STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105643	A. Building B. Wing	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Island Lake Center	155 Landover Place Longwood, FL 32750

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 35086 Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services according to standards of practice for 1 of 1 resident reviewed for IV care, out of 32 total sampled residents, (#215). Findings: Resident #215 was admitted to the facility from an acute care hospital on 5/4/23 with diagnoses including fractured sacrum, diabetes, chronic kidney disease, and muscle weakness. Review of resident #215's medical record revealed a physician order dated 5/5/23 for 1 liter NS (normal saline) solution 0.9% at 75 ml. (milliliters) per hour x 1 only for BUN 111 (blood urea nitrogen) for 3 days. Blood urea nitrogen is a medical test that measures the amount of urea nitrogen found in blood . Normal human adult blood should contain 6 to 20 . (www.wikipedia.com). On 5/7/23 at 10:20 AM, resident #215 was observed lying in bed in her room. She had a midline IV inserted in her left upper arm with undated gauze dressing over the IV site. She was alert and oriented and stated she was getting IV fluids for dehydration. The 1000 ml. bag of 0.9% NS was hanging on the IV pole and was attached to the resident's midline IV left upper arm but was not infusing. The NS bag had 400 ml. of fluid remaining and was dated 5/5/23 with the time of 11:55 PM. A midline catheter is put into a vein by the bend in your elbow or your upper arm . The midline tube ends in a vein below your armpit .midline catheter may allow you to receive long-term intravenous (IV) medicine or treatments .(www.drugs.com). Review of the medical record revealed a contracted company's Registered Nurse (RN) had placed a midline IV catheter on 5/5/23 at 5:48 PM in resident #215's left basilic vein. (continued on next page)

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/23 at 10:35 AM, Licensed Practical Nurse (LPN) F said she was resident #215's assigned nurse yesterday and today on the day shift and was not aware the resident had an IV or fluids as she did not receive this information in report. LPN F validated the resident had NS bag of fluids still connected to the IV line dated 5/5/23 and timed 11:55 PM and it was not infusing. The nurse then opened the clamp on the IV tubing and the fluid did not drip. The LPN looked at the dressing and acknowledged it was gauze over the left upper arm IV site with no date. The LPN stated, IV tubing and fluids should be changed at least every 24 hours. On 5/7/23 10:45 AM, the Director of Nursing (DON) acknowledged resident #215's bag of IV fluids NS dated 5/5/23 with 400 ml. of fluid remaining and the IV site left arm with gauze over insertion site that was not dated. After reviewing the medical record, the DON verified that resident #215 had a 1-time order for IV fluids for hydration. The DON explained the nurse on 5/5/23 did not enter the batch orders into the electronic medical record and a task would not be generated for nurses to monitor the IV site each shift or make sure the fluids were infusing. She reported that 3 nurses worked on Saturday 5/6/23 and did not document monitoring the IV site or the bag of fluids hanging on the IV pole adjacent to the resident. The DON said nurses should have questioned the bag of normal saline IV hanging with no orders for monitoring. The DON added any of the nurses could have entered the needed batch orders for IV care/services for resident #215 whose fluids should have been completed by Saturday 5/6/23 at 1 PM. On 5/7/23 at 1:26 PM, after further review of the medical record, the DON said that although LPN D documented she hung the IV fluids on 5/5/23 at 11:54 PM, it was done by RN C. The DON added since RN C hung the IV fluids, he should have signed the medication administration record instead of LPN D. The DON verified there was no evidence in the medical record that once the IV was inserted and fluids were started on 5/5/23 that any further care/services were provided until the concerns were identified by the surveyor on 5/7/23 at 10:35 AM. The DON noted that because the orders were not entered correctly of Friday 5/5/23, the weekend supervisor RN was not aware the resident had an IV or IV fluids. The DON verbalized the IV batch orders included monitoring IV site, dressing changes and flushes. On 5/9/23 at 3:48 PM, during a telephone interview, LPN B verified she worked the 3 PM to 11 PM shift on Saturday 5/6/23 and was assigned to resident #215. She explained she did not receive report from the off going nurse that resident #215 had IV or was getting IV fluids. The nurse verbalized, she did see the bag of IV fluids hanging on the IV pole for resident #215 during her shift but did not look at the IV site left arm, nor did she notice if the fluids were infusing. LPN B stated she should have checked for the IV orders and if there were no orders, she should have informed the weekend supervisor or the DON. By the end of the survey, on 5/10/22, the DON did not provide an interview from LPN A who was agency nurse assigned to the resident on 5/6/23 to 5/7/23 on the 11 PM to 7 AM shift as the nurse would not return her calls. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure, Intravenous Administration of Fluids and Electrolytes, revised 3/28/2018, read, Staff will be knowledgeable regarding the safe and aseptic administration of intravenous fluids and electrolytes for hydration .Assessment: Inspect intravenous catheter and insertion site for signs and symptoms of complications at scheduled intervals [per facility policy], during routine site care and changing administration sets .Inspect solution for leaks, cracks, precipitate, and expiration dated .When infusion is complete: For intermittent therapy: Clamp tubing and disconnect from catheter. If tubing will be reused, replace sterile cap. Flush catheter per protocol .Documentation: The following information should be recorded in the resident's medical record .The condition of the IV site before and after administration .Quote from resident stating how they tolerated the procedure .Notify provider, supervisor, and oncoming shift of complications .Report other information in accordance with facility policy and professional standards of practice. The facility's policy and procedure, Midline Dressing Changes and Care, revised April 2016, read, The purpose of this procedure is to prevent catheter related infections associate with contaminated, loosened, or soiled catheter site dressing and care of the site .Care of Midline Site: Observed site for signs and symptoms of infections, redness, presence of edema or purulent drainage every shift. Observe for signs and symptoms of pain or discomfort at IV site and intervene appropriately .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview, and record review, the facility failed to act on physician order as per pharmacy recommendations for 1 of 5 residents reviewed for Medication Regimen Review (MRR) from a total sample of 32 residents, (#3). Findings: A review of the medical record revealed resident #3 was admitted to the facility on [DATE] and readmitted from an acute care hospital on 5/08/2022 with diagnoses including dementia, psychosis, delusional disorder, depression, anxiety, malnutrition, hemiplegia, diabetes, and hyperlipidemia. The Order Summary Report showed the resident had active medication orders including Risperidone 1 milligram (MG) at bedtime, and 0.5 MG once daily for psychosis, Lexapro 5 MG once daily for depression, Melatonin 3 MG at bedtime for sleep, Tramadol 50 MG as needed for pain, and Pravastatin 40 MG at bedtime for high cholesterol. The MRR dated 1/27/2023 noted a lipid profile blood test was recommended to monitor effects of Risperidone and Pravastatin. On 2/02/2023, the physician signed orders to follow the pharmacist's recommendations. Review of the February 2023 Treatment Administration Record documented nurses signed laboratory blood testing was completed on 2/02/2023 and 2/07/2023 for a lipid profile. Review of the resident's laboratory results showed there was not a lipid profile test completed on 2/02/2023 or 2/07/2023. On 5/10/2023 at 4:10 PM, the Director of Nursing said she was not able to locate records to show the physician's order for lipid profile on 2/02/2023 was completed. She explained the order should have been completed on 2/02/2023 or 2/07/2023 when nurses signed it as completed. She stated, I can't believe it didn't get done. The facility's policy titled, Medication Regimen Reviews dated May 2019, read, 4. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication., 5. to prevent, identify, report, and resolve medication related problems. f. potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences.