STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105258	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Pompano Beach	2401 NE 2nd Street Pompano Beach, FL 33062

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to provide eating assistance in a dignified manner for 1 of 22 residents observed during in-room dining (Resident #51) and failed to provide privacy during personal care for 1 of 22 residents observed during the initial tour (Resident #26). The findings included: Review of the facility's policy titled Bathing/Showering revised on 09/01/17 documented .assure privacy . Review of the facility's policy titled Perineal Care revised on 09/05/17 documented .provide privacy . 1) Review of Resident #51's clinical record documented an admission on 08/02/23 with no readmissions. The resident's diagnoses included Cerebral Infarction, Anemia and Major Depression. Review of Resident #51's physician orders dated 07/11/23 documented Admit to local hospice services, physician order dated 10/05/23 documented Resident needs assistance with feeding. Review of Resident #51's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3 indicating the resident had severe cognition impairment. The assessment documented under Functional Abilities that the resident needed substantial/maximal assistance from the staff with her eating activity. On 03/31/25 at 8:36 AM, observation revealed Resident #51in bed and assisted with feeding by an aide. Further observation revealed the aide was standing while feeding the resident, the aide was not at the resident's eye level. Subsequently, an interview was conducted with the aide who stated she did not work for the facility and that she was Resident #51's hospice aide. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/25 at 12:19 PM, an interview was conducted with the hospice aide who confirmed she was standing while feeding Resident #51 on 03/31/25. The hospice aide was asked if she sits or stands while feeding a resident and stated it dependent on how comfortable she felt, she may stand or sit. The aide was asked if she had education from the facility staff or the hospice nurse regarding providing feeding assistance to resident and dignity and replied that no one had educated her about it. The hospice aide was apprised of dignity concerns with her standing and feeding Resident #51. On 04/03/25 at 1:19 PM, during an interview, the Regional Nurse was asked to submit the facility's policy related to assistance with feeding and/or Activities of Daily Living and stated they did not have one, and provided the policies cited above. On 04/03/25 at 6:01 PM, during an interview, the Director of Nursing was made aware of findings. 2) Review of Resident #26's clinical record documented an admission on 05/06/24 and readmission on 01/14/25. The resident diagnoses included COPD, Cerebral Infarction, Aphasia and Convulsions. Review of Resident #26's Minimum Data Set (MDS) significant change assessment dated [DATE] documented a BIMS score of 0, indicating that the resident had severe cognition impairment. The assessment documented under Functional Abilities that the resident needed substantial/maximal assistance from the staff to complete bathing and lower body dressing activities of daily living. Review of Resident #26's care plan titled Resident has an ADL self-care performance deficit r/t Hemiplegia, Limited Mobility . Interventions to include resident is totally dependent on (2) staff for repositioning and turning . On 03/31/25 at 11:05 AM, during an initial tour of the residents room, Resident #26's room had an open wall, a walk thru between the resident's room and another room. The open wall did not have a privacy curtain and the surveyor observed Staff G, Certified Nursing Assistant (CNA) providing care to Resident #26. The resident was uncovered, showing his adult brief and uncovered lower extremities. On 03/31/25 at 11:17 AM, the surveyor entered Resident #26's room, observation revealed the resident was in bed and Staff G was providing care. Further observation revealed, no privacy curtains, the window blinds were not down. Resident #26 was not provided privacy during personal care. Resident #26 was not interviewable. Consequently, an interview was conducted with Staff G who stated she did not know when the privacy curtains were removed. On 04/03/25 at 9:51 AM, during an environmental tour, the Director of Environmental Services (DES) stated they were waiting for Resident #26's room privacy curtain ordered last month. The DES was asked what the purpose of the privacy curtains was and replied to provide privacy. The DES was apprised of the lack of privacy during Resident #26's care. The DES was asked regarding a privacy curtain between Resident #26's room and the open wall between the next room, the DES stated Resident #26 pulled the curtain down and it had not been replaced. On 04/03/25 at 12:15 AM, an interview was conducted with Staff G, CNA, who confirmed Resident #26 did not have privacy curtains in the room and that privacy was very important. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/25 at 12:40 PM, an interview was conducted with Staff G who stated that she had to provide the residents with privacy during care and confirmed Resident #26 and his roommate did not have privacy curtains.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations and interviews, the facility failed to provide a safe, clean, comfortable and homelike environment for 8 out of 39 rooms. The findings included: 1) On 04/01/2025 at 8:45 AM, an observation revealed that room [ROOM NUMBER]'s bathroom toilet seat is peeling off. The bathrooms wall has a hole in it that is filled with gloves and hair. The floor of the shower has black spots. 2) On 04/01/2025 at 8:55 AM, an observation revealed that room [ROOM NUMBER]'s door laminate is coming off which is impeding the door from opening smoothly. 3) On 04/01/2025 at 9:00 AM, an observation revealed that room [ROOM NUMBER]'s door cannot close. 4) On 04/01/2025 at 9:10AM, an observation revealed that room [ROOM NUMBER]-CD and room [ROOM NUMBER]-CD have loose baseboards. 5) On 04/01/2025 at 9:15 AM, an observation revealed that room [ROOM NUMBER]-AB is missing the room separator curtain. 6) On 04/01/2025 at 9:20 AM, an observation revealed that room [ROOM NUMBER]-AB's window crank handle is broken. 7) On 04/02/2025 at 8:35 AM, an observation revealed that room [ROOM NUMBER]s curtain is stained. 36057 8) On 03/31/25 at 10:41 AM, observation revealed resident room [ROOM NUMBER] C and D baseboard by the sink is in disrepair and the bathroom sink. is loose. 9) On 03/31/25 at 10:48 AM, observation revealed resident room [ROOM NUMBER] A and B's residents dresser bottom drawer wood and the window crank were in disrepair. 10) On 03/31/25 at 11:25 AM, observation revealed resident room [ROOM NUMBER] C and D with one privacy curtain that did not cover the whole resident's area. On 03/31/25 at 11:23 AM, an interview was conducted with Resident # 49 who stated he did not remember when the privacy curtains were removed from his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 2:00 PM, an interview was conducted with Staff O, CNA who stated she was assigned to room [ROOM NUMBER] and she did not know how long the privacy curtains were removed. Staff O stated the residents needed privacy and was not provided because there were no privacy curtains. Staff O showed that room [ROOM NUMBER] privacy curtain did not cover the whole resident's area to provide privacy during care. On 04/03/25 at 11:05 AM, an interview was conducted with Resident #49 who was asked if it was important for him to have a privacy curtain pulled around when he was bathe and replied, it's important. On 04/03/25 at 11:17 AM, an interview was conducted with Staff O, CNA assigned to Resident #49 who stated housekeeping knew about the curtains, and stated privacy is very important. 11) On 04/03/25 at 10:34 AM, the DES submitted a copy of a quote for six (6) cubicle curtains ordered date 02/07/25. The DES stated she called the company two days later and was told once the order is ready they will send it. The DES stated she had not heard from the company since. The DES stated she will be contacting the sister facility for privacy curtains.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview and record review, the facility failed to address catheter care in the baseline care plan for 1 of 2 sampled residents (Resident #182). The findings included: Resident #182 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Urinary Tract Infection and Dysuria. He was admitted with a Foley Catheter (an indwelling urinary catheter). His Brief Interview for Mental Status (BIMS) was 12 on 03/28/25. This indicated mild cognitive impairment. In an interview with the resident on 04/01/25 at 8:41 AM he stated he was not sure why he has a catheter and stated he came from the hospital with it. A review of the resident's baseline care plan revealed no documentation regarding the resident's Foley catheter. On 04/02/25 at 2:03 PM an interview was conducted with the Minimum Data Set (MDS) coordinator. She stated that his baseline care plan is effective because tomorrow is his Assessment Reference Date (ARD) date. She cannot print the comprehensive care plan yet but the baseline care plan is the one that is effective now. She acknowledged the Foley Catheter should have been on the baseline care plan.

