STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105205	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41837 Based on observations, interview and record review, the facility failed to treat residents in dignified manner during catheter care for 1 of 1 sampled resident observed for catheter care, Resident #35; during medication administration in the hallway for 1 of 25 sampled residents, Resident #249; and staff referring to residents who need assistance with dining as feeders. The findings included: Review of the facility's policy, titled, Dignity, with a revised date of February 2021, included in part the following: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times. 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. 1. On 10/02/24 at 10:59 AM, an observation was conducted of catheter care for Resident #35 performed by Staff K, Certified Nursing Assistant (CNA). Staff K adjusted the bed, pulled the covers down, said to resident I am going to remove your diaper as she was removing the adult brief from the resident. Once the CNA was finished with the catheter care, she then had resident roll side to side to remove and replace the pad under resident. The CNA then proceeded to place a new adult brief under the resident, and as she did, she asked the resident to turn again so she could but the diaper on him. An interview was conducted on 10/02/24 at 11:19 AM with Staff K who stated she has worked at the facility for 4 months. When asked about referring to the adult brief as a diaper, she said that is what it is. During an interview conducted on 10/02/24 at 11:46 AM with Resident #35 who was asked how it made him feel that Staff K CNA had referred to his adult brief as a diaper during his catheter care, he said it is not very nice. (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 - Few	2. On 10/01/24 at 5:00 PM, an observation was made of Staff C, Licensed Practical Nurse (LPN), who was administering medication to Resident #249 in the hallway next to the med cart. An interview was conducted on 10/01/24 at 5:07 PM with Staff C who stated she has worked at the facility since February 2024. When asked if she normally administers medications to residents in hallway next to the med cart, she said 'normally yes'. Staff C said sometimes it is the resident's choice. If the resident is in the hallway and asks for their medications and they are due to be given, she will give it. When Staff C was asked about administering medication in the hallway to Resident #249, the LPN said it that is the resident's choice. During an interview conducted on 10/01/24 at 5:15 PM with Resident #249 who was asked about the nurse administering her the medication in the hallway, how it made her feel, she said I don't want to get anyone in trouble. When asked if requested the medications be given to her while she was in the hallway, the resident refused to answer anymore of the surveyor's questions. 3. An interview was conducted on 10/01/24 at 5:11 PM with Staff C, LPN, who when asked about a tube feeding for a resident, she said she hung the tube feeding one hour early, because they usually get the dinner trays on the floor around 5:00 PM and they have a lot of feeders. She was asked if referring to residents who need dining assistance as feeders is something she normally does, she said 'yes, they all do it. There is a lot of staff that don't speak English to well, so we need to speak to them very clear about which residents need to be fed, so we call them feeders, it is just common sense.' 38893 4. During an observation of lunch being served to the residents in their rooms, on 09/30/24 at 12:40 PM, Staff B, RN/Unit Manager, was overheard by the surveyor calling to staff, Are you ready for a feeder, referring to Resident #201. Staff B then pulled a tray out of the cart containing the lunch trays and stated, she is a feeder, referring to Resident #199. When asked about referring to the residents as 'feeders' and labeling the residents, Staff B replied, If he's a feed, you have to stay in there with him (referring to #201). Staff B further stated that she was not aware of the facility's policy to not label residents in a manner such as referring to a resident as a 'feeder'.

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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** 41837 Based on observations, interviews and record review, the facility failed to implement care plans for 2 of 5 sampled residents reviewed for smoking, Residents #19, and #8; failed to implement care plans for 1 of 1 sampled resident reviewed with an urinary catheter, Resident #35; failed to implement care plans for 1 of 1 sampled resident reviewed with significant weight loss and receiving tube feedings, Resident #90; and failed to develop care plans for 1 of 1 sampled resident reviewed with a diagnosis of Post Traumatic Stress Disorder (PTSD), Resident #70. The findings included: 1. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Fracture of Humerus Right Arm Subsequent Encounter for Fracture with Routine Healing, History of Falling, Anxiety and Muscle Weakness (Generalized). Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 05/09/34 documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating an intact cognitive response. Review of the Nursing Progress Note for Resident #8 dated 08/18/23 documented the following: Resident AAOX3 (Awake, alert, and oriented times 3). Spoke to MD (Medical Doctor) about resident decision not to smoke anymore and asked to discontinue Nicotine patch and Spiriva. OK given verbally by MD. Review of the Nursing Progress Note for Resident #8 dated 09/10/23 documented the following: Resident AAOX3; no distress noted. Administer medications as per order with fluid. Resident started smoking again. Care rendered by staff. All safety measures in place; will continue to monitor. Review of the Nursing Progress Note for Resident #8 dated 12/20/23 documented the following: Pt [patient] complained of pain in lung area after coming back from smoking, pain pills provided to pt as requested. Pt taught to keep HOB [head of bed] elevated for lung expansion and comfort. Thoracic X-ray ordered for pt. Pt left awake, watching television with HOB elevated, all safety and comfort measures maintained. Review of the Smoking Risk Form for Resident #8 dated 12/01/23 documented in part the following: D Frequency: morning, afternoon, and evening E Safety: 6. resident can light own cigarette - yes 8. plan of care is initiated to assure resident is safe while smoking - yes. Review of the Smoking Risk Form for Resident #8 dated 10/01/24 documented in part the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D Frequency: morning and afternoon E Safety: 6. resident can light own cigarette - yes Resident need for adaptive equipment: 7c. supervision 8. plan of care is initiated to assure resident is safe while smoking - yes. On 09/30/24, review of the Care Plans for Resident #8 dated 12/04/24 with a focus on the resident chooses to smoke with a goal of the resident will remain free from injury was conducted. The interventions included: Instruct resident / family on smoking policy. Intervene promptly when smoking in an unsafe manner. Monitor for non-compliance with smoking policy. Resident may keep cigarette and smoking items in her possession. Cigarettes and lighter to be kept in a secure location. Smoking in designated area only. On 09/30/24 at 12:19 PM, an observation was made of Resident #8 with cigarettes, lighter in a Styrofoam bowl and vaping device on the overbed table. On 09/30/24 at 12:23 PM, an interview with Resident #8 was conducted who was asked if she was a smoker, she said, 'yes'. When asked if she has smoked since being admitted to the facility, she said, 'yes'. When asked if staff hold her cigarettes and lighter, she said, 'no, she holds them, and they know it.' When asked if staff supervise her while smoking, she said, 'they come in and out, its different staff all of the time.' On 10/01/24 at 10:17 AM, during a side-by-side observation with Staff B, Registered Nurse / Unit Manager (RN UM), she acknowledged the resident should not have the cigarettes, lighter and vape device at the bedside. Staff B took them and informed the resident she could not have those items at the bedside. On 10/01/24 at 10:30 AM, an interview was conducted with Staff B who was asked if residents are assessed for smoking, she said she does not do the smoking assessments, that would be administration. When asked how often the smoking assessments or evaluations are completed, she said she is not sure. When asked if a resident can have cigarettes, lighter and vape device at the bedside, she said no, it needs to be secured. An interview was conducted on 10/03/24 at 2:35 PM with Staff O, MDS coordinator, who stated she has worked at the facility for [AGE] years. When asked about care plans related to smoking, she stated she would not update smoking care plan unless the status changed regarding smoking. The smoking items, lighter and electronic cigarettes were not secured. 2. Record review for Resident #19 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cerebral Infarction, Type 2 Diabetes with Hyperglycemia, and Epilepsy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly MDS assessment for Resident #19 dated 08/29/24 revealed in Section C, a BIMS score of 13 indicating an intact cognitive response. Review of the Smoking Risk Form for Resident #19 dated 08/31/23 documented in part the following: D Frequency - evenings E Safety: 6. Can resident light own cigarette - no Resident need for adaptive equipment: 7a. Smoking apron 8. Plan of care is initiated to assure resident is safe while smoking - yes. Review of the Smoking Risk Form for Resident #19 dated 12/05/23 documented in part the following: D Frequency- morning, afternoon, and evenings E Safety: 6. Can resident light own cigarette - yes Resident need for adaptive equipment: 7a. Smoking apron 8. Plan of care is initiated to assure resident is safe while smoking - yes. Review of the Care Plan for Resident #19 dated 09/01/23 with focus on the resident chooses to smoke, documented the resident as: Non-compliant with smoking policy despite education. The goal was for the resident to remain free from smoking related injury. The interventions included: Cigarettes and lighter to be kept in a secure location. Instruct resident / family on smoking policy. Intervene promptly when smoking in an unsafe manner. Monitor for non-compliance with smoking policy. Smoking apron to be worn when smoking. Smoking in designated area only. Supervised smoking by staff member. An interview was conducted on 09/30/24 at 1:45 PM with Resident #19 who was asked how long she has smoked at the facility, and she said, 'years'. When asked about the covering (smoking apron) on her she said she, 'keeps it on the back of her wheelchair and puts it on herself when she comes out to smoke'. When asked if staff come out to supervise her smoking, she said, 'sometimes staff come out for a few minutes when they come out, but they do not come out every time'. When asked if she can light her own cigarettes, she said, 'sometimes she cannot, but most times she can.' When asked where her cigarettes and lighter are kept, she said, 'the nurse hold her cigarettes and lighter and give them to her when she asks then she will bring them back when she is done smoking.' (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 1:15 PM, Resident #19 was observed on the smoking patio with smoking apron partially covering her and she lit her own cigarette, and no staff member was present. At approximately 1:22 PM, Staff N, Certified Nursing Assistant (CNA), came to smoking patio to observe the resident. An interview was conducted on 10/02/24 at 1:20 PM with Staff M, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3-4 months. When asked about Resident #19, she said she was not aware the resident was an unsafe smoker until today. Staff M stated she holds the resident's cigarettes and lighter in the med [medication] cart. Staff M had come down this morning with the resident to smoking area and helped her with the smoking apron and with lighting a cigarette. There was another staff member on the smoking patio, and she was under the impression the staff member was assigned to the smoking patio to observe the residents. When the resident requested cigarettes to smoke around 1:10 PM on 10/02/24, Staff M gave the resident 2 cigarettes and the resident went downstairs, and she assumed the resident would be supervised by another staff member that she thought was assigned to the smoking patio. On 10/02/24 at 1:23 PM, a side-by-side observation with the Administrator was conducted of Resident #19 with smoking apron partially covering her and smoking a cigarette on the smoking patio. There was no risk assessment form since the 12/05/23 date, until after it was brought to their attention. 3. Record review for Resident #35 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 09/26/24 with diagnoses that included in part the following: Urinary Tract Infection (UTI), Acute Kidney Failure, Type 2 Diabetes Mellitus without Complications, Encounter for Fitting and Adjustment of Urinary Device, and Obstructive and Reflux Uropathy. Review of the MDS for Resident #35 dated 09/02/24 documented in Section C, a BIMS score of14 indicating an intact cognitive response. Review of the Physician's Orders for Resident #35 revealed an order dated 09/30/24 for Catheter / Foley: Catheter care every shift. every shift and as needed. Review of the Physician's Orders for Resident #35 revealed an order dated 09/26/24 for Eliquis Oral Tablet 5 MG (Apixaban) give 1 tablet by mouth two times a day for Atrial Fibrillation (Eliquis is a blood thinner). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #35 dated 09/05/24 and revised on 09/30/24 with a focus on the resident has an Indwelling Catheter r/t (related to) Obstructive Uropathy 16f/10cc documented the following: The goal was for the resident to be/remain free from catheter-related trauma through review date. The interventions included the following: The resident will show no s/sx [signs and symptoms] of Urinary infection through review date; Catheter: The resident has 16f/10cc. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Check tubing for kinks every shift. Enhanced Barrier Precautions: wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and catheter care. Monitor and document intake and output as per facility policy. Monitor for s/sx of discomfort on urination and frequency. Monitor / document for pain / discomfort due to catheter. Monitor / record / report to MD [Medical Doctor] for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of progress notes for Resident #35 for 10/02/24 revealed no documentation of the nurse contacting physician to report bleeding or pain during catheter care. On 09/30/24 at 12:55 PM, an observation was made of Resident #35 with an indwelling urinary catheter drainage bag on side of bed covered with privacy cover. An interview was conducted on 10/02/24 at 8:58 AM with Resident #35 who was asked if he recently went to the hospital for pain with his indwelling catheter, he said, 'yes'. He said they changed the catheter in the hospital, and he returned to the facility with the new catheter in place. When asked if the staff have been performing catheter care since he returned, he said, 'yes, they come and put cream on it'. On 10/02/24 at 10:59 AM, an observation was conducted of catheter care for Resident # 35 performed by Staff K, Certified Nursing Assistant (CNA). During the catheter care while washing the tip of the penis around where the catheter was inserted, there was blood observed on the white washcloth. Staff K then proceeded to dry the resident with a dry bath towel, and he screamed out in pain. An interview was conducted on 10/02/24 at 11:19 AM with Staff K who stated she has worked at the facility for 4 months. When asked if she notified the nurse about Resident #35 having pain and bleeding during catheter care, she said 'they already knows this'. An interview was conducted on 10/02/24 at 11:24 AM with Staff L, Registered Nurse (RN), who was assigned to take care of Resident #35 and stated she has worked at the facility for 1 year. When asked about Resident #35 and having any pain or bleeding with catheter care, she said before he had a UTI and went out to the hospital recently and just came back last week. She said sometimes he has pain with catheter care, and he has pain medication, but they only give him pain medication if he asks for it. When asked if the resident has pain with catheter care, she said, 'yes sometimes'. 4. Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Progressive Supranuclear Ophthalmoplegia [Steel-[NAME]-[NAME]] (a rare brain disease that affects walking, balance and eye movements and swallowing), Gastrostomy Status, Dysphagia, Crohn's Disease, and Parkinson's Disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment for Resident #90 dated 09/07/24 documented in Section C a BIMS score of 'could not be conducted due to the resident is rarely/never understood'. Review of the Physician's Orders for Resident #90 revealed an order dated 08/27/24 for Enteral Feed Order two times a day Give Osmolite 1.5 (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hours [hrs]) Give H20 (water) Flush (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm and was discontinued on 09/21/24 Review of the Physician's Orders for Resident #90 revealed an order dated 09/22/24 for Enteral Feed Order one time a day give Osmolite 1.5/1000ml @ @50ml/hour. Give H20 Flush/1000ml @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm and was discontinued on 09/26/24 Review of the Physician's Orders for Resident #90 revealed an order dated 09/27/24 for Enteral Feed Order one time a day via Gtube give Osmolite 1.5/1000ml @62ml/hr. give H20 flush/500ml @31ml/hr. Start at 5pm and run until complete (~16hrs) Total kcal 1500, Total Pro 62.7gm. See additional H20 flush order. Total Kcal 1500,Total Pro 62.7, Total Fluid 1620ml -and was discontinued on 09/30/24. Review of the Physician's Orders for Resident #90 revealed an order dated 09/30/24 for Enteral Feed Order one time a day via Gtube give Osmolite 1.5/1000ml @62ml/hr. give H20 flush/500ml @62ml/hr. Start at 5pm and run until complete *See additional H20 flush order. Total Kcal 1500, Total Pro 62.7, Total Fluid 1620ml. Review of the weights for Resident #90 revealed the following: On 08/27/24 at 10:25 AM, the resident weighed 92.0 Lbs (pounds) via Mechanical Lift. On 08/27/24 at 4:20 PM, the resident weighed 92.0 Lbs via Mechanical Lift. On 08/27/24 at 4:22 PM, the resident weighed 92.0 Lbs via Mechanical Lift. On 08/27/24 at 5:06PM, the resident weighed 92.0 Lbs via Mechanical Lift. On 09/05/24 at 9:54 AM, the resident weighed 82.0 Lbs via Standing. On 09/27/24 at 4:35 PM, the resident weighed 83.0 Lbs via Standing. In summary, this indicated form 08/27/24, to 09/05/27, the resident lost 10 Lbs which is a significant 10.87% Loss. On 10/01/24 at 10:15 AM, Resident #90 was weighed with the Staff J, Restorative Aide, the Director of Nursing and the surveyor present. The resident weighed 77.6 Lbs which indicated the resident has had a weight loss of 14.4 pounds from 08/27/24 to 10/01/24 which was a significant weight loss of 15.65%. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Risk Assessment for Resident #90 dated 08/26/24 included the following in part: Continuous feeding - Osmolite 1.5 (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hours) give H20 Flush (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total feeding - Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm, Free water 1762ml. Estimated Nutritional Needs (Kcal/kg): 42 x 35-40= 1470 - 1680; Protein: 42 x 1.2 - 1.3 = 50-55: MDS Triggers BMI <18.5 or >/= 24.9. Care plan resident will gain 1-21 lbs/month by nrd (next review date). Review of the Care Plan for Resident #90 dated 09/02/24 with a focus on the resident required tube feeding for nutritional support BMI [Body Mass Index] 16. Dx (Diagnosis) dysphagia. The goals were for the resident to tolerate tube feeding without complications such as: aspiration, infection, abdominal pain/distention, dehydration, diarrhea, constipation/fecal impaction, vomiting and the resident will gain at least 1-2 lbs monthly by next review date 12/11/24 . The interventions included: Monitor labs when available - report abnormal data to physician / provider promptly. Monitor tolerance of tube feeding. Monitor weight monthly / weekly. Provide tube feeding as ordered. Provide water flush as order. Review of the Nutrition / Dietary Note for Resident #90 dated 09/05/24 included the following: Resident's care plan meeting today with resident's [spouse], MDS nurse, Therapy director and this RD. Tube feeding regimen reviewed with resident's [spouse]. Resident has been tolerating tube feeding. [The spouse] is in agreement with poc [plan of care] regarding tube feeding at this time. Weight gain desired as [spouse] stated that resident had lost weight prior to admission. Current tube feeding will provide enough calories for gradual weight gain. F/U [follow up] for weekly weight x 3. Adjust poc as needed. Review of the Nutrition / Dietary Note for Resident #90 dated 09/09/24 included the following: Resident's weight on 09/05/24 was 82lbs. Admit weight recorded as 92lbs. Resident is NPO [nothing by mouth] on tube feeding which is providing adequate nutrition / hydrations. F/U with resident's [spouse] who stated she is definitely not 92. [The spouse] stated that she was 78 in the hospital and that he observed her being weighed in this facility on standing scale at 82lbs. 92 lbs may have been an error in recording the weight. Will request reweigh as gradual weight gain is desired. Current estimated needs = 37 x 35-40 = 1295-1480 calories/day, 37 x 1.2 -1.3 = 44-48 gm protein /day, 37 x 30-35 = 1110-1295 ml fluid. F/U for reweigh. Per nursing resident is tolerating tube feeding well. Adjust poc as needed. Review of the Nutrition / Dietary Note for Resident #90 dated 09/26/24 included the following: Resident's tube feeding to be adjusted. Recommend changing to Osmolite 1.5/1000ml @ 62ml/hour via G Tube. Start at 5pm and run until complete (~16 hrs) H2O flush/1000ml @ 31ml/hour via G tube with total of 500ml H20. Start at 5pm and run ~16 hrs. Tube feeding will provide 1500 kcal, 62.7 gm protein, 1262 free H20. Recommend H20 flush 120ml once daily via G tube. Total free water 1382ml Weight 82lbs. Tube feeding provides 40 kcal/kg, 1.6 gm/kg protein, Total free water 37ml/kg. F/U for tolerance/weight/changes. Adjust POC as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/01/24 at 12:12 PM with spouse of Resident #90 who stated the resident's normal body weight was 135 pounds and the last time she was weighed her normal body weight was in March. He said this disease is terrible and now she cannot swallow so she has to be on tube feeding. He said they had some kind of meeting when his wife first arrived at the facility just over a month ago. He expressed his concern over his wife's weight and does not want her to lose any more weight and hopes she can gain weight. He said during that meeting was the only time he talked to the dietician, and they told him they would adjust the tube feeding as they went along. He stated he was never told she had any weight loss since being in the facility, he was under the impression she would have gained weight, but nobody really talks to him or answers question when he asks. He said he comes to the facility just about every day and he sees the tube feeding bottle off and still has about 3 inches of tube feeding left in it and they throw it away and start a new bottle later. He feels she may not be getting all of the tube feeding she is supposed to for this reason. On 10/02/24 at 10:31 AM, an observation was made of Resident #90 sitting up in bed with bottle Osmolite 1. 5 tube feeding below the 200 mark out of a 1,000-milliliter capacity bottle. The tube feeding was infusing via pump at 62 milliliters per hour. The tube feeding bottle was labeled with start date of 10/01/24 at 4:00 PM. An interview was conducted on 10/03/24 11:18 AM with the Registered Dietician (RD) who stated she has worked at the facility for [AGE] years and is full time since June 2024. When asked about residents who receive tube feeding, she said for a resident receiving tube feeding, she would generally not expect to see weight loss. She stated she rounds to spot check resident to make sure the tube feeding orders are followed as ordered. When asked about Resident #90 and weight loss, she said when the resident was admitted , she weighed 92 pound and on 09/05/24 she weighed 82 pounds. When asked if that was a significant weight loss, she said, 'yes it was 10%'. When asked what interventions were put in place, the RD stated that on 09/05/24 she did not change the tube feeding orders because it was meeting the resident needs even though she had a 10% weight loss but after her conversation with the husband on 09/09/24, he reported her weight from the hospital was 78 pounds and she was definitely not 92 pounds, and he had observed her being weighed on the standing scale at 82 pounds. 49060 5. Review of the facility's policy, titled, Trauma-Informed and Culturally Competent Care, dated 05/19/23, included the following: Resident Care Planning 1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. 3. Recognize the relationship between past trauma and current health concerns (e.g., substance abuse, eating disorders, anxiety, and depression). (continued on next page)

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Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review for Resident #70 revealed that the resident was admitted to the facility on [DATE] with diagnoses that included: Malignant Neoplasm of Endometrium, Bipolar Disorder, Psychosis Not Due to a Substance or Known Physiological Condition, Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). Review of Section C of the MDS dated [DATE] revealed that Resident #70 had a BIMS score of 15, which indicated that she was cognitively intact. Review of section I revealed Resident #70 diagnosis included: Bipolar Disorder, Psychotic Disorder, Depression, PTSD, and anxiety disorder. Review of Resident #70's Care Plans dated 08/12/24 revealed there was no care plan developed to address PTSD, which would have included implementation of individualized interventions. An interview was conducted on 10/02/24 at 1:31 PM with Staff O, MDS coordinator, who stated she has been working at the facility for [AGE] years. She stated she uses the information from the resident assessments, notes, and physician orders to put together the resident's MDS and care plans. Staff O acknowledged that for Resident #70's care plan dated 08/22/24, her diagnoses were added including anxiety, psychosis, and depression along with individualized interventions, but the PTSD diagnosis was not used because she felt it was covered under those diagnosis. Staff O was unsure if there was anything under the MDS coding for PTSD. An interview was conducted on 10/02/24 at 4:59 PM with the Social Services Director (SSD), who stated she has been working at the facility for [AGE] years. She stated the resident's diagnoses are derived from the hospital documentation when the resident is transferred to the facility, and the physician would be the one to diagnose the resident with PTSD. The SSD stated during Resident #70's initial assessment, the resident was not assessed for PTSD and the resident did not show signs of any acute PTSD. She acknowledged not questioning Resident #70 about her PTSD since the resident had no change in mood and did not express any sign of PTSD.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to provide the necessary care and services to ensure residents' abilities in activities of daily living (ADLs) do not diminish including transfer, ambulation and walking for 1 of 1 sampled resident reviewed for rehabilitation services, Resident #80. The findings included: Review of Resident #80's clinical record documented an admission on 10/27/23 with a readmission on 04/08/24. The resident's diagnoses included Difficulty in Walking, Metabolic Encephalopathy, Diabetes Mellitus, Muscle Weakness, and Acquired Absence of Right Leg Below Knee (BKA). Review of Resident #80's Minimum Data Set (MDS) end-of-skilled-services assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 13 indicating the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff for putting on and taking off footwear and needed partial to moderate assistance with transfers and most activities of daily living (ADLs). Review of Resident #80's care plan initiated on 04/04/24 and revised on 06/18/24, documented, [resident name] requires assist with activities of daily living related to Dementia, Right BKA with prosthesis, . interventions included: RLE [right lower extremity] prosthesis to be worn when out of bed for transfers and activity participation . Chair / bed to chair transfer: Partial / moderate assistance required by two (2) Staff . On 10/01/24 at 12:15 PM, observation revealed Resident #80 in bed, and awake. An interview was conducted with the resident who stated that he walked three times wearing the right leg prosthesis, from the gymnasium to the 'birds area' before, but Medicare benefits ended. The resident added that for about a week or 10 days he had not been able to wear his right leg prosthesis because he had a sore behind his right knee (below the knee amputee extremity - BKA). Observation revealed Resident #80 lifted his below the knee amputee (BKA) right leg and showed the sore to the surveyor. Photographic Evidence Obtained. Observation revealed a round open skin area, approximately 0.2 x 0.2 centimeters (cm), with bright redness surrounding skin. The resident stated that he spoke with the nurse and believes the therapist came in and looked at the sore. The resident added the prosthesis is loose, and it hurts when he puts it on, it needs adjustment, and he was waiting on the therapist who was going to check on it and had not heard anything back. On 10/02/24 at 8:58 AM, observation revealed Resident # 80 wheeling himself down the hallway entering his room. Observation revealed the resident had his right leg prosthesis on. An interview was conducted with the resident who stated he had to use the prosthesis to go to eat but it hurts. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 9:00 AM, an interview was conducted with the Unit Manager who stated that Resident #80 goes to the dining room to eat. On 10/03/24 at 9:40 AM, an interview was conducted with the Director of Rehabilitation (DOR) who stated Resident #80's spoke with her regarding his prosthesis in the morning of 10/02/24 and she called [name], the prosthesis specialist, and was waiting on a call back from them. The DOR added the resident came to the therapy gym later, spoke with her and told her he felt his prosthesis was digging into his leg. The DOR stated the resident told her he had a sore and asked if he told the nurse and told her he did. The DOR was asked if she notified the nurse and replied she did not tell the nurse. The DOR stated resident was discharge from Physical Therapy (PT) on 07/16/24 and was currently receiving Occupational Therapy (OT) since 07/18/24. The DOR stated that on discharge from PT, Resident #80 was walking 150 feet, was not hurting then and the plan was to receive OT. The DOR was asked if the OT plan was to walk with the resident since he was able to walk on discharge and stated that OT will work with the resident transfer and functional skills. The DOR was asked why the resident was not referred to Restorative Care so he can continue to walk and stated because he could not receive both OT and Restorative Care at the same time. The DOR was apprised that the resident wanted to walk and had not done so for at least a week or two. The DOR was asked to provide Resident #80's PT discharge summary. On 10/03/24 at 10:06 AM, an interview was conducted with Staff X, Occupational Therapist (OT), who stated she had worked with Resident #80 for the most part. The OT stated Resident #80 was very motivated, the resident wanted to walk and did some functional mobility, like walked the resident from bed to the bathroom. Staff X stated the last therapy treatment was on 10/02/24. Staff X was asked if Resident #80 complaint of any issues with his right leg prosthesis and replied that a week ago the resident told her that something did not feel right with the prosthesis. Staff X was asked if she documented or notify the DOR of the resident's prosthesis concerns and replied she did not document it or tell the DOR. Review of Resident #80's PT discharge summary dated 07/16/24 documented .Baseline - 04/09/24 -distance on feet: Zero (0) 07/16/24- distance on feet: 150 feet-supervision or touching assistance .patient progress and response to treatment: patient is slowly progression with current treatment interventions and plan of treatment. Patient's condition has potential to improve as a result of skilled rehab and patient's functional performance is progressing as a result of exercises.

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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** 36057 Based on record review, observations and interviews, the facility failed to provide care and services to 2 of 2 sampled residents reviewed for skin conditions, Residents #63 and #80, as evidenced by the physician orders not being followed for Resident #36 and an open would not being timely identified for Resident #80. The findings included: 1. Review of Resident #63's clinical record documented an admission on 05/03/24 and no readmissions. The resident's diagnoses included Chronic Systolic (Congestive) Heart Failure, Malignant Neoplasm of Prostate, and Muscle Weakness. Review of Resident #63's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The assessment documented under Functional Abilities and Goals that the resident needed substantial assistance from the staff to complete the activities of daily living (ADLs). Review of Resident #63's care plan initiated on 09/24/24 and revised on 09/24/24, titled, Alteration in skin integrity - skin tear to left elbow. Interventions that included: .Administer treatments / medications as ordered and monitor for effectiveness . Review of Resident #63's active physician order dated 09/23/24 documented Cleanse skin tear to left elbow with N/S (normal saline) apply Xeroform, and cover with a silicone dressing every day shift. Review of Resident #63's September 2024 Treatment Administration Record (TAR) documented Cleanse skin tear to left elbow with N/S (normal saline) apply Xeroform, and cover with a silicone dressing every day shift, start date 09/24/24. The TAR was initialed as care administered by the nurses on 09/24/24, 09/25/24, 09/26/24, 09/27/24, 09/28/24 and 09/29/24. On 09/30/24 at 10:17 AM, observation revealed Resident #63 in his room sitting in a wheelchair accompanied by his Private Duty Aide (PDA). Further observation revealed the resident had a dressing on his left elbow dated 09/23/24. Resident # 63 was asked what happened to his left elbow and stated he bumps into things. The PDA stated the resident had fragile skin. On 09/30/24 at 10:23 AM, a side-by-side review of Resident #63 physician order for the left elbow was conducted with Staff U, Licensed Practical Nurse (LPN). Staff U stated the dressing to the left elbow skin tear was ordered to be done every day shift. On 09/30/24 at 10:25 AM, an interview was conducted with Staff Q, LPN who stated working in the facility for 2 years on and off and did not know who was responsible to change the resident's wound care dressing. On 09/30/24 at 10:27 AM, an interview was conducted with the Unit Manager (UM) who was apprised of Resident #63's left elbow dressing dated 09/23/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 10:29 AM, an interview was conducted with the dedicated Wound Care Nurse (WCN) who stated she works Monday through Friday but was off from last Thursday (09/26/24) until today (09/30/24). The WCN stated she was responsible for all resident's wound care including skin tears. The WCN was asked who was responsible to do the residents' wound care on the weekends and replied sometimes the facility designates someone (nurse) to do the wounds or the floor nurse do it. The WCN was asked how she knew about resident's skin tears and replied that residents with new wound, somebody will tell her, the CNA, the Unit Manager, and added she would look at the computer first for new residents and new orders. The WCN stated she was not aware of Resident #63 left elbow skin tear. The WCN was directed to see Resident #63's left elbow dressing date. On 09/30/24 at 10:39 AM, observation revealed the Unit Manager (UM) at Resident's #63 bedside. The UM stated she removed the dressing. A side-by-side observation of Resident #63 left elbow wound was conducted with the UM and the WCN. The wound was bleeding and had an approximately one (1) inch skin flab. The manager was asked to provide the wound measurements. On 10/02/24 at 10:19 AM, an interview was conducted with Staff O, MDS Coordinator, who stated the team is notified during daily morning meeting of resident's skin tears. Staff O stated that on 09/24/24, the resident sustained a left elbow skin tear and a care plan was initiated. On 10/02/24 at 10:30 AM, during an interview, the Unit Manager was asked to submit the notes for the wound care provided on 09/30/24 with the wound description and measurements. The Manger replied she documented the care on the TAR, did not documented the measurements. On 10/02/24 at 2:14 PM, an interview was conducted with Staff M, LPN, who had been working in the facility for three (3) months. Staff M stated her responsibilities included to pass medications, take vital sings, give enemas and change dressings. Staff M was asked if she had done dressing changes to Resident #63 and stated she did one dressing change to the leg in the past. Staff M was asked if she changed the resident's left elbow dressing and stated she did not. Staff M was apprised that she signed off the resident's left elbow treatment in the TAR three times (09/24/24, 09/25/24 and 09/28/24). Staff M stated she did not do the treatment and was under the impression the WCN done it. She added she won't touch the dressing, will leave to the WCN, and will wait to the end of the shift to sign it off. Staff M stated that she signed off at the end of the shift because she was under the impression that the WCN would do it. Staff M was asked if she coordinated, contacted the WCN or looked at the resident's dressing before she signed it off and stated she did not check with the WCN or check the resident's dressing. Staff M stated that when the WCN is not in the facility, they rotate one of the Registered Nurse to do the residents' wound care. On 10/03/24 at 9:43 AM, an interview was conducted with Staff R, RN, who stated he has been working in the facility for eight (8) months and his responsibilities were to give care (helping the residents), safety, administration of medications and assist with dining. Staff R stated he does not know who does the resident's wound care on the weekends. Staff R was asked what his initial on the TAR meant and replied when he signed the TAR, it means that he did the treatment. Staff R was apprised that on 09/30/24, Resident #63's left elbow dressing was dated 09/23/24 and that he signed off the resident's TAR on 09/27/24 as treatment done. Staff R stated he 'clicked it by mistake'. Staff R was asked if he checked with the WCN to see if the treatment was done and replied he did not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #80's clinical record documented an admission on 10/27/23 with a readmission on 04/08/24. The resident's diagnoses included Difficulty in Walking, Metabolic Encephalopathy, Diabetes Mellitus, Muscle Weakness, and Acquired Absence of Right Leg Below Knee. Review of Resident #80's Minimum Data Set (MDS) end-of-skilled-services assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 13 indicating no cognitive impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff to put on and take off footwear. Review of Resident #80's care plan initiated on 04/04/24 and revised on 06/18/24 documented (resident name) requires assist with activities of daily living related to Dementia, Right BKA with prosthesis . interventions included: RLE (right lower extremity) prosthesis to be worn when out of bed for transfers and activity participation .Remove before bed, for skin checks and hygiene .Skin inspection: monitor for redness, open areas, scratches, cuts, bruises and immediately report changes to the nurse . Review of Resident #80's care plan initiated on 10/30/23 and revised on 06/18/24 documented (resident's name) is at risk for pressure injury development related to decrease in mobility, diagnosis of PVD (Peripheral Vascular Disease) and DM (Diabetes Mellitus), has right BKA (below knee amputation), interventions included: Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care . Review of Resident #80's care plan initiated on 02/12/24 and revised on 08/12/24 documented (resident's name) has Diabetes Mellitus, interventions include: .check all of body for breaks in skin and treat promptly as ordered by doctor . Review of Resident # 80's nursing progress notes dated 09/30/24 at 6:52 AM documented the resident was medicated for right leg pain. Further review of skilled nursing Flowsheet from 09/20/24 through 09/27/24 documented .skin was also observed; has no skin concerns . Review of nursing progress note dated 09/25/24 documented alert and oriented .received a shower . On 10/01/24 at 12:15 PM, observation revealed Resident #80 in bed uncovered wearing an adult brief. During an interview, Resident #80 stated that he used to walk three times wearing the right leg prosthesis, from the gymnasium to the 'birds area' before, but for about a week or 10 days he had not been able to because he had a sore behind his right knee (below the knee amputee extremity- BKA) where the prosthesis sits in. Observation revealed Resident #80 lifted his below the knee amputee right leg and showed the sore to the surveyor. Photographic Evidence Obtained. Observation revealed a round open skin area, approximately 0.2 x 0.2 centimeters (cm), with bright redness skin surrounding the open sore. The resident stated that he spoke with the nurse and believe the therapist came in and looked at the sore. The resident was unable to provide the staffs' name). The resident added the prosthesis was loose, it hurts when he put it on, stated, needs adjustment, and that he was waiting on the therapist who was going to check on it and had not heard anything back. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 8:58 AM, observation revealed Resident #80 wheeling himself down the hallway entering his room. Observation revealed the resident had his right leg prosthesis on. An interview was conducted with the resident at this time who stated he had to use the prosthesis to go to eat but it hurts. The resident was asked if the nurse had seen the open sore and stated no. On 10/02/24 at 9:00 AM, an interview was conducted with the Unit Manager who stated that Resident #80 goes to the dining room to eat. An observation was conducted on 10/02/24 at 9:25 AM of Resident #80 in his wheelchair by his room door speaking with a therapy staff about his prosthesis. Staff U, Licensed Practical Nurse (LPN), was actively preparing medication right next to Resident #80's room. After the therapy staff left, Resident #80 turned to Staff U and stated that she needed to see his leg wound and his prosthesis. Staff U stated she would look at it after she was done with the medications. As the surveyor passed by, Staff U turned to Resident #80 and stated, let me see your leg. On 10/03/24 at 8:50 AM, a side-by-side review of Resident # 80's Weekly Skin Evaluation dated 10/02/24 was conducted with the Unit Manager (UM). The evaluation documented skin observation - no new open areas noted . A joint interview was conducted with the UM and Staff U, LPN, who signed the skin evaluation. Staff U confirmed she checked Resident #80's skin on 10/02/24 and did not see any new open skin, and stated the resident had an ankle and back rash from before. The UM and Staff U were apprised that on 10/01/24, Resident #80 complained of pain behind his right BKA to the surveyor and showed an open skin area where the prosthesis sits. A side-by-side observation of Resident #80's behind the right BKA skin was conducted with the UM and Staff U. Staff U stated, It is open. During the observation, Resident #80 stated the wound was checked by the therapist on 10/02/24 and knew about the open wound. The resident added he did not want the sore to get bad and to have his knee cut off higher. Staff U was asked to measure the open wound and stated the measurements were 0.3 x 0.4 cm. On 10/03/24 at 9:40 AM, an interview was conducted with the Director of Rehabilitation (DOR) who stated Resident #80's spoke with her regarding his prosthesis in the morning of 10/02/24 and she called [Name] (Prosthesis Specialist), and was waiting on a call back from them. The DOR added the resident came to the therapy gym later, he spoke with her and told her he felt his prosthesis was digging into his leg. The DOR stated the resident told her he had a sore and asked if he told the nurse and told her he did. The DOR was asked if she notified the nurse and replied she did not tell the nurse.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to act on recommendations for an air mattress for a resident admitted with a Stage 4 pressure for 1 of 1 sampled resident reviewed for pressure ulcers, Resident #200. The findings included: Record review revealed Resident #200 was admitted to the facility on [DATE]. Review of the Nursing Progress note upon admission documented the resident as alert and oriented and that resident was bed-bound. Review of Resident #200's care plan for skin integrity, dated 09/25/24 with a revision date of 09/27/24, documented, Alteration in skin integrity-actual pressure injury present upon admission related to Recent hospitalization Wound with vac to right knee. Stage 4 to sacrum and Stage 3 to right gluteal. The goals of the care plan were documented as: o Resident will be free of further alteration in skin integrity through next review date. With a target date of 12/24/24. o Stage 4 to sacrum will resolve and show no s/s [signs and symptoms] of infection through next review. With a target date of 12/24/24. o Stage 3 to right gluteal will show s/s of healing and no s/s of infection through next review. With a target date of 12/24/24. Interventions in the care plan included: o Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, and odor-notify physician of significant findings. o Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. o Remind/assist resident to frequently change position when in bed and/or chair. Review of Resident #200's care plan for Pressure Ulcer Development, initiated on 09/25/24, documented, At risk for pressure injury development related to Recent hospitalization . The goal of the care plan was documented as, Resident will be free of pressure injury development through next review date.09/25/24 with a target date of 12/25/24. Interventions included: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. o Remind/assist resident to frequently change position when in bed and/or chair. Review of a Skin and Wound Evaluation, dated 09/26/24, completed by Staff D, Registered Nurse (RN), documented Resident #200 had a Stage 3 pressure injury to the right gluteus that was present on admission (09/25/24) with treatment that included an air mattress. A second Skin and wound Evaluation, dated 09/26/24, completed by Staff D, RN, documented Resident #200 had a Stage 4 Pressure injury to the sacrum upon admission (09/25/24) with treatment that included an air mattress. During an interview with Resident #200, on 09/30/24 at 1:32 PM, when asked about having any skin issues or impairments, Resident #200 replied, I am supposed to get a new mattress, I got sores on my butt and my doctor wants me on an air mattress. They found them bleeding a little in the hospital (prior to admission). During the interview, Resident #200 was noted to be on a standard mattress. During an observation of Resident #200, on 10/01/24 at 4:08 PM, Resident #200 was noted to be on a standard mattress. During an interview, on 10/01/24 at 10:40 AM, with Staff B (RN/Unit Manager / UM), when asked about the Skin and Wound Evaluations, Staff B confirmed that she did the evaluations and recommended an air mattress. When asked about the air mattress not being provided to the resident, Staff replied, I just forgot to order it. Staff B further stated that the facility had the air mattress on site and that the resident would be getting one prior to returning from a doctor's appointment later this day. During an interview with Resident #200, on 10/02/24 at 7:17 AM, Resident #200 was noted to be on a standard mattress. On 10/02/24 at 12:49 PM, Resident #200 was not in her bed and had left for an appointment, Staff B reported to the surveyor, I just told maintenance, and they should be bringing it.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record reviews, the facility failed to ensure adequate protection and assistance to residents who smoke with smoking aprons for 1 of 5 sampled residents reviewed for smoking, Resident #19; failed to provide adequate supervision for 5 of 5 sampled residents reviewed and observed for smoking, Residents #19, #8, #249, #46, and #197; failed to secure smoking materials for 1 of 5 sampled residents reviewed for smoking, Resident #8; and failed to ensure the environment remained as free of hazards as possible for 1 of 1 supply room on the second floor. The findings included: Review of the facility's policy, titled, Smoking Policy - Residents, with a revised date of October 2023, included, in part, the following: This facility has established and maintains safe resident smoking practices. 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking in not allowed inside the facility under any circumstances. 3. Electronic cigarettes and smokeless tobacco are permitted in designated areas only. 5. Metal containers with self-closing covers are available in smoking areas. 6. Ashtrays are emptied into designated receptacles. 7. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. Current level of tobacco consumption b. Method of tobacco consumption (traditional cigarettes, electronic cigarettes, pipe, etc.) c. Desire to quit smoking d. Ability to smoke safely with or without supervision (per Safe Smoking Evaluation) 8. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation 9. A resident's ability to smoke safely is re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Any smoking-related privileges, restrictions and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 11. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 12. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 13. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. 14. Residents are not permitted to give smoking items to other residents. Review of the manufacturer's instructions for the Smoker's Apron with no date included, in part, the following: Application for Instructions: 1) Place the apron over the resident and attach the neck strap to the apron by engaging the hook and loop located on the strap and at the top of the apron. 2) Adjust the strap until the apron reaches the neckline 3) To protect cigarettes and ashes from falling between resident and their wheelchair, wrap the side straps around the wheelchair frame and engage the hook and loop under the apron. Warning: This apron is not a substitute for proper supervision. Patients or residents should always be closely supervised while smoking. 1. Record review for Resident #19 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cerebral Infarction, Type 2 Diabetes, and Epilepsy Unspecified Intractable without Status Epilepticus. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #19 dated 08/29/24 revealed in Section C, a Brief Interview of Mental Status (BIMS) score of 13 indicating an intact cognitive response. Review of the Annual MDS assessment for Resident #19 dated 05/29/24 revealed in Section J for tobacco use, is 'yes'. Review of the Smoking Risk Form for Resident #19 dated 12/05/23 documented the resident smokes 2-5 times per day and likes to smoke in the morning, afternoon and evening. She can light her own cigarette and needs adaptive equipment: smoking apron. There were no other Smoking Risk forms completed until surveyor intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Smoking Risk Form for Resident #19 dated 10/01/24 documented the resident smokes 1-2 times per day in the morning and afternoon. She can light her own cigarette. She needs adaptive equipment to include a smoking apron and supervision. Record review for Resident #19 from 12/06/23 to 09/30/24 revealed no Smoking Risk Form. This indicated the resident was not re-evaluated quarterly for safe smoking. Review of the Alteration in Skin Integrity documentation for Resident #19 dated 05/20/24 documented in part the following: Incident description: Resident was observed with a new cigarette burn on her upper left thigh in the healing process. Per resident the cigarette burn happened over a week ago. Immediate action taken: wound was clean and dry, healing observed. The resident was not taken to the hospital. Predisposing Physiological Factors: none of the above. Predisposing Situation Factors: none of the above. People notified: Physician and Family member/responsible family member. Review of the care plan for Resident #19 dated 09/01/23 with a focus on the resident chooses to smoke. Non-compliant with smoking policy despite education. The goal was for the resident to remain free from smoking related injury. The interventions included the following: Cigarettes and lighter to be kept in a secure location. Instruct resident/family on smoking policy. Intervene promptly when smoking in an unsafe manner. Monitor for non-compliance with smoking policy. Smoking apron to be worn when smoking. Smoking in designated area only. Supervised smoking by staff member. On 09/30/24 at 1:40 PM, an observation was made of Resident #19 and Resident #249 smoking on the smoking patio. Resident #19 had a smoking apron that was not secured, laying across her and only partially covering her chest and lap. Resident #19's ashes from her cigarette were dropping unto the ground. She was positioned in her wheelchair away from the ashtray on a table and it was out of her reach. When Resident #19 finished with her cigarette, she placed it in the red smoking post. An interview was conducted on 09/30/24 at 1:45 PM with Resident #19 who was asked how long she has smoked at the facility, and she said, 'years'. When asked about the covering on her (smoking apron), she said she keeps it on the back of her wheelchair and puts it on herself when she comes out to smoke. When asked if staff come out to supervise her smoking, she said sometimes staff come out for a few minutes but not every time. When asked if she can light her own cigarettes, she said sometimes she cannot, but most times she can. When asked where her cigarettes and lighter are kept, she said the nurse holds her cigarettes and lighter and gives them to her when she asked for them, then she will bring them back when she is done smoking. On 10/02/24 at 1:15 PM, an observation was made of Resident #19 on the smoking patio with a smoking apron not secured around her neck and was partially covering her chest and lap as she lit her own cigarette. No staff member was present. At approximately 1:22 PM, Staff N, Certified Nursing Assistant (CNA), came to smoking patio to supervise the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/02/24 at 1:20 PM with Staff M, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3-4 months. When asked about the resident, she said she was not aware the resident was an unsafe smoker until today. The LPN stated she hold the resident's cigarettes and lighter in the med cart. The LPN stated she came down this morning with the resident to smoking area and helped her with the smoking apron and with lighting a cigarette. There was another staff member on the smoking patio, and she was under the impression the staff member was assigned to the smoking patio to observe the residents. She stated when the resident requested cigarettes to smoke around 1:10 PM on 10/02/24, she gave the resident 2 cigarettes and the resident went downstairs, and she assumed she would be supervised by another staff member she thought was assigned to the smoking patio. An interview was conducted on 10/02/24 at 1:23 PM with administrator who did side-by-side observation of resident with smoking apron partially covering her and smoking a cigarette on the smoking patio. 2. Record review for Resident #249 revealed the resident was admitted to the facility on [DATE] with diagnoses including in part the following: Thyrotoxicosis with Diffuse Goiter Without Thyrotoxic Crisis or Storm, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Unsteadiness on Feet, Muscle Weakness, and Parkinson's Disease Without Dyskinesia. Review of the Social Service Evaluation for Resident #249 dated 09/25/24 documented a BIMS score of 9 indicating moderately impaired cognition. Review of Smoking Risk Form for Resident #249 dated 09/30/24 documented the resident has a cognitive loss, cannot light own cigarette, needs supervision, and other listed as needs assist to light cigarette / stay with. Review of the Care Plan for Resident #249 dated 09/30/24 was a care plan with a focus on the residents' choices to smoke. The goal was for the resident to remain free from smoking related injury. The interventions included: Cigarettes and lighter to be kept in a secure location. Instruct resident / family on smoking policy. Intervene promptly when smoking in an unsafe manner. Monitor for non-compliance with smoking policy. Needs assist to light cigarette. Smoking in designated area only. Supervised smoking by staff member On 09/30/24 1:40 PM, an observation was conducted of Resident #249 smoking on smoking patio with Resident #19 unsupervised. Resident #249 was using the covered ashtray with the cover off. There were cigarette butts on the patio floor. During an interview conducted on 09/30/24 at 1:40 PM with Resident #249 who was asked how long she has been smoking at the facility, she said since she got here about a week ago. When asked who holds her cigarettes and lighter, she said she usually gets cigarettes from some of the other residents when she comes outside on the smoking patio to smoke. When asked if any staff supervise them or come out to the patio when she is smoking, she said sometimes they come out to see them smoking but they do not stay. 3. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Unspecified Fracture of Humerus, History of Falling, Anxiety and Muscle Weakness (Generalized). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS assessment for Resident #8 dated 05/09/24 documented in Section J tobacco use, documented 'no'. Review of the MDS assessment for Resident #8 dated 08/09/24 documented in Section C, a Brief interview of Mental Status score of 15, indicating an intact cognitive response. Review of the Smoking Risk Form for Resident #8 dated 12/01/23 documented the resident smokes 2-5 times per day in the morning, afternoon and evening. The Resident can light her won cigarette. No adaptive equipment needed including supervision. Review of the Smoking Risk Form for Resident #8 dated 10/01/24 documented the resident smokes 1-2 times per day in the morning and afternoon. Resident can light her won cigarette. Need for adaptive equipment documented supervision. Record review from 12/02/23 to 09/30/24 for Resident #8 revealed no Smoking Risk Form was completed. Review of the Care Plan for Resident #8 dated 12/04/23 with a focus on the resident chooses to smoke. The goal was for the resident to remain free from smoking related injury. Instruct resident / family on smoking policy. Intervene promptly when smoking in an unsafe manner. Monitor for non-compliance with smoking policy. Smoking in designated area only. Supervised smoking by staff member On 09/30/24 at 12:19 PM, an observation was made of Resident #8 sitting up in bed with electronic cigarette, regular cigarettes and lighter on overbed table. Photographic Evidence Obtained. On 10/01/24 at 10:17 AM, a side-by-side observation was made with Staff B, Registered Nurse / Unit Manager (RN/UM), who acknowledged the resident should not have the cigarettes, lighter and electronic cigarette at the bedside and took them. The RN/UM informed the resident she could not have those items at the bedside. An interview was conducted on 09/30/24 at 12:23 PM with Resident #8 who was asked if she was a smoker, who responded 'yes'. When asked if she has always smoked since being a resident at the facility, she said yes. When asked if staff hold her cigarettes and lighter, she said no, she holds them, and they know it. When asked if staff supervises her while smoking, she said they come in and out, but nobody stays with them. She said it is different staff all of the time. An interview was conducted on 10/01/24 at 10:30 AM with Staff B who was asked if residents are assessed for smoking. She said she does not do the smoking assessments, that would be administration. When asked how often the smoking assessments or evaluations are completed, she said she is not sure. When asked if a resident can have cigarettes, lighter and electric cigarette at the bedside, she said no, it needs to be secured. An interview was conducted on 10/03/24 at 2:35 PM with Staff O, RN / Minimum Data Set Coordinator who stated she has worked at the facility for [AGE] years. When asked about smoking care plans being updated, she said she would not update smoking care plans for any resident unless the smoking status changed for the resident. 38893 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Record review revealed Resident #46 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Quarterly MDS, dated [DATE], revealed Resident #46 had a BIMS score of 15, indicating the resident was cognitively intact. The MDS documented the resident ambulated independently via manual wheelchair and required minimal assistance for bed mobility and transfer. Resident #46's diagnoses at the time of the assessment included Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Muscle weakness, and History of falling, Resident #46's care plan for smoking, initiated on 07/12/23, documented, Resident chooses to smoke / has been evaluated to be safe and knows to keep smoking materials secure. The goal of the care plan was documented as Resident will remain free from smoking related injury. Date Initiated: 07/12/2023. Revision on: 04/02/2024. Target Date: 12/11/2024. Interventions in the care plan included: o Instruct resident/family on smoking policy o Smoking in designated area only Date Initiated: 07/12/2023. On 09/30/24 at 10:06 AM, two residents, including Resident #46, were observed in the designated smoking area. It was noted that there were no staff members on the patio to provide supervision for the residents. On 09/30/24 at 10:22 AM, the MDS Coordinator arrived at the smoking patio. During an interview, on 09/30/24 at 11:04 PM with the MDS Coordinator, when asked about providing supervision to residents while smoking, the MDS Coordinator replied, Normally there is someone there to supervise them. The Administrator was supposed to go with them this morning. On 09/30/24 at 11:51 AM, Resident #46 was observed going to the smoking patio and smoking independently. It was noted that there were no staff to provide supervision while Resident #46 was smoking. On 10/01/24, at 6:45 AM, Resident #46 was observed going to the smoking patio and smoking independently. It was noted that there were no staff to provide supervision while Resident #46 was smoking. On 10/02/24, at 6:30 AM, Resident #46 was observed on the smoking patio and smoking independently. It was noted that there were no staff to provide supervision while Resident #46 was smoking. 5. Record review revealed Resident #197 was admitted to the facility on [DATE]. Review of the resident's most recent full assessment, a Medicare 5-day MDS, dated [DATE], revealed Resident #197 had a BIMS score of 14, indicating an intact cognitively response. The assessment documented that Resident #197 required partial / moderate assist for bed mobility and transfer and ambulated independently with use of a manual wheelchair (w/c). [The resident was observed walking behind w/c on multiple occasions during the survey.] Resident #197's diagnoses at the time of the assessment included: Hypertension, Depression, and Chronic lung disease. Resident #197's care plan for smoking, imitated on 09/20/24 with a revision date of 10/01/24, documented, Resident chooses to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The goal of the care plan was documented as, Resident will remain free from smoking related injury, dated 09/20/24 with a target date of 10/02/24. Interventions of the care plan included: o Cigarettes and lighter to be kept in a secure location o Instruct resident/family on smoking policy o Smoking in designated area only. Review of the Smoking Risk Form, dated 09/12/24, and second form dated 09/30/24, indicated: No cognitive loss, No visual deficit, and No safety concerns. On 09/30/24 10:06 AM, two residents, including Resident #197, were observed in the designated smoking area. It was noted that there were no staff on the patio to provide supervision for the residents. On 09/30/24 at 10:22 AM, the MDS Coordinator arrived at the smoking patio. During an interview, on 09/30/24 at 11:04 PM with the MDS Coordinator, when asked about providing supervision to residents while smoking, the MDS Coordinator replied, Normally there is someone there to supervise them. The Administrator was supposed to go with them this morning. During an interview, on 10/01/24 at 12:46 PM, when asked about smoking without staff supervision, Resident #197 stated that there is normally no supervision. Resident #197 further stated, I keep them (cigarettes) in the pocket of my wheelchair. My daughter will bring me in a pack or two and I keep them with me. The pocket is good for keeping them. On 10/02/24 at 9:12 AM, Resident #197 was observed walking behind a wheelchair to the elevator and did not stop at nurse's station on the second floor for smoking supplies (cigarettes and lighter). On 10/02/24 at 9:15 AM, Resident #197 was observed on the smoking patio smoking independently. On 10/02/24 at 12:52 PM, Resident #197 was observed walking behind a wheelchair to the elevator and did not stop at nurse's station on the second floor for smoking supplies (cigarettes and lighter). On 10/03/24 at 10:00 AM, Resident #197 was observed on the smoking patio with Resident #19. Resident #197 was observed providing a cigarette and lighter to Resident #19 with no staff intervention. 6. On 09/30/24 at 10:00 AM, an observation was made of the supply room on the second floor across from the nursing station The supply room was unlocked, and no staff were present inside. Inside the supply room, there were 19 razors. An interview was conducted on 09/30/24 at 10:05 AM with Staff B, RN/UM, who was asked about the supply room. She said normally it will automatically lock when the door shuts. She acknowledged that the supply room was unlocked and unattended with 19 razor blades.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observation, interview and record review, the facility failed to obtain physician orders for catheter care, provide catheter care, and report complications associated with catheter care and failed to ensure adequate hand hygiene for 1 of 1 sampled resident observed for urinary catheter care, Resident #35. The findings included: Review of the facility's policy, titled, Catheter Care, Urinary, with a revised date of August 2022, included, in part, the following: The purpose of this procedure is to prevent urinary catheter -associated complications, including urinary tract infections. Complications 1. Observe resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately. a. If the resident indicated that his or her bladder is full or that he or she needs to void (urinate). b. If urine has an unusual appearance (i.e., color, blood, etc.). c. Complains of burning, tenderness, or pain in the urethral area; or d. If signs and symptoms of urinary tract infection or urinary retention occur. Review of the facility's policy, titled, Handwashing/Hand Hygiene, with a published date of 12/29/22 included, in part, the following: This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff to use to encourage compliance with hand hygiene policies. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Procedure Applying and Removing Gloves (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down and folding it into the first glove. 5. Perform hand hygiene. Record review for Resident #35 revealed the resident was originally admitted to the facility on [DATE], transferred to the hospital on 09/22/24 and was readmitted to the facility on [DATE]. The resident's diagnoses included in part the following: Urinary Tract Infection Site not Specified, Acute Kidney Failure, Type 2 Diabetes Mellitus without Complications, Encounter for Fitting and Adjustment of Urinary Device, and Obstructive and Reflux Uropathy Unspecified. Review of the Minimum Data Set (MDS) assessment for Resident #35 dated 09/02/24 documented the resident had a Brief Interview of Mental Status (BIMS) score of 14 indicating an intact cognitive response. Review of the Physician's Orders for Resident #35 from 09/26/24 to 09/29/24 revealed no orders for urinary catheter care. Review of the Physician's orders for Resident #35 revealed an order dated 09/30/24 for Catheter/ Foley: Catheter care every shift. every shift and as needed. Review of the Physician's orders for Resident #35 revealed an order dated 09/26/24 for Eliquis (to prevent a blood clot from forming) Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for Atrial Fibrillation. Review of the 3008 form from the hospital dated 09/26/24 documented in Section E, Medical Condition, as Complicated UTI [Urinary Tract Infection]. Section P, Patient Health Status, had Foley catheter checked. The Treatment Administration Record (TAR) for Resident #35 from 09/26/24 to 09/29/24 revealed no documentation of catheter care. Review of the Care Plan for Resident #35 dated 09/05/24 documented a focus on the resident has an Indwelling Catheter r/t [related to] Obstructive Uropathy 16f/10cc. The goals were for the resident to be / remain free from catheter-related trauma and for the resident to show no s/sx [signs/symptoms] of Urinary infection through review date. The interventions included in part the following: Monitor / document for pain / discomfort due to catheter. Monitor / record / report to MD [Medical Doctor] for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes for Resident #35 for 10/02/24 revealed no documentation of the nurse contacting physician to report bleeding or pain during catheter care. On 09/30/24 at 12:55 PM, an observation was made of Resident # 35 with an indwelling urinary catheter drainage bag on the side of bed covered with a privacy cover. On 10/02/24 at 10:59 AM, an observation was conducted of catheter care for Resident #35 performed by Staff K, Certified Nursing Assistant (CNA). Staff K gathered supplies, donned appropriate PPE including gown, mask, washed hands and applied and gloves. She adjusted the privacy curtain, touched the bed control to adjust the bed, pulled the covers down, removed brief and said to resident I am going to remove your diaper. The resident asked if the staff was going to put medicine inside, she said no. She added soap to water and washed the resident with soapy washcloth twice moving from tip of penis down tubing away from resident and around meatus of penis. Blood was noted, and the CNA then used a washcloth with just water to wipe tubing and meatus. She removed her gloves, did not perform hand hygiene, and put new gloves on. The resident asked if she was going to put cream on, and she said she was going to dry him. She then proceeded to dry the resident with a dry bath towel, removed her gloves, did not perform hand hygiene, and applied new gloves. She then used wipes to clean the resident's fold under the abdomen and creases on each side of the groin. The resident screamed in pain. She removed her gloves, did no hand hygiene, applied new gloves, and applied cream to abdominal fold and creases next to groin. She then had resident roll side-to-side to remove and replace the pad under the resident. The CNA removed her gloves, did no hand hygiene, had the resident roll side-to-side to place a clean brief on him. She gathered all the garbage into a bag, placed in trash, removed her gloves, did no hand hygiene, applied gloves, pulled the covers over resident, and adjusted the bed. The CNA then removed her gloves and washed her hands. In summary Staff K changed her gloves 5 times during the procedure without performing hand hygiene. When asked how often she checks the drainage bag, she said every 2 hours. An interview was conducted on 10/02/24 at 8:58 AM with Resident #35 who was asked if he recently went to the hospital for pain with his indwelling catheter. He said yes. He said they changed the catheter in the hospital, and he returned to the facility with the new catheter in place. When asked if the staff have been performing catheter care since he returned, he said yes, they come and put cream on it. An interview was conducted on 10/02/24 at 11:19 AM with Staff K, CNA, who stated she has worked at the facility for 4 months. When asked if she notified the nurse about Resident #35 having pain and bleeding during catheter care, she said they already know this. When asked about hand hygiene during glove changes, she said sometimes she uses hand sanitizer, but she could not find any today. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/02/24 at 11:24 AM with Staff L, Registered Nurse (RN), who was assigned to take care of Resident #35 who stated she has worked at the facility for 1 year. When asked about Resident #35 and having any pain or bleeding with catheter care, she said, 'before he had a UTI and went out to the hospital recently and just came back last week'. She said, 'sometimes he has pain with catheter care, and he has pain medication, but they only give him pain medication if he asks for it'. When asked if the resident has pain with catheter care, she said, 'yes sometimes'. When asked how often urinary catheter care is performed, she said, 'every shift'.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to ensure a resident receiving enteral feeding (tube feeding) received appropriate care and services to prevent complications for 1 of 2 sampled residents reviewed for tube feeding with significant weight loss not addressed in a timely manner, Resident #90; and for 1 of 2 sampled residents reviewed for tube feeding to ensure residents are receiving tube feeding in a manner to prevent complications, Resident #199. The findings included: Review of the facility's policy, titled, Nutrition Support: Enteral Feed, with a date of 11/10/22 included in part the following: Policy: To provide appropriate nutritional care to all patients who require enteral nutrition support. Procedure: Indication for Enteral Nutrition (EN) Enteral feeding is generally indicated for patients who are unable to meet their nutrient requirements orally and have a functioning gastrointestinal tract. Initiation of Enteral Nutrition Patients who are at high nutrition risk or severely malnourished should be advanced to goal as quickly as tolerated over 24-48 hours while monitoring for refeeding syndrome. (efforts to provide >80% of estimated or calculated goal energy and protein within 48-72 hours should be made to achieve the clinical benefit of EN over the first week). Nurses: c) Administer enteral feeding as per order d) Minimize or avoid holding feedings e) Document intake and output as per MD order as applicable. Document if feeding held, reason for holding and rate adjustment. Complete feeding as applicable. f) Ensure head of bed is elevated at least 30 to 45 degrees, unless contraindicated. Dieticians: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Assess nutritional status and nutritional needs of all patients on enteral nutrition support, as per Evidence Based Nutrition Care Practice Guidelines (Aspen/Academy of Nutrition and Dietetics). The nutrition assessment will include an estimation of calories, protein, and free water provided through the enteral feeding. The RD (Registered Dietician) will compare these to the estimated needs to ensure nutrient needs are met utilizing Aspen method of documentation: actual feeding provided via kg. (When calculating free water, include water provided through formula and through free water flush.) Recommend enteral feeding and fluid flush adjustments as needed to meet the resident's estimate needs adequately. b) Make recommendations as to formula selection, administration, rate, free water flushes, monitoring, and intolerance issues for optimal outcomes. c) The dietician will review the written physician order to ensure that it meets requirement (or use the Enteral Feeding Form/EMR process). Estimating Nutritional Needs Nutritional needs are dependent on the patient's current medical status, presence of inflammation, mechanical ventilation, wounds, weight, age and gender among many other factors. Ideally caloric needs should be estimated using indirect calorimetry. Mifflin-St Jeor (MSJ) can be used in estimating caloric needs. Otherwise, a good starting point for estimating caloric needs can be as follows: For a malnourished, underweight individual (BMI <18.5 to <30): 25-30 kcal/kg/day protein. Review of the facility's policy, titled, Policy Interdisciplinary Management and Prevention of Significant Weight Loss Of Nursing Facility Residents, with a revised date of 11/01/22, included in part the following: Policy: There will be a systemic an interdisciplinary approach to monitoring resident weights in the facility. The facility will develop a standardized process in the management and prevention of unplanned significant weight loss of Nursing Facility residents. Residents who lose weight will be identified and managed in a timely manner. Purpose: The purpose is to provide guidelines for detection of early unplanned weight loss. This includes communication and appropriate action by the interdisciplinary team to maintain acceptable parameters of nutritional status of nursing facility residents. For the purpose of this policy the early unplanned weight loss is defined as 5 pounds in 30 days. Procedure: The nursing staff will: weigh all new admissions and readmissions upon admission and the day after if necessary. Weights ae then taken weekly x 4 weeks (one month) and [NAME] monthly unless the physician order states otherwise. All heights and weights are recorded in the Electronic Medical Records (EMR) per facility policy. Weight discrepancy: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Reweigh residents with significant weight discrepancies within 24 hours, if needed reweigh the following: Residents weighing ,/+ to 100 pounds - if the weight variance ins +/- >3 pounds weight variance from the previous weight, the resident will be reweighed within 24 hours. As applicable in the EMR, strikeout the incorrect weight. 2. The Clinical Dietician will: If a discrepancy still exists and the change is unplanned or undesirable, place the resident on weekly weights or more often as ordered by physician. The physician will be notified of any weekly or monthly significant weight changes, or as needed. The dietician will be responsible for reviewing all monthly weights. Residents who have a weight loss of >3% or insidious weight change should be seen by the RD by the 9th of each month. Monitor all of the interventions for efficacy and feasibility. Care Plans will be under continuous revisions to meet resident's needs with goal of achieving a desired outcome. A) Calculate percentage of resident's weight loss. B) Monitor appropriateness of the diet prescription. I) Coordinate with the interdisciplinary clinical team/other disciplines (IDT) for a Focus Meeting to discuss significant weight loss and findings J) Modify and/or change current interventions. K) Monitor resident's progress and document weekly or sooner in the medical record until weight status resolve. Significant Weight Loss For the purposes of this policy, the facility considers significant unplanned weight loss a Significant Change which would require IDT Meeting be held to discuss the reason(s) and to review and/or modify the plan of care. Suggested parameters as per Regulatory Standards for evaluating significance of unplanned and undesired weight loss are: 1 month 5% Greater than 5% Appendix CMS Definitions: Avoidable means that the resident did not maintain acceptable parameters of nutritional status and that the facility did not do one or more of the following: evaluate the resident's clinical condition and nutritional risk factors; define and implement interventions that are consistent with resident needs, resident goals and recognized standard of practice; monitor and evaluate the impact of the interventions/ or revise the interventions as appropriate. ' (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following Progressive Supranuclear Ophthalmoplegia [Steel-[NAME]-[NAME]] (a rare brain disease that affects walking, balance and eye movements and swallowing), Gastrostomy Status, Dysphagia, Crohn's Disease, and Parkinson's Disease. Review of the Minimum Data Set (MDS) assessment for Resident #90 dated 09/07/24 documented in Section C, a Brief Interview of Mental Status (BIMS) score could not be conducted due to the resident is rarely / never understood. Review of the Physician's Orders for Resident #90 revealed an order dated 08/27/24 for Enteral Feed Order two times a day Give Osmolite 1.5 (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hours [hrs]) Give H20 (water) Flush (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm and was discontinued on 09/21/24. Review of the Physician's Orders for Resident #90 revealed an order dated 09/22/24 for Enteral Feed Order one time a day give Osmolite 1.5/1000ml @ @50ml/hour. Give H20 Flush/1000ml @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm and was discontinued on 09/26/24. Review of the Physician's Orders for Resident #90 revealed an order dated 09/27/24 for Enteral Feed Order one time a day via Gtube give Osmolite 1.5/1000ml @62ml/hr. give H20 flush/500ml @31ml/hr. Start at 5pm and run until complete (~16hrs) Total kcal 1500, Total Pro 62.7gm. See additional H20 flush order. Total Kcal 1500, Total Pro 62.7, Total Fluid 1620ml - and was discontinued on 09/30/24. Review of the Physician's Orders for Resident #90 revealed an order dated 09/30/24 for Enteral Feed Order one time a day via Gtube give Osmolite 1.5/1000ml @62ml/hr. give H20 flush/500ml @62ml/hr. Start at 5pm and run until complete *See additional H20 flush order. Total Kcal 1500, Total Pro 62.7, Total Fluid 1620ml. Review of the weights for Resident #90 revealed the following: On 08/27/24 at 10:25 AM, the resident weighed 92.0 # (pounds) via Mechanical Lift. On 09/05/24 at 9:54 AM, the resident weighed 82.0 # via Standing. On 09/27/24 at 4:35 PM, the resident weighed 83.0 # via Standing. In summary, this indicated from 08/27/24 to 09/05/27, the resident lost 10#, which is a significant weight loss of 10.87%. On 10/01/24 at 10:15 AM, Resident #90 was weighed by Staff J, Restorative Aide, with the Director of Nursing and the surveyor present, and the resident weighed 77.6 pounds. If initial weight of 92 pounds is accurate, this would have indicated the resident had a weight loss of 14.4 pounds from 08/27/24 to 10/01/24 and was a significant weight loss of 15.65%. If initial weight was 82 pounds, as noted by the spouse and RD (Registered Dietician), this would have indicated the resident had a weight loss of 4.4 pounds , which is a weight loss of 5.3%. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutrition Risk Assessment for Resident #90 dated 08/26/24 included the following in part: Continuous feeding - Osmolite 1.5 (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hours) give H20 Flush (1000ml) @50ml/hour. Start at 4pm and run until complete (~20 hrs). Total feeding - Total fluid 2000ml, Total calories 1500, Total protein 62.7 gm, Free water 1762ml. Estimated Nutritional Needs (Kcal/kg): 42 x 35-40= 1470 - 1680; Protein: 42 x 1.2 - 1.3 = 50-55: MDS Triggers BMI <18.5 or >/= 24.9. Care plan resident will gain 1-21 lbs/month by nrd (next review date). Review of the Nutrition / Dietary Note for Resident #90 dated 09/05/24 included the following: Resident's care plan meeting today with resident's husband, MDS nurse, Therapy director and this RD. Tube feeding regimen reviewed with resident's husband. Resident has been tolerating tube feeding. He is in agreement with poc [plan of care] regarding tube feeding at this time. Weight gain desired as husband stated that the resident has lost weight prior to admission. Current tube feeding will provide enough calories for gradual weight gain. F/U [follow-up] for weekly weight x 3. Adjust poc as needed. Review of the Nutrition / Dietary Note for Resident #90 dated 09/09/24 included the following: Resident's weight on 9/5/24 was 82lbs. Admit weight recorded as 92lbs. Resident is NPO on tube feeding which is providing adequate nutrition / hydrations. F/U with resident's husband who stated she is definitely not 92. He stated that she was 78 in the hospital and that he observed her being weighed in this facility on standing scale at 82lbs. 92 lbs may have been an error in recording the weight. Will request reweigh as gradual weight gain is desired. Current estimated needs = 37 x 35-40 = 1295-1480 calories/day, 37 x 1.2 -1.3 = 44-48 gm protein /day, 37 x 30-35 = 1110-1295 ml fluid. F/U for reweigh. Per nursing resident is tolerating tube feeding well. Adjust poc as needed. Review of the Nutrition / Dietary Note for Resident #90 dated 09/26/24 included the following: Resident's tube feeding to be adjusted. Recommend changing to Osmolite 1.5/1000ml @ 62ml/hour via G Tube. Start at 5pm and run until complete (~16 hrs) H2O flush/1000ml @ 31ml/hour via G tube with total of 500ml H20. Start at 5pm and run ~16 hrs. Tube feeding will provide 1500 kcal, 62.7 gm protein, 1262 free H20. Recommend H20 flush 120ml once daily via G tube. Total free water 1382ml Weight 82lbs. Tube feeding provides 40 kcal/kg, 1.6 gm/kg protein, Total free water 37ml/kg. F/U for tolerance/weight/changes. Adjust POC as needed. On 10/01/24 at 10:00 AM, an observation was made of Resident # 90 lying in bed asleep with no tube feeding hung or infusing. On 09/30/24 11:35 AM, an observation was made of Resident #90 lying in bed with the tube feeding Osmolite 1.5 (formulary type) at 350 mark out of 1,000 milliliter capacity bottle. The tube feeding bottle was labeled with a start date of 09/29/24 at 6:00 PM, infusing at 62 milliliters per hour. On 10/01/24 at 4:23 PM, an observation was made of Resident #90 lying in bed with Osmolyte 1.5 (formulary type) tube feeding connected to the resident with tube feeding just above the 1,000 mark out of a 1, 000-milliliter capacity bottle and infusing at 62 milliliters per hour via pump. The tube feeding bottle is labeled with a start date of 10/01/24 at 4:00 PM. On 10/02/24 at 8:45 AM, an observation was made of Resident #90 sitting up in bed with bottle Osmolite 1.5 tube feeding at the 200 mark out of a 1,000-milliliter capacity bottle. The tube feeding was infusing via pump at 62 milliliters per hour. The tube feeding bottle was labeled with start date of 10/01/24 at 4:00 PM. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 10:31 AM, an observation was made of Resident #90 sitting up in bed with bottle Osmolite 1. 5 tube feeding below the 200 mark out of a 1,000-milliliter capacity bottle. The tube feeding was infusing via pump at 62 milliliters per hour. The tube feeding bottle was labeled with start date of 10/01/24 at 4:00 PM. An interview was conducted on 10/01/24 at 12:12 PM with the husband of Resident # 90 who stated his wife's normal body weight was 135 pounds. The last time she weighed her normal body weight was in March. He said this disease is terrible and now she cannot swallow so she has to be on tube feeding. He said they had some kind of meeting when his wife first arrived at the facility just over a month ago. He expressed his concern over his wife's weight and does not want her to lose any more weight and hopes she can gain weight. He said during that meeting was the only time he talked to the dietician, and they told him they would adjust the tube feeding as they went along. He stated he was never told she had any weight loss since being in the facility. He was under the impression she would have gained weight, but nobody really talks to him or answers question when he asks. He said he comes to the facility just about every day and he sees the tube feeding bottle off and still has about 3 inches of tube feeding left in it and they throw it away and start a new bottle later. He feels she may not be getting all of the tube feeding she is supposed to for this reason. An interview was conducted on 10/01/24 at 10:30 AM with Staff J, Restorative Aide, who stated she has worked at the facility for just over 1 year and has been the Restorative Aide for about 1 year. She said she is the one to do the weights for residents unless she is not scheduled to work, then other staff fill in to do the weights. She said she gets a list of the newly admitted residents and will do admission weights weekly for 4 weeks then monthly unless the dietician instructs her otherwise. She then gives the list of residents with their weights to the dietician once she obtains them and the dietician puts the weights into the resident's medical record. She added sometimes the dietician will asks her to reweigh the residents and she gives the dietician the reweight to enter into the resident's medical record. When asked about the scales she said there is 2 mechanical lifts, one for the second floor and one for the third floor and they have a standing scale that can also accommodate a wheelchair, and that scale is located on the first floor. She said the scales are maintained by maintenance and have just been serviced before she returned from a leave on 08/19/24. When asked about the process for weighing residents with a scale, she said she zeros out the scale the resident is to be weighed on then weighs the resident; if the resident is weighed on the mechanical lift, she will then take the sling used for the resident and weigh it immediately after weighing the resident and subtract the weight of the sling from the weight of the resident and that net weight is what she submits to the dietician. An interview was conducted on 10/03/24 at 11:18 AM with the Registered Dietician (RD) who stated she has worked at the facility for [AGE] years and has been full time since June 2024. When asked what would constitute a significant weight loss she said, a weight loss of 5% or greater in 1 month, or 7.5% or greater in 3 months, or 10% or greater in 6 months. When asked how often residents are weighed, she said they are weighed on admission by someone from nursing department who will enter the admission weight for the resident. They do not take the weight from the hospital. The resident is weighed on admission, then the Restorative Aide will weigh the resident within next 3 days. Then the resident will be weighed weekly x 4 weeks, then evaluated for what the frequency will be based on any trend and usually will monthly thereafter. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about residents who receive tube feedings, she said she would generally not expect to see weight loss. She stated she ensures tube feeding orders are followed by doing rounds to spot check the resident to make sure the tube feeding orders are followed as ordered. When asked about the estimated needs for Resident #90, she said on 08/26/24 according to her calorie and protein the estimated needs of the resident were 1470 -1680 calories per day and 50-55 grams protein per day. When asked what was prescribed for the resident at that time, she said it was 1500 calories per day and 62.7 grams of protein per day (this was on the lower end of the estimated calories per day). When asked about Resident #90's weight, she said the resident weighed 92 pounds on admission to the facility on [DATE]. When asked if she put any interventions in place to address the significant weight loss of 10% in only 9 days, she said no because on 09/09/24 she spoke to the husband who stated his wife was not 92 pounds, she was 82 pounds, and he had witnessed her being weighed on a standing scale. The resident's husband stated his wife had weighed 78 pounds in the hospital and there was no way she could have weighed 92 pounds. She added that on 09/05/24, they had a IDT meeting, and she did not change the tube feeding orders because the tube feeding was meeting the resident needs. When asked if she thought the tube feeding was meeting the resident's needs even when the resident had an unexpected / unanticipated and undesirable significant weight loss of 10 pounds (10%) in less only 9 days, she said even though she had a 10% weight loss after her conversation with the resident's husband he reported her weight from the hospital was 78 pounds and she definitely could not have been 92 pounds because he had observed her being weighed on the standing scale at 82 pounds. The RD then acknowledged the resident's next weight was on 09/21/24 and she was 82 pounds. On 09/27/24 she was 83 pounds, which she acknowledged was a significant weight loss of 9% if you base it on the facility admission weight, but she was basing weight loss on what the husband had informed her was 82 pounds that he saw his wife being weighed on the standing scale. The RD insisted she did not change the tube feeding orders because she felt it was meeting her needs and was actually above her needs. When asked about the witnessed weight on 10/01/24 of 77.6 pounds, she insisted there was no need to adjust the tube feeding because the current tube feeding was above her needs. The RD stated on 10/02/24 she weighed the resident again on the standing scale and she weighed 79.6 pounds which still was a significant weight loss of 13% (12.4 pounds) based on the facility admission weight of 92 pounds but she still did not adjust or change the tube feeding because she was going by what the husband had told her was a weight of 82 pounds he had seen on the standing scale in the facility. She discussed the weight loss and tube feeding with the resident's husband, and he said his wife conveyed to him that she was feeling a little hungry and asked the nurse to start the tube feeding about an hour early. The husband informed her he was going to move his wife to an Assisted Living Facility (ALF), and she needed to be on bolus feeding to be admitted to ALF. The RD said the order for the tube feeding will be the same formulary and was to be 1 carton (355 calories per carton/14.9 grams of protein per carton) and she would receive 5 cartons per day starting in the evening around 4:00 PM on 10/03/24. When asked what the total calories and protein was for the day the resident would be receiving while on the 5 cartons a day, she said it would be 1775 calories per day and 74 grams of protein per day. When asked if the resident had any issue with tolerating the tube feeding, she said the resident has had no issue with tolerating the tube feeding since admission. When asked if she addressed the significant weight loss, she said no. When asked if she updated the care plan for the significant weight loss, she said unfortunately no. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38893 2. Record review revealed Resident #199 was admitted to the facility on [DATE]. Review of the resident's most recent full assessment, an admission MDS, dated [DATE], documented Resident #199 had a BIMS score of 04, indicating Resident #199 was severely cognitively impaired. The MDS documented Resident #199 was dependent upon staff for all activities of daily living (ADLs). Resident #199's diagnoses at the time of the assessment included: Anemia, Hypertension, Obstructive uropathy, Non-Alzheimer's dementia, Seizure disorder, Malnutrition, Gastrostomy malfunction, Guillain-Barre syndrome, Metabolic encephalopathy, Dysphagia following cerebral infarction, Speech/Language deficits following cerebral infarction, Sarcoidosis, and Pressure ulcer of sacral region stage 2. Resident #199's orders included: On 09/23/24 with a start date of 09/24/24 for, Enteral Feed Glucerna 1.2/1500ml at 83ml/hr (milliliters per hour). On 09/19/24, Head of Bed (HOB) elevated at 30-45 degrees while tube feed is running. On 10/02/24 at 7:20 AM, Resident #199 was observed in bed with the supplement being provided via an enteral pump. During the observation, Resident #199 was noted to be laying in a nearly supine position. When the concern was brought to the attention of Staff G, LPN, and Staff H, Staff H confirmed that Resident #199 was not positioned properly. Staff G stated, she should be at 45 degrees.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to ensure residents with a Post-Traumatic Stress Disorder (PTSD) received trauma-informed care in accordance with professional standards of practice and failed to account for the resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization for 1 of 1 sampled resident reviewed for PTSD, Resident #70. The findings included: Review of the facility's policy, titled, Trauma-Informed and Culturally Competent Care, dated 05/19/23, included the following purpose: To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Resident Screening 1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events. 3. Screening may include information such as: a. Trauma history, including type, severity and duration; b. Depression, trauma-related or dissociative symptoms; f. historical mental health diagnosis Resident Assessment 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. 2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. Record review for Resident #70 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Malignant Neoplasm of Endometrium, Bipolar Disorder, Psychosis Not Due to a Substance or Known Physiological Condition, Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Review of section I revealed Resident #70 diagnosis included: Bipolar Disorder, Psychotic Disorder, Depression, Post-Traumatic Stress Disorder (PTSD), and anxiety disorder. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders showed that Resident #70 had an order dated 05/23/24 which included: [NAME] psychology to evaluate and treat as needed. An interview was conducted on 10/02/24 at 1:43 PM with DON. He acknowledged that Resident #70 has not been seen by a psychologist since she was admitted in 05/15/24. An interview was conducted on 10/02/24 at 4:48 PM with Resident #70. She stated she was seeing a psychologist before she was admitted to the facility because of her diagnosis of bipolar disorder and depression. Resident #70 stated she would like to be seen by the psychologist. She does not recall being monitored for any behaviors. An interview was conducted on 10/02/24 at 4:59 PM with the Social Services Director (SSD). She stated the resident's diagnosis are derived from the hospital documentation when the resident is transferred to the facility, and the physician would be the one to diagnose the resident with PTSD. She acknowledged not questioning Resident #70 about her PTSD since the resident had no change in mood and did not express any sign of PTSD. The SSD acknowledged that Resident #70 should have had a psychology evaluation upon admission due to her psychological diagnosis including PTSD. She stated she was unable to find any psychology consultation at all for Resident #70.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to obtain orders for bed rails, failed to develop and implement a care plan for bed rails, and failed to regularly inspect rails for fit and function for 2 of 2 sampled residents reviewed for bed rails, Residents #197 and #199 The findings included: Review of the facility policy, titled, Bed Safety and Bed Rails, with a revision date of August, 2022, documented, in part: Facility Statement: The use of bed rails is prohibited unless the criteria for use of bd rails have been met. Policy Interpretation and Implementation 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping havits and bed environment 6. Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. 7. the maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection result and QAPI committee recommendations are maintained by the administrator and/or safety committee. Use of Bed Rails 3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment and informed consent. 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards b. foam bumpers (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. lowering the bed d. use of concave mattresses to reduce rolling off the bed 8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails b. The residents' risks from the use of bed rails and how these will be mitigated c. The alternatives that were attempted but failed to meet the residents' needs d. The alternatives that were considered but not attempted and the reasons. 1. Record review revealed Resident #197 was admitted to the facility on [DATE]. Review of the resident's most recent full Minimum Data Set (MDS) assessment, a Medicare 5-day MDS, dated [DATE], dcoumented Resident #197 had a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact. The assessment documented Resident #197 required partial / moderate assist for bed mobility and transfer and ambulated independently with use of a manual wheelchair (w/c). The resident was observed walking behind a w/c on multiple occasions during the 4-day survey. Resident #197's diagnoses at the time of the assessment included: Hypertension, Depression, and Chronic Lung Disease. Review of Resident #197's medical records revealed that there were no orders for bedrails and no care plan for the use of the rails. During an interview, on 10/01/24 at 12:50 PM, with Resident #197, it was noted that the resident had bilateral rails in a raised position from the head of the bed to approximately the middle of the bed. When asked about the bed rails, Resident #197 replied, I don't use them, they just put them here. During an interview, on 10/03/24 at 10:51 AM, with the Therapy Director and the Occupational Therapist, when asked about the use of bedrails for Resident #197, the Occupational Therapist replied, he is high-functioning, I see them working with safety orientation and things like that. The Therapy Director stated, we do the bedrail assessments, the nurse does the order for the bedrails, we recommended that he have them. 2. Record review revealed Resident #199 was admitted to the facility on [DATE]. Review of the resident's most recent full assessment, an admission MDS, dated [DATE], documented Resident #199 had a BIMS score of 04, indicating that Resident #199 was severely cognitively impaired. The MDS documented Resident #199 was dependent on staff for all activities of daily living (ADLs). Resident #199's diagnoses at the time of the assessment included: Anemia, Hypertension, Obstructive Uropathy, Non-Alzheimer's dementia, Seizure Disorder, Malnutrition, Gastrostomy Malfunction, Guillain-Barre Syndrome, Metabolic Encephalopathy, Dysphagia, Speech / Language deficits, Sarcoidosis, and Pressure Ulcer of sacral region Stage 2. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #199 was not interviewable. Review of Resident #199's medical records revealed that there were no orders and no care plan for the use of bedrails. An interview was conducted on 10/01/24 at 10:44 AM with Resident #199's family member. Resident #199 was observed in bed with a supplement being provided via an enteral pump. It was noted the resident had bilateral siderails, from the head of the bed to approximately the middle of the bed. When asked about the benefit of the use of the bed rails for Resident #199, the family member stated the resident would not be able to use them as the resident did not have enough upper body mobility to grab and hold onto the rails. On 10/02/24 at 7:20 AM, Resident #199 was observed in bed with a supplement being provided via an enteral pump. During the observation, it was noted that the resident had bilateral siderails from the head of the bed to approximately the middle of the bed in a raised position. Review of the Siderail / Bedrail Review (assessment), dated 09/15/24, documented: Recommendations - none. Side rails are not indicated at this time. An interview was conducted on 10/03/24 at 10:51 AM with the Therapy Director and the Occupational Therapist (OT). When asked about the use of bedrails for Resident #199, the OT provided documentation of recommendation for the resident to not have rails. The OT stated, the concern would be that the resident could get caught in the rails by involuntary movement. The OT stated Resident #199 did not have upper body mobility to use the rails or be a benefit from the use of the rails. The OT stated the resident was not at risk for falling from the bed due to the limited mobility. 3. An interview ws conducted on 10/03/24 at 8:39 AM with the Maintenance Director, who when asked about monitoring and inspecting bedrails for fit and function, the Maintenance Director replied, every time someone is discharged , we check the rails to make sure they are not loose and that they fit the bed properly. When asked about inspecting the rails for residents that have not been discharged and are long term, the Maintenance Director replied, quarterly. On 10/03/24 at 11:19 AM, the Maintenance Director reported to the surveyor that there were no audits being done and provided a blank spreadsheet that was to be used to conduct audits of the bed rails.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to post the nursing staff's total number and actual hours, before the beginning of each shift, and failed to ensure nursing staffing hours posted were accurate and current for random sampled dates. The findings included: On 09/30/24 at 8:45 AM, observation upon arrival to the facility's reception area revealed a glass window with a nursing staffing posting dated 09/29/24. The facility did not post the nursing staffing hours at the beginning of the shift for 09/30/24. On 10/01/24 at 8:35 AM, observation upon arrival to the facility's reception area revealed a glass window with a nursing staffing posting dated 09/30/24. The facility did not post the nursing staffing hours at the beginning of the shift for 10/01/24. On 10/02/24 at 8:00 AM, observation upon arrival to the facility's reception area revealed a glass window with a nursing staffing posting dated 10/01/24. The facility did not post the nursing staffing hours at the beginning of the shift for 10/02/24. On 10/03/24 at 12:04 PM, an interview was conducted with the Staffing Coordinator / Human Resources who stated she provides the receptionist with the nursing staff schedule for all three shifts, the receptionist fills out the nursing staffing posting with the hours scheduled and the receptionist would post it. The Staffing Coordinator stated she will let the receptionist know of any nursing staffing changes for any shift and the receptionist would update the posting. The Staffing Coordinator stated the Nursing staffing hours are posted by the receptionist at 8:00 AM. The Staffing Coordinator was asked if the nursing staffing posting had the actual staffing hours and replied, no, the posting showed scheduled hours only. Subsequently, a side-by-side review of the Staffing Coordinator job description was conducted. The Staffing Coordinator job description signed and dated 10/26/23 documented, .responsibilities include: create and post schedules for nursing department, track and post changes . A side-by-side review of the Receptionist job description was conducted with the Staffing Coordinator / Human Resources. The receptionist job description did not include to create and post schedules for the nursing department, nor other duties as assigned. On 10/03/24 at 12:43 PM, an interview was conducted with Staff AA, Receptionist, who stated she has been a receptionist in the facility for [AGE] years. Staff AA stated her responsibilities included posting nursing staff hours responsible for the resident's care. Staff AA stated she posted the nursing staffing hours in the morning as soon as she came in at 8:00 AM. Staff AA stated she gets the nursing schedule from Human Resources and she then filled out a form with the amount of nurses and CNAs (Certified Nursing Assistants), multiply 8 hours for each nurses and CNA scheduled for the shift and wrote down a total hours for the discipline (nurse or CNA), then posted the hours scheduled for the day. Staff AA was asked what she would do if an updated nursing staff schedule was given, and replied she will correct the change and the amount of hours if it was not the same she posted before. Staff AA added the updates did not happen a lot. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 10/03/24 at 1:15 PM, a side-by-side review with the Staffing Coordinator of random sampled nursing staffing hours posted and the Scheduling Master spreadsheet revealed the following: *Posting dated 07/02/24 - Tuesday, documented thirteen (13) CNAs scheduled for the 7:00 AM to 3:00 PM shift. The scheduling master report documented that on 07/02/24, two (2) CNA called off for the 7:00 AM to 3:00 PM shift. The posting was not updated and accurate. *Posting dated 07/04/24 - Thursday, documented twelve (12) CNAs scheduled for the 7:00 AM to 3:00 PM shift and zero (0) nurses scheduled for the 3:00 PM to 11:00 PM shift. The scheduling master report documented that on 07/04/24, 13 CNAs were scheduled and one (1) Registered Nurse (RN) scheduled for the 3:00 PM to 11:00 PM shift. The posting was not updated and accurate. *Posting dated 08/30/24 - Friday, documented five (5) CNAs for the 11:00 PM to 7:00 AM shift. The scheduling master report documented that on 08/30/24, six (6) CNAs were scheduled not five (5) as per the posting. The posting was not updated and accurate. *Posting dated 09/01/24 - Sunday, documented 24 hours for the evening nurse. The Staffing Coordinator stated the evening nurse was supposed to be 20 hours and not 24 hours as posted because the supervisor works 12 hours shift. The posting was not accurate. *Posting dated 09/02/24 - Monday documented tweleve (12) CNAs scheduled for the 3:00 PM to 11:00 PM shift. The scheduling master report documented that on 09/02/24, one (1) CNA called off for the 3:00 PM to 11:00 PM shift. The posting was not updated and accurate. *Posting dated 09/23/24 - Monday, documented eleven (11) CNAs scheduled for the 3:00 PM to 11:00 PM shift. The scheduling master report documented that on 09/23/24, one (1) CNA called off for the 3:00 PM to 11:00 PM shift. The posting was not updated and accurate. *Posting dated 09/28/24 - Saturday, documented thirteen (13) CNAs scheduled for the 7:00 AM to 3:00 PM shift. The scheduling master report documented that on 09/28/24, one (1) CNA called off for the 7:00 AM to 3:00 PM shift. The Staffing Coordinator stated the posting documented eleven (11) CNAs scheduled for the 3:00 PM to 11:00 PM shift and it was supposed to document twelve (12) CNA on duty. The posting was not updated and accurate. *Posting dated 09/29/24 - Sunday, documented eleven (11) CNAs scheduled for the 3:00 PM to 11:00 PM shift. The scheduling master report documented that on 09/29/24, one (1) CNA called off for the 3:00 PM to 11:00 PM shift. The posting was not updated and accurate. During the review, the staffing coordinator confirmed the posting inaccuracies. On 10/03/24 at 1:40 PM, an interview was conducted with the Administrator who stated the receptionist had always completed the nursing staff posting. The Administrator was apprised that the postings were inaccurate and did not reflect the actual staff hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to accurately reconcile controlled medications and failed to ensure discontinued controlled medications were removed from the medication cart for 2 of 5 sampled residents reviewed for controlled medications reconciliation, Resident #33 and Resident #41. The findings included: Review of the facility's policy, titled, Controlled Substances, dated November 2022, included the following: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 13. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. 14. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. 15. The consultant pharmacist or designee routinely monitors controlled substance storage records. Review of the facility's policy, titled, Administering Medications, dated April 2019, included the following: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medications are administered in accordance with prescriber orders 22. The individual administering the medication initials the resident's Medication Administration Records (MAR) on the appropriate line after giving each medication and before administering the next ones. 23 .As required or indicated for a medication, the individual administering the medication records in the resident's medical record. An observation of medication storage and reconciliation of controlled medications was conducted on 10/02/24 at 10:12 AM on the third-floor [NAME] hallway with Staff Q, Licensed Practical Nurse / LPN. 1. Record review for Resident #33 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Unspecified Fracture of Right Femur and Dementia. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #33 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated that she was rarely / never understood. Review of the Physician's Orders revealed Resident #33 had an order dated 08/21/23 for Tramadol HCL tablet 50 mg to give 1 tablet by mouth every 6 hours as needed (PRN) for moderate and severe pain. Non-Acute pain. Review of the September Medication Administration Records (MAR) revealed Resident #33 was administered Tramadol 50 mg PRN on the following dates: 09/01/24 at 4:44 PM with a pain level of 5 of 10. 09/04/24 at 3:12 PM with a pain level of 0 of 10. 09/07/24 at 10:50 AM with a pain level of 0 of 10. 09/13/24 at 9:00 AM with a pain level of 5 of 10. 09/16/24 at 8:43 PM with a pain level of 5 of 10. 09/18/24 at 2:58 PM with a pain level of 0 of 10. 09/25/24 at 1:05 PM with a pain level of 0 of 10. 09/25/24 at 8:47 PM with a pain level of 6 of 10. 09/28/24 at 5:40 PM with a pain level of 7 of 10. However, review of the Medication Monitoring / Control Record revealed Resident #33 was administered Tramadol 50 mg PRN on 09/07/24 at 9:00 PM and 09/20/24 at 3:50 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #41 revealed the resident was readmitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus, Immunodeficiency, and End Stage Renal Disease. Review of Section C of the MDS assessment dated [DATE] revealed that Resident #41 had a BIMS score of 07, which indicated that he was severely cognitive impaired. Review of the Physician's Orders showed that Resident #41 had an order dated 04/09/24 for monitor for Pain every shift; and on 04/19/24 an order was added for Tramadol HCL tablet 50 mg to give 1 tablet by mouth every 6 hours as needed (PRN) for pain, with a discontinued date of 09/06/24. Review of the September Medication Administration Records (MAR) revealed Resident #41 was not administered Tramadol 50 mg PRN prior to the discontinued date 09/06/24. In addition, the MAR also revealed on 09/08/24, Resident #41 was monitored for pain reporting a pain level of 0 for every shift. Review of the Medication Monitoring/Control Record revealed Resident #41 was administered Tramadol 50 mg PRN on 09/08/24 at 0100 [AM]. An interview was conducted on 10/03/24 at 2:20 PM with Staff R, Registered Nurse (RN), who stated he has been working at the facility for 7 months. He stated if a resident requests pain medication, such as Tramadol, he would conduct a pain assessment and check physician's orders for pain medication. Staff R stated if there's no order for pain medication, he would contact the doctor for an order and administer the medication. He then will document almost at the same time in the MAR and in the Medication Monitoring/Control Record. An interview was conducted on 10/03/24 at 3:59 PM with the Director of Nursing (DON). He stated that per protocol the nurse will check physician's orders for the controlled medication and document when administered in the MAR and in the Medication Monitoring/Control Record. The DON was asked about a policy for reconciliation of controlled medications and was not sure if a policy existed. He stated the nurses do counts of the controlled medications on every change of shift with the incoming nurse. The DON stated as per protocol the count of the controlled medications in the medication cart drawer is compared to the number in the Medication Monitoring / Control Record, and this is done every shift. When asked if any unit manager/DON randomly conducts periotic reconciliation of controlled medications, he stated, no.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to adequately monitor for side effects and behaviors for resident receiving antipsychotic medication and the consultant pharmacist failed to recommend the monitoring for side effects and behaviors for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #70). The findings included: Record review for Resident #70 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Malignant Neoplasm of Endometrium, Bipolar Disorder, Psychosis Not Due to a Substance or Known Physiological Condition, Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that she was cognitively intact. Review of section I revealed Resident #70 diagnosis included: Bipolar Disorder, Psychotic Disorder, Depression, PTSD, and anxiety disorder. Review of Section N revealed that Resident #70 was on antipsychotic, antidepressant, and anticoagulant. Review of the Physician's Orders revealed that Resident #70 had an order dated 05/16/24 which included: Aripiprazole tablet 2 mg, give 1 tablet by mouth one time a day for psychosis. There was no evidence of a physician's order for monitoring side effects and behaviors for antipsychotic medication such as Aripiprazole. Review of the Care Plan dated 08/12/24 documented Resident #70 uses psychotropic medications to r/t [related to] Bipolar, Psychoses, and Anxiety. Goals included: resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation / impaction or cognitive/behavioral impairment through next review date; and the resident will reduce the use of psychoactive medication through the review date. Interventions were to: Administer medications as ordered and to monitor/document for side effects and effectiveness. Review of the September Medical Administration Record (MAR) revealed no documentation that Resident #70 was monitored for behaviors and side effects for the antipsychotic medication, Aripiprazole. Review of the medication Regimen Reviews performed by the consultant pharmacist since the admission of Resident #70 (May-September 2024) reported no recommendations for monitoring of behaviors or side effects for the antipsychotic medication, Aripiprazole. An interview was conducted on 10/02/24 at 12:47 PM with the consultant Pharmacist. She stated Resident #70 should have been monitored for behaviors and side effects since she is taking an antipsychotic medication. She acknowledged no behavior or side effect monitoring orders from the physician or psychologist for Resident #70. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/02/24 at 1:31 PM with the Staff O, MDS Coordinator. She stated that she was unable to find any psychology notes or orders for monitoring behaviors for Resident #70. However, she acknowledged Resident #70 is on antipsychotic medications and should be monitored for behavior and side effects. An interview was conducted on 10/02/24 at 1:43 PM with Director of Nursing (DON). He stated he was unable to find the order for behavior monitoring for Resident #70's or monitoring for side effects for the antipsychotic medication. He also acknowledged that Resident #70 has not been seen by a psychologist since she was admitted in May 2024. An interview was conducted on 10/02/24 at 4:48 PM with Resident #70. She stated she has never been asked about her behavior or side effects of medications. An interview was conducted on 10/02/24 at 4:59 PM with the Social Services Director (SSD). She acknowledged that Resident #70 should be monitored for behavior due to her medications. She mentioned that she was unable to find any psychology consultation at all for Resident #70. The SSD stated she does not know why Resident #70 was not followed by psychology.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interview and record review, the facility failed to ensure medications were stored securely for 1 of 4 sampled residents observed for medication administration, Resident #246, and 1 of 25 sampled residents, Resident #8. The findings included: Review of the facility's policy, titled, Medication labeling and Storage, with a published date of 08/06/24, included, in part, the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 1. Record review for Resident #246 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on 08/19/24. The resident's diagnoses included, in part, the following: Cerebral Infarction Unspecified, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Immunodeficiency, Other Idiopathic Peripheral Autonomic Neuropathy, Other Speech and Language Deficits Following Cerebral Infarction, and Type 2 Diabetes Mellitus with other Specified Complication. Review of the Minimum Data Set (MDS) for Resident #246 dated 09/19/24 documented in Section C a Brief Interview of Mental Status score of 12, indicating moderate cognitive impairment. Review of the Physician's Order for Resident #246 revealed an order dated 09/23/24 for Voltaren Arthritis Pain External Gel 1 % (Diclofenac Sodium (Topical). Apply to right knee topically two times a day for arthritis pain Apply 4 grams. Review of the Physician's Order for Resident #246 revealed an order dated order dated 08/19/24 for Gabapentin Capsule 300 MG give 1 capsule by mouth three times a day for Neuropathic Pain. During an observation of a medication pass conducted on 10/01/24 at 4:30 PM with Staff A, Registered Nurse (RN), for Resident #246, Staff A brought the following medications into the resident's room to be administered: Carvedilol 12.5mg tab, Buspirone hcl 5mg tab, Metformin 1,000mg tab, Elder tonic 15milliliters, Magnesium Oxide 400mg tab, and Diclofenac sodium (Voltaren Arthritis) topical gel 1%. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff A then placed all of the medications on the resident's overbed table, next to him and went into the resident's bathroom (out of sight of the medications) to wash her hands, she then proceeded to administer the medications to the resident. After Staff A administered the medications, she left the Diclofenac Sodium topical gel 1% on the overbed table, next to the resident, and entered the resident's bathroom a second time leaving the medication out of her sight, while she went into the bathroom to remove gloves and wash her hands. An interview was conducted on 10/01/24 at 4:50 PM with Staff A who stated she has worked at the facility for about 1 month. When asked about leaving the medication at the bedside next to the resident and out of her sight to wash her hands in the resident's bathroom, she said she should not have left the medications unattended. 2. On 09/30/24 at 12:19 PM, an observation was made of Resident #8 lying in bed with the overbed table in front of her. It was noted that on the overbed table was Systene Complete PF eye drops. On 10/01/24 at 10:15 AM, a second observation was made of Resident #8 lying in bed with overbed table in front of her. It was noted that on the overbed table was Systene Complete PF eye drops, still in plain sight. An interview was conducted on 10/01/24 at 10:15 AM with Resident #8 who was asked about the eye drops, she said she uses them every night for her dry eyes. An interview was conducted on 10/01/24 at 10:30 AM with Staff B Registered Nurse / Unit Manager (RN/UM) who was asked about medications (meds) at the bedside, she said residents should not have meds at the bedside. During a side-by-side observation with the RN/UM of Resident #8 with the Systene Complete eye drops on the overbed table, she acknowledged the resident should not have those and they needed a doctor's order. She then informed the resident she could not have the eye drops at the bedside and removed them.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38893 Based on observations, interviews and record review, the facility failed to provide portions of pureed food according to the approved menu, with the potential to affect 14 residents with orders for puree diets, including Residents #4, #40, #48, #199 and #201. The findings included: Review of the approved menu for the lunch being served on 10/02/24 was for 4-ounces of Beef Stew for residents with 'Regular' diet orders and 6-ounces of the beef stew for residents with 'Puree' diet orders. During the kitchen tour, on 10/02/24 at 11:32 AM, accompanied by the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager, while plating the lunch meal, Staff F, Cook, placed a scoop of the beef stew that accounted for a serving and plated the remainder of the lunch and passed it off to staff to cover and placed on a tray and in a cart. At the request of the surveyor, Staff F placed a portion of the beef stew in the same manner on the facility's calibrated kitchen scale. The portion of beef stew weighed 4-ounces. At this same time, when a meal of pureed food was called for, Staff F placed a scoop of the pureed beef stew that accounted for a serving and plated the remainder of the lunch and passed it off to staff to cover and place on a tray and in a cart. At the request of the surveyor, Staff F placed a portion of the pureed beef stew in the same manner on the facility's calibrated kitchen scale. The portion of beef stew weighed 4-ounces. It was noted that Staff F used a 4-ounce scoop for both the regular and the pureed portion of the beef stew. At the time of the observation, the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager acknowledged the residents with orders for pureed diet orders were not being served according to the approved menu.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to prepare pureed vegetables in a manner to preserve their nutritive value, with the potential to affect 14 residents with orders for pureed diets, including sampled Residents #4, #40, #48, #199 and #201. The facility failed to follow the recipe for carrots, with the potential to affect all residents that eat from the approved menu. The findings included: Review of the facility's recipe for Carrots, Diced, (no reference date), documented the following instructions: Procedures: 1. Peel and cut carrots into 1/8 inch slices. Steam about 4 minutes. 2. Add broccoli florets and steam another 7-8 minutes or until vegetables are tender. 3. Add butter. Mix. Add salt and pepper to taste just before serving. Notes: 1. For pureed: Measure desired # of servings into food processor. Blend until smooth. Add liquid if product needs thinning. Add commercial thickener if product needs thickening. 2. Puree Level 4: [NAME] texture, no lumps, liquid must not separate from solid, may not be sticky, cannot be drunk from a cup or sucked through a straw. Shows some very slow movement under gravity, but cannot be poured, hold shape of spoon and fall off spoon in a single spoonful. During the kitchen tour, on 10/02/24 at 11:32 AM, accompanied by the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager, the pureed carrots that were in a 1/3 sized 6-inch deep hotel pan hot holding unit appeared to be soupy and sloshed about the pan when Staff B stirred the carrots. Additionally, there was a 1/3 sized 6-inch deep hotal pan of diced carrots in the hot holding unit that did not appear to have any other vegetable type or ingredient in it. While Staff B, Cook, was placing a portion of the pureed carrots into a small bowl to place on the plate, the pureed carrots appeared to be soupy and pooled in the bowl. When asked about the preparation of the pureed carrots, Staff B replied, I use frozen carrots and thaw them out and put them in the blender and add water to it so that it will mix better, I reheat them and put them on the line. Staff B did not indicate that there were any other vegetables or ingredients in either pan of carrots. At the time of the observation, the Dietetic Tech / Kitchen Supervisor acknowledged that the amount of water added to the carrots to obtain the consistency that was observed diminished the nutritional value of the carrots.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to prepare pureed vegetables in a form to accomodate the residents' needs, with the potential to affect 14 residents with orders for pureed diets, including Residents #4, #40, #48, #199 and #201. The findings included: Review of the facility's recipe for, Carrots, Diced, (no reference date), documented the following instructions: Puree Level 4: [NAME] texture, no lumps, liquid must not separate from solid, may not be sticky, cannot be drunk from a cup or sucked through a straw. Shows some very slow movement under gravity, but cannot be poured, hold shape of spoon and fall off spoon in a single spoonful. During the kitchen tour, on 10/02/24 at 11:32 AM, accompanied by the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager, the pureed carrots that were in a 1/3 sized 6-inch deep hotel pan hot holding unit appeared to be soupy and sloshed about the pan when Staff B, Cook, stirred the carrots. While Staff B, was placing a portion of the pureed carrots into a small bowl to place on the plate, the pureed carrots appeared to be soupy and pooled in the bowl and did not hold the shape and consistency of the other pureed foods that were plated with the carrots. The Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager acknowledged the findings. The Dietitic Teach instructed Staff B to add thickener to the carrots to obtain a thicker consistency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observation, interview and record review, the facility failed to prepare, store, and served meals in a safe and sanitary manner and in accordance with standards for food safety. The findings included: During the initial kitchen tour, on 09/30/24 at 9:03 AM, accompanied by the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager, the following was observed: 1. Upon entering the kitchen and making an introduction to the staff, the surveyor proceeded to perform hand hygiene at the designated hand washing sink. The surveyor turned on the hot water and waited for the water to get hot. After several minutes, the water did not get to the appropriate temperature for hand hygiene. 2. In the walk in cooler, there was a full sized 6-inch deep hotel pan of par-cooked chicken stored over packages of ready to eat deli meats. The Dietetic Tech and Staff B, Cook, confirmed that the chicken was partially raw. 3. There was a damp towel kept on the handles of the convection oven. When asked about the purpose for having the towels kept in that manner, Staff B stated that it was to remind her that there was food still in the oven. 4. There was an accumulation of residue on the pipes of the fire suppression system over the cooking equipment. 5. Cleaned and sanitized hotel pans were found to be wet nesting on the shelf of the basin used for sanitizing wares in the three compartment sink. 6. There was an accumulation of food residue and debris on the slier blade and in the assembly of the sharpening stones. 7. The temperature of the hot water in the mechanical dishwasher failed to reach the required 120 degrees Fahrenheit (F) necessary to properly clean and sanitize wares. The temperature was observed to be at the approximate 88 to 90 (F) mark. Photographic Evidence Obtained. At the conclusion of the tour, the Dietetic Tech / Kitchen Supervisor and the Regional Dietary Manager acknowledged the findings. The Dietetic Tech/Kitchen Supervisor stated that meals would be served using single use and disposable wares until the dish washer was properly washing and sanitizing the wares. On 09/30/24 at 9:51 AM, the Maintenance Director reported that the hot water heater that supplied hot water to the kitchen had to be shut off due to plumbing issues and that the facility was working on the repairs.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41837 Based on interview and record review, the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to maintain an environment free of accident hazards. The findings included: Review of the Job Description: Administrator, with no date, included in part the following: Purpose of the Position The primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. Delegation of Authority As the Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities: Administrative Functions 1. Plan, develop, organize, implement, evaluate and direct the facility's programs and activities. 2. Review policies and procedures that govern the operation of the facility. Safety and Sanitation 1. Assure that all facility personnel, residents, visitors, etc., follow established safety regulations, to include fire protection/prevention, smoking regulations, infection control, etc. 2. Assur that the building and grounds are maintained in good repair 3. Review accident/incident reports and establish an effective accident prevention program. Miscellaneous 1. Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Assure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical function status as defined by the comprehensive assessment and care plan 3. Assist the Quality Assurance Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. An interview was conducted on 10/03/24 at 10:15 AM with the Administrator who stated she is also the Risk Manager and has worked at the facility for about 6 years. When asked about the cigarette burn sustained by Resident #19 on 05/20/24, she said she honestly did not remember the incident until she reread the report that was asked for (by the surveyor) on alteration in skin for the resident. She said they had another issue under investigation at that time that she was more focused on. She acknowledged she never went back to review the incident or make sure any interventions were put in place. She said that the Director Of Nursing and several other staff had left the facility in the weeks following the investigation. The Administrator said she was aware residents were coming down to smoke at various times on the smoking patio. She said all but one are safe smokers. She also stated she was not aware that the smoking risks forms / evaluations were not being performed quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105205	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. 49060 Based on observations, interviews, and record review, the facility failed to ensure the closet space in residents' rooms had doors or coverings to maintain the residents' clothing clean, protected, and to provide privacy for 30 of 60 total residents' rooms, located on the 3rd floor, that were reviewed for a home-like environment. The findings included: During the initial tour of the facility conducted on 09/30/24 at 9:37 AM, it was observed that all the residents' rooms on the third floor were missing closet doors revealing residents' personal clothing and items. In several of those rooms, observation revealed the resident's clothing whad been thrown on the bottom shelf of the closet in a disorganized manner and visible to residents and visitors. An interview was conducted on 10/02/24 at 9:34 AM with Staff S, Certified Nursing Assistant (CNA). Staff S stated she has worked at the facility for one year and always works on the third floor. Staff S stated since she has been working in the facility, the closets in the residents' rooms have always been without a curtain or a door. An interview was conducted on 10/02/24 at 9:45 AM with Staff T, CNA. Staff T stated she has been working at the facility for about 9 months and has been assigned mainly to the third floor. Staff T acknowledged never seeing the residents' closets with doors. On 10/03/24 at 9:00 AM, an environmental tour was conducted with the Director of Maintenance (DOM) who acknowledged the findings that the residents' closets on the third floor did not have doors or coverings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105205	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savoy at Fort Lauderdale Rehabilitation and Nursin	2121 E Commercial Blvd Fort Lauderdale, FL 33308

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to ensure bathrooms located in residents' rooms were adequately equipped with an emergency call system pull cord to allow residents to call for staff assistance, for 6 of 60 rooms reviewed for the residents' call light system on the 2nd (second) and 3rd (third) floors, room [ROOM NUMBER], 222, 232, 304, 307 and 314). The findings included: During the initial tour conducted on 09/30/24 at 10:44 AM of the facility's 3rd floor rooms, it was observed that room [ROOM NUMBER]'s bathroom was missing the pull cord for the emergency call light system. Photographic Evidence Obtained. Further observation at this time of the 3rd floor rooms revealed rooms [ROOM NUMBERS] were also missing the pull cord for the call light system in the residents' bathrooms. During the 2nd floor tour, two resident bathrooms, rooms [ROOM NUMBERS], were observed to be missing the pull cords of the call light system, and in room [ROOM NUMBER], the emergency pull cord was observed to be wrapped around the grabbing bar, making the pull cord not accessible or useable for the resident. On 10/02/24 at 10:15 AM, further observation was conducted of rooms [ROOM NUMBERS] bathrooms. The pull cords were still missing from the emergency call light system. An interview was conducted on 10/02/24 at 10:25 AM with Staff P, Certified Nursing Assistant (CNA). Staff P stated she has worked at the facility since 2008, and is assigned to provide care to the residents in room [ROOM NUMBER]. Staff P stated both residents required assistance for toileting. She stated she would assist the resident to the toilet, stand outside of the bathroom door to provide privacy, but would stay close by to assist the resident once they are done in the bathroom. Staff P stated both residents are vocal and can communicate when they are done in the bathroom. She acknowledged the resident located by the window can wheel herself around the room with her wheelchair. An interview was conducted on 10/03/24 at 4:30 PM with Staff Z, CNA, assigned to provide care to residents in room [ROOM NUMBER]. Staff Z stated she has worked at the facility for [AGE] years. She stated only one of the residents in room [ROOM NUMBER] can wheel herself to the bathroom and requires slight assistance with toilet transfer. Staff Z was asked if the resident was to have a fall in the bathroom how would the resident call for help. She stated there's a call light in the bathroom the resident can use. When Staff Z was asked to show the surveyor how the resident would use the call light system in the bathroom, she realized that there was no pull cord for the resident to use in case of an emergency. Staff Z was not sure how long the pull cord for the call light had been missing. An environmental tour was conducted on 10/03/24 at 9:00 AM with the Director of Maintenance (DOM) who acknowledged the findings of the bathrooms in resident's rooms not having the pull cords for the emergency call light system.