the secure unit if needed. I don't think I probably wrote a care plan for her. On 6/04/21 at 9:34 AM, an interview was conducted with the DON (Director of Nursing). The DON said she would think a care plan for wandering would be created for a resident going into other resident rooms uninvited. The DON said just like a fall, it should probably be put in right away. Review of the policy Elopements and Wandering Residents, dated 2020, revealed the following: Policy: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their personalized plan of care addressing unique factors contributing to wandering or elopement risk. Definitions: Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. Policy Explanation and Compliance Guidelines: 3. The facility shall establish and utilize a systemic approach for monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement and Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 40775 2. A review of Resident #49's Medical Record revealed that Resident #49 was admitted to the facility on [DATE] with a diagnosis of epilepsy. A review of Resident #49's Physician's Orders revealed the following orders: - An order, dated 10/22/2020, for bilateral padded half side rails for bed mobility and seizures. - An order, dated 07/08/2020 for seizure precautions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order, dated 07/09/2020 for Keppra solution 100 milligrams (mg) per 1 milliliter (ml), administer 5 ml by mouth two times daily for seizures. A review of Resident #49's Care Plan revealed a problem, dated 07/27/2020, that Resident #49 had a diagnosed seizure disorder and was at risk for potential injury. Interventions included to administer seizure medications as ordered, place bed in lowest position for safety, and Resident #49 may have padded side rails. An observation was made on 06/01/2021 at 1:10 PM of Resident #49 resting in bed in her room. Resident #49 was observed to have bilateral half side rails to her bed and in the upward position. The side rails on Resident #49's bed were not observed to be padded. An observation was made on 06/02/2021 at 9:36 AM of Resident #49 resting in bed in her room. Resident #49 was observed to have one half side rail to her bed and in the upward position and the other one half side rail to her bed in the downward position. The side rails on Resident #49's bed were not observed to be padded. An interview was conducted on 06/04/21 at 8:50 AM with the facility's DON. The DON stated that Resident #49 was known to have a seizure disorder, but had not had a seizure in a long time. The DON also stated that the nursing staff had been putting padding on Resident #49's side rails but then stated I guess they don't need them anymore. The DON then stated that if Resident #49 had a physician's order for padded side rails then the side rails should be padded. The DON stated that she was not sure if Resident #49 needed the padded side rails anymore because she had been working as the DON at the facility for 2 months and no residents had experienced a seizure. The DON also stated that she would think that if Resident #49 had a diagnosis of a seizure disorder and was on medications for seizure, then the resident should have seizure precautions in place. The DON was not able to state whether or not Resident #49 had padded side rails in place. An interview was conducted on 06/04/2021 at 9:45 AM with Staff E, Certified Nurse's Aide (CNA). Staff E, CNA stated that she was not aware of Resident #49 having seizure precautions in place and addressed that Resident #49 did not have padded side rails. An interview was conducted on 06/04/2021 at 9:55 AM with Staff F, Licensed Practical Nurse (LPN). Staff F, LPN verified by looking at Resident #49's Physician's Orders that Resident #49 had an order for seizure precautions, but Staff F, LPN was not able to state what seizure precautions meant. Staff F, LPN addressed that Resident #49 did not have padded side rails but did have a physician's order for them.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews, and record reviews, the facility failed to properly assess the activity needs to ensure an individualized and meaningful activity program was developed for two (#49, #5) of three residents sampled for activities. Findings included: A review of Resident #5's Medical Record revealed that Resident #5 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, mood disorder, anxiety disorder, and age related cognitive decline. A review of Resident #5's Physician's Orders revealed an order, dated on 09/05/2020, for activities as tolerated. A review of Resident #5's Minimum Data Set (MDS) Assessment revealed, under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impact. A review of Resident #5's Care Plan revealed a problem, revised on 06/03/2021, that Resident #5 declined attending most group activities because of her condition and diagnosis. Interventions included to encourage and assist resident to activities of interest, offer books and magazines for entertainment, offer pet and volunteer visits when available, and offer spiritual visits when available. A review of Resident #5's Medical Record did not reveal an Activity Assessment. A review of Resident #49's Medical Record revealed that Resident #49 was admitted to the facility on [DATE] with diagnoses of alcohol induced persisting dementia, delusional disorders, anxiety disorder, and hallucinations. A review of Resident #49's Physician's Orders revealed an order, dated on 07/08/2020, for activities as tolerated. A review of Resident #49's Care Plan revealed a problem, revised on 07/27/2020, that Resident #49 declined activities because of her condition and diagnosis. Interventions included to encourage and assist resident to activities of interest, invite resident to outdoor activities, offer books and magazines for entertainment, offer pet and volunteer visits when available, and offer spiritual visits when available. A review of Resident #49's MDS Assessment revealed, under Section C - Cognitive Patterns, that a BIMS score was not recorded due to Resident #49 rarely or unable to be understood. A review of Resident #49's Medical Record did not reveal an Activity Assessment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 06/01/2021 at 11:45 AM of Resident #5 and Resident #49, who were roommates. Resident #49 was observed to be awake in her bed and dressed in a gown. Resident #49's television appeared to be on, but the volume to the television was turned all the way down. Resident #5 was observed resting in bed and dressed in a blue sweater. Resident #5 was observed to be awake and staring at the ceiling above her bed. No television, pictures, or music sources were observed on Resident #5's side of the room. An observation was made on 06/02/2021 at 09:33 AM of Resident #5 and Resident #49. Resident #49 was observed to be awake in her bed and dressed in a gown. Resident #49's television appeared to be on, but Resident #49 did not appear to be watching it. Resident #5 was observed awake and resting in bed. Resident #5 was observed to be staring at the ceiling above her bed. No television, pictures, or music sources were observed on Resident #5's side of the room. An observation was made on 06/03/2021 at 11:47 AM of Resident #5 and Resident #49. Resident #49 was observed to be awake in her bed and dressed in a gown. Resident #49's television appeared to be on, but Resident #49 did not appear to be watching it. Resident #49 was observed staring at the wall in front of her bed. Resident #5 was observed awake and resting in bed. Resident #5 was observed to be staring at the ceiling above her bed. No television, pictures, or music sources were observed on Resident #5's side of the room. An interview was conducted on 06/04/21 at 09:20 AM with Staff G, Activity Director (AD). Staff G, AD stated that residents were to be assessed within 5 days and quarterly for activity needs as well as with any significant change with the resident. Resident #49 enjoyed music activities and was able to clap along with music during the activity. Staff G, AD stated that Resident #49 was being kept in the bed more often and that staff had not been assisting her with getting out of bed to go to activities. Staff G, AD addressed that Resident #49 did not have an Activity Assessment documented in her record. Staff G, AD stated that Resident #5 had previously enjoyed activities such as folding clothing and that she often carried a baby doll around with her before her decline. Resident #5 required more 1 to 1 activities such as lotion therapy and music therapy due to her cognitive deficits. Staff G, AD stated that Resident #5 did not have an Activity Assessment completed until 06/03/2021 and addressed that the assessment should have been completed sooner. Staff G, AD expressed the importance of residents, especially those residents that were cognitively impaired to be encouraged and offered activities because it keeps their mind alive. A review of the facility policy titled Activities, dated only by year of 2021, revealed under the section titled Policy that it was the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility-sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the community. The policy also revealed, under the section titled Policy Explanation and Compliance Guidelines, that each resident's interest and needs would be assessed on a routine basis and shall include an activity assessment to include resident's interest, preferences, and needed adaptations. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. All staff will assist residents to and from activities when necessary.

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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** 40775 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure respiratory equipment was stored in accordance with professional standards of practice for one (Resident #195) of one resident sampled out of 12 residents in the facility receiving respiratory care and treatment. Findings included: A review of Resident #195 Medical Record revealed that Resident #195 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure, and Congestive Heart Failure (CHF). A review of Resident #195's Physician's Orders revealed the following orders: - An order, dated 05/06/2021 to change nebulizer tubing and external bag every Sunday on night shift. Date tubing and external bag. - An order, dated 05/06/2021 to change oxygen tubing and bag every Sunday on night shift. Label and date tubing. - An order, dated 05/12/2021 for Ipratropium-Albuterol solution 0.5-2.5 milligrams/3 milliliters, 1 dose inhalation every 6 hours for shortness of breath. - An order, dated 05/06/2021 for oxygen at 3 liters per minute via nasal cannula every shift for COPD, CHF, and shortness of breath. A review of Resident #195's Care Plan revealed a problem, dated on 05/12/2021, that Resident #195 exhibited or was at risk for respiratory complications related to diagnoses of CHF and COPD. Interventions included to medicate as ordered and provide respiratory treatment as ordered. An interview was conducted on 06/02/2021 at 09:38 AM with Resident #195. Resident #195 was observed to have a nasal cannula, which was connected to an oxygen concentrator. A storage bag was observed to be hanging from the oxygen concentrator, which was dated 05/17/2021. Resident #195 stated that staff had just changed all of his respiratory equipment and bags on 05/31/2021. Resident #195 also stated that he was administered breathing treatments via nebulizer machine 4 or 5 times a day. An observation was made of Resident #195's nebulizer machine and nebulizer mask and tubing. Resident #195's nebulizer mask was observed laying on Resident #195's bedside table and on top of a storage bag dated on 05/31/2021. Resident #195 stated that he had taken the nebulizer mask off of himself after the treatment and placed it on the bedside table because the nurse never came back to take it off. An observation was made on 06/03/2021 at 11:50 AM in Resident #195's room. Resident #195's nebulizer mask was observed sitting on the bedside table and on top of a newspaper. Resident #195's nebulizer mask was not stored in a storage bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/04/2021 at 10:09 AM with Staff F, Licensed Practical Nurse (LPN). Staff F, LPN stated that Resident #195 was administered respiratory medications through a nebulizer and that she stayed inside of the room during the administration. Nebulizer masks, respiratory tubing, and storage bags were to be changed out every Sunday on night shift. Staff F, LPN also stated that nebulizer masks were supposed to be kept inside of the provided storage bag when it was not in use. Staff F, LPN stated that normally she would not clean the nebulizer mask before putting it back into the storage bag and was not sure how the nebulizer mask could be cleaned. An interview was conducted on 06/04/2021 at 10:30 AM with Staff H, Registered Nurse (RN) Unit Manager and Assistant Director of Nursing. Staff H, RN stated that when nebulizer treatments were completed, the mask should be cleaned before placing it back into the storage bag and that respiratory equipment was changed out weekly on Sundays during the night shift, including the storage bags. An interview was conducted on 06/04/2021 at 12:39 PM with the facility's Director of Nursing (DON). The DON stated that it was her expectation that staff members should be storing respiratory equipment, such as nebulizer masks and oxygen tubing, inside of a storage bag when it was not in use and that nurse's should be wiping down the mask with soap and water before storage. The DON stated that respiratory equipment was supposed to be changed out every week, and she would expect nursing staff to return to the resident's room to ensure that respiratory equipment was properly stored, even if the resident was able to remove it themselves. A review of the facility policy titled Nebulizer Therapy, implemented in 2020, revealed under the section titled Care of the Equipment the following procedures: - Clean after each use. - Wash hands before handling equipment. - Disassemble parts after every treatment. - Rinse the nebulizer cup and mouthpiece with sterile or distilled water. - Shake off excess water. - Air dry on an absorbent towel. - Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. - Change nebulizer tubing every 7 days. Photographic evidence was obtained.