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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** 51663 Based on observations, interviews and record reviews, the facility failed to initiate a personalized Care Plan for 4 out of 22 sampled residents (Resident #48, Resident #74, Resident #2, Resident #31). The findings included: 1. A record review showed that Resident #48 was admitted on [DATE] with diagnosis of other bacterial meningitis and metabolic encephalopathy. The Minimum Data Set (MDS) quarterly dated 01/25/2025 revealed that the Brief Interview of Mental Status (BIMS) score is 3, which indicates severe cognitive impairment. Section GG of the MDS showed that Resident #48 is dependent on toileting hygiene, bathing/showering and personal hygiene. Based on abused allegations regarding Resident #48, a review of the care plans was conducted and revealed the following: care plan dated 01/24/2025 stated that Resident #48 is dependent on staff for meeting emotional, intellectual, physical, and social needs with Cognitive deficits, Physical Limitations. But no care plan was found for Resident #48 indicating tendencies to aggressive behaviors. In an interview conducted on 04/03/2025 at 12:15 PM, The Minimum Data Set Coordinator stated that she would care plan a resident that is combative under the behavior. The MDS Coordinator further stated that she would wait for an incident to happen to Care Plan it or elaborate a Care Plan if she got a report from Certified Nurse Assistants (CNA). In an interview conducted on 04/01/2024 at 2:20 PM with the Licensed Practical Nurse (LPN), Staff N stated that she has been working in this facility for a year, and that she is familiar with Resident #48. Staff N further stated that Resident #48 has a tendency of being combative during care especially when getting changed and rarely during medicaton Pass. In an interview conducted on 04/01/2025 at 2:10 PM, the Assistant Director Of Nursing (ADON), stated that she is familiar with Resident #48, which tends to have combative behaviors from time to time. The ADON further explained that Resident #48's right side is his strong side so when changing the resident to avoid getting hurt it's better to do so from the left side. 40153 2. A record review revealed Resident #74 was admitted on [DATE] with diagnoses of Pneumonia, Dysphagia, and Hemiplegia. The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #74 has a Brief Interview of Mental Status (BIMS) score of 13, which is slightly cognitively impaired. On 3/30/25 at 3:40 PM, the facility ' s Administrator was notified of a staff-to-resident physical abuse regarding Staff D, Certified Nursing Assistant (CNA). While providing care, Resident #74 asked Staff D to stop because she was in pain, and Staff D did not stop. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 4/1/25 at 3:03 PM with the Administrator, he stated Resident #74 ' s sister made the allegation of abuse regarding Staff D. Resident #74 must have told her sister what happened, and she told him. He had not had a chance to interview Staff D, who was suspended pending the investigation. In a phone interview conducted on 4/1/25 at 3:25 PM with Staff D, she stated that she was told of an abuse allegation towards her while providing care to Resident #74 on 3/30/25. According to Staff D, Resident #74 always screams in pain during care, especially when touched. In an interview on 4/1/25 at 4:10 PM with Resident #74 ' s roommate, Resident #27 stated that on the morning of the Incident on 3/30/25, she was awakened by Resident #74 screaming in pain. Resident #74 usually complained of pain when changed, but nothing like this. She knew immediately that Resident #74 was having incontinence care and that Staff was in the room. In an interview conducted on 04/2/25 at 8:40 AM, Resident #74 stated that in the Incident on 3/30/25, Staff D pulled her to the left side of the bed and told her to stop. I then screamed and told her, Wait, wait, but she did not stop. In an interview conducted on 4/2/25 at 10:20 AM with Staff F, Licensed Practical Nurse (LPN) she reported Resident #74 did not like to be touched and that she will try and give her pain medication before providing personal care. Her right leg has been stiffening, and she noticed it for the first time 3 weeks ago. In an interview conducted on 4/2/25 at 10:45 AM, Staff H, CNA, said that Resident #74 has pain in her right leg and arm and will not let you provide care at times, saying it hurts. She does not scream in pain but may groan in pain or say it is painful during personal care. In an interview conducted on 4/2/25 at 11:10 AM with the Assistant Director of Nursing, she said that when she worked on the floor as a Nurse, Resident #74 used to scream during care or when repositioning or turning. A review of the care plan for Resident #74 revealed a care plan for Resident #74, which was initiated on 4/1/25 after the Incident on 3/30/25. The care plan showed Resident #74 has pain related to arthritis and chronic physical disability and expresses pain while repositioning. It further shows to anticipate the Resident ' s need for pain relief and respond immediately to any complaint of pain. An interview conducted on 4/3/25 at 11:21 AM with the Corporate Minimum Data Set Coordinator, she stated that every time you go into the care plan in the electronic system to update or revise the information, the system will only show the latest date when the data was changed. This is why the care plan for pain was initiated on 4/1/25 and not earlier. In an interview conducted on 4/3/25 at 12:00 PM with the facility ' s Minimum Data Set Coordinator, she reported that the Resident had a care plan for pain that did not necessarily have to address her screaming during care. The revision dates will only show on quarterly care plans and will not show for any other types of revised care plans. 36057 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Review of Resident #2's clinical record documented an admission on 02/10/22 with a readmission on 07/11/24. The resident's diagnoses included Cerebral Infarction, Diabetes Mellitus type 2, Cerebral Vascular Disease, Peripheral Vascular Disease, and Apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked). Review of Resident #2's MDS significant change assessment dated [DATE] documented a BIMS score of 15 indicating the resident has no cognition impairment. The assessment documented that the resident did not receive an anticoagulant medications during the look-back period of seven (7) days. Review of Resident #2's clinical record documented an active physician order dated 07/11/24 for Rivaroxaban (anticoagulant) 15 milligrams give one tablet in the evening for anticoagulants. Review of the resident's February 2025 and March 2025 Medication Administration Record (MAR) documented Resident #2 received Rivaroxaban 15 milligrams give one tablet in the evening for anticoagulants as ordered. Review of Resident # 2's care plans revealed the lack of an active written care plan related to an anticoagulant (Rivaroxaban) use. On 04/02/25 at 12:15 PM, an interview and a side by side review of Resident #2's care plans was conducted with the MDS Coordinator. The MDS Coordinator stated the resident had a care plan related to Peripheral Vascular Disease (PVD) initiated on 07/22/22 with interventions to administer medications as ordered for PVD. The care plan interventions did not mention anticoagulant medication. The review revealed a care plan related to anticoagulant medication was not created. On 04/03/25 at 6:15 PM, an interview was conducted with the MDS Coordinator who confirmed Resident #2 was receiving an anticoagulant and she did not code the MDS significant change assessment dated [DATE] for anticoagulant therapy. 39026 4) Resident #31 was initially admitted to the facility on [DATE] with the most recent admission on 02/25/25. Diagnoses included Spinal Stenosis, Trach Status, Paraplegia, and Paralysis of Vocal Cords and Larynx. A Brief Interview for Mental Status (BIMS) revealed a score of 15 per the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/25/25. This indicated the resident was cognitively intact. A urine culture received 02/22/25 and reported on 02/25/25 revealed escherichia coli and Extended-spectrum beta-lactamase (ESBL) confirmation test positive. He was on Invanz Injection solution reconstituted 1 gram use 1 gram intravenously one time a day. This was given 03/01/25-03/07/25. Invanz is a antibiotic used to treat bacterial infections. On 04/01/25 at 10:00 AM an observation was made of Resident #31's room. On the door to his room there was a sign indicating he was on Enhanced Barrier Precautions. A review of the resident's Physician Orders revealed an order dated 03/03/25 for contact precautions. There was no stop date on this order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/03/25 at 8:54 AM a phone call was placed to Resident #31's primary physician. The Physician stated he should still be on contact precautions until a repeat urine culture was done. There was no repeat urine culture noted in the resident's electronic health record. A review of the resident's care plan revealed no care plan for contact precautions. This was discussed with the Director of Nursing on 04/03/25 at 5:30 PM who stated he had another culture but this was not documented and she acknowledged that the contact precaution order was not discontinued.

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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 observations, interviews and record review, the facility failed to provide incontinence care in a timely manner for 1 of 1 sampled resident for incontinence care (Resident #65) and failed to obtain a physician order for hospice services for 1 of 1 sampled resident (Resident #71). The findings included: 1) Review of Resident #65's clinical record documented an admission on 08/13/24 and readmission on 02/23/25. The resident diagnoses included Epilepsy, Fracture of Left great toe, Contusion of Eyeball and Orbital tissues, Acute Cystitis without Hematuria and Anxiety Disorder. Review of Resident #65's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 12 indicating that the resident had moderate cognition impairment. The assessment documented under Functional Abilities and Goals that the resident needed partial/moderate assistance from the staff for toileting and walking was not attempted due to medical condition or safety concerns. Review of Resident #65's care plans record did not address incontinence care. On 03/31/25 at 7:40 AM, an interview was conducted with Resident #65 who stated there was an incident in her room last night, around 5:00 AM and could not go back to sleep. The resident was asked to elaborate and stated to check her roommate (Resident #2). On 03/31/25 at 8:01 AM, a second interview was conducted with Resident #65 who was asked if Staff D, Certified Nursing Assistant (CNA) assigned to her changed her brief last night after the incident with her roommate and she replied after she saw what happened with her roommate, she was afraid Staff D was going to treat her the same way she did to her roommate. The resident stated Staff D was telling her roommate to shut up, this is my job, the resident added it may not be the exact words, but she was treating her so bad and did not want Staff D to change her wet adult brief. Resident #65 was asked if her brief needed to be changed and stated Yes, stated her brief was last changed around 11:00 PM on 03/30/25. The resident stated she wears an adult brief at all times and the CNAs assisted her with the change. On 03/31/25 at 8:15 AM, an interview was conducted with Staff F, Licensed Practical Nurse (LPN) who was apprised of Resident #65's adult brief not changed by Staff D, CNA before the end of the shift because the resident was afraid. Consequently, side by side observation of Resident #65 adult brief was conducted with Staff F who stated, Yes, I can see her brief is wet. Observation revealed Resident # 65's adult brief was soaked wet. On 03/31/25 at 8:17 AM, an interview was conducted with night shift Staff E, Registered Nurse (RN), who stated she helped Staff D, CNA assigned to Resident #65 to change some residents. Staff E stated she was not informed of Resident #65 not been changed. On 04/01/25 at 3:35 PM, a telephone interview was codncuted with Staff D, CNA who stated Resident #65 was not wet and did not want to keep a pad underneath. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39026 2). Resident #71 was admitted to the facility on [DATE]. A review of hospice documentation in a separate binder by the nurses's desk revealed she was on hospice for Wernicke's encephalopathy. A review of the hospice notes for Resident #71 revealed she was being seen by the hospice nurse since the beginning of February, 2025. A review of Physician orders for this resident did not reveal an admission order for hospice nor a date or diagnosis when she started on hospice. An interview was conducted with the Director of Nurses on 04/03/25 at 5:30 PM as to the expectation of a Physician order for hospice. She stated there should be an order and acknowledged that Resident #71 should have had an admit order for hospice with a diagnosis.

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Aspire at the Sea - Pompano Beach	2401 NE 2nd Street Pompano Beach, FL 33062

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record review, the facility failed to identify a severe weight loss in a timely manner, provide adequate nutritional supplements to prevent further severe weight loss and follow weight policy for 3 out of 4 residents sampled for nutrition (Resident #36, Resident #13 and Resident #9). The findings included: A review of the facility's policy titled Weighing the Resident effective on 11/30/2014 showed that residents will be weighed unless ordered otherwise by the physician: admission/re-admission x3 days, weekly x 4 weeks, monthly thereafter, and as needed. 1. A record review showed that Resident #36 was admitted on [DATE] and readmitted on [DATE] with diagnosis of Idiopathic Interstitial Pneumonia and Hypothyroidism. The Minimum Data Set (MDS) entry dated 03/11/2025 revealed that the Brief Interview of Mental Status (BIMS) score is 13, which indicates mild cognitive impairment. A thorough review of the weight log for Resident #36 showed the following respectively: 03/05/2025: 111.3 pounds, 02/12/2025: 112.4 pounds, 01/22/2025: 111.4 pounds, 12/09/2024: 121.2 pounds, 11/19/2024: 120.8 pounds, 11/05/2024: 122.2 pounds, 10/18/2024: 118.8 pounds, 10/11/2024: 126.1 pounds. Further review showed a 9.8 pounds of weight loss from 12/09/2024 to 01/22/2025 which is an 8.08% weight loss in a month. Resident #36 had an overall trending weight loss of 11.7% from 10/11/2024 to 03/05/2025 (past 6 months). A review of the Dietary progress note dated 01/23/2025 (the day after the 8.08% weight loss was identified) revealed the following: The Registered Dietitian stated that Resident #36 has a Body Mass Index (BMI) of 18.5 which is underweight for age. Resident #36 was placed on weekly weights and monitor which was not perform per review of record. In an interview conducted on 04/02/2025 at 12:25PM, the Registered Dietitian (RD) stated that the weight loss recorded on 01/22/2025 is a significant weight loss. The RD further stated that he may have told the facility that the weekly weights were no longer needed because she was stable on 03/05/2025. 2. A record review showed that Resident #13 was admitted on [DATE] and readmitted on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease with Exacerbation and Nonrheumatic mitral (valve) insufficiency. The Minimum Data Set (MDS) discharge return anticipated dated 03/17/2025 revealed that Resident #13 was unable to conduct the interview for the Brief Interview of Mental Status (BIMS). A thorough review of the weight log for Resident #13 showed the following respectively: 04/03/2025: 127.9 pounds, 02/12/2025: 134.1 pounds, 01/22/2025: 132.2 pounds, 12/09/2024: 141.6 pounds, 11/05/2024: 146.6 pounds, 10/06/2024: 149.2 pounds, 09/06/2024: 152.8 pounds. Further review showed a 9.4 pounds of weight loss from 12/09/2024 to 01/22/2025 which indicates a 6.6% weight loss in a month. Resident #13 had an overall trending weight loss of 12.23% from 09/06/2024 to 02/12/2025 (past 5 months). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dietary progress note dated 02/10/2025 (19 days after the 6.6% weight loss was identified) revealed the following: The Registered Dietitian stated that Resident #13's meal intake was 75%, a BMI of 20. 1 which is low for age and a recording of a non-desired 9.8% weight loss in 90 days and 13% in 180 days. Resident #13 received MedPass 2.0 120cc twice a day for 480 kilocalories (kcals), 20g protein. A review of Resident #13's census indicated that on one occasion Resident was discharged to the Hospital between the recording period of the weight loss and the dietitian's assessment. The resident was discharged to hospital on 01/22/2025 and readmitted to facility on 01/25/2025. There is a 16-day gap between the readmitted to the facility (01/25/2025) and the dietitian's assessment date (02/10/2025). In an interview conducted on 04/02/2025 at 12:21PM, the Registered Dietitian (RD) stated that he comes once a week on Wednesdays so he might have missed this resident if the weight loss was recorded on a Wednesday after he left. The RD further stated that a Resident going to the hospital might delay his assessment process. 40153 3. A record review revealed Resident #9 was readmitted on [DATE] with diagnoses of Anxiety, Depression, and Psychosis. The annual Minimum Data Set (MDS) dated [DATE] revealed that Resident #9 had a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. A review of Physicians' orders revealed the following: Nepro (nutritional supplements) two times a day, dated 3/24/25. Weekly weights once a day every 7 days for 8 weeks, dated 3/24/25. Renal diet dysphagia advanced texture regular thin liquids consistency with large portion protein at Breakfast dated 3/24/25. A med pass was ordered two times a day, starting on 12/11/24 and ending on 2/9/25. In an observation conducted on 03/31/25 at 12:22 PM, Resident #9 was in the 2nd-floor Main Dining room. He ate about 25% of his meals with no assistance from Staff, and no Nepro (nutritional supplement) supplement was noted on his meal tray. In an observation conducted on 4/1/25 at 7:50 AM, Resident #9 noted in the room with no Breakfast tray or Nepro supplement noted at the bedside. In an observation conducted on 4/1/25 at 8:03 AM, Resident #9 was noted in the room with no Breakfast tray or Nepro supplement noted at the bedside. In an observation conducted on 4/1/25 at 8:15 AM, Resident #9 was noted in the room with no Breakfast tray or Nepro supplement noted at the bedside. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 4/1/25 at 11:30 AM, Resident #9 stated that he did not get his Nepro supplement today. In an interview conducted on 4/1/25 at 11:35 AM with Staff L, a Licensed Practical Nurse (LPN) stated she gave Resident #9 his Nepro supplement at 8:00 AM during medication time, and he drank 100% of the supplement. In an observation conducted on 04/2/25 at 8:20 AM, Resident #9 was in the room eating his breakfast tray. Closer observation did not show a double portion of protein or Nepro supplement on the Breakfast tray. In an observation conducted on 04/2/25 at 9:30 AM, no Nepro supplement was noted in the room. In an observation conducted on 04/2/25 at 10:30 AM, no Nepro supplement was noted in the room. In this observation, Resident #9 said he did not get his Nepro supplement. In an interview on 04/02/25 at 11:38 AM, Staff J, LPN, stated she had been working in the facility for about one year. She reported Resident #9 is on Nepro twice daily, and he gets it in the morning. She said that she gave it to him during morning meds around 9:00 AM today. The supplements come from the kitchen on the meal trays and said that Resident #9 received them on his meal tray this morning. A review of the weights for Resident #9 showed the following: 9/13/24, a weight of 138 pounds. 9/20/24, a weight of 140.6 pounds. 10/6/24, a weight of 141.2 pounds 12/9/24, a weight of 137.6 pounds. 1/8/25, a weight of 124 pounds. 2/15/25, a weight of 143 pounds. 3/19/25, a weight of 125.8 pounds. This showed a severe 12.8% weight loss in one month. No weights were taken 3 days after readmission or weekly for 4 weeks. The Nutritional readmission assessment dated [DATE] showed the following: Resident #9 is receiving Nepro once a day and is eating 25% to 100% of his meals. His Usual Body Weight is around 140 pounds. At risk for malnutrition related to abnormal nutritional labs and suboptimal po intake is related to hydration and dementia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dietary follow-up note dated 3/24/25 showed Significant weight loss related to comorbidities, large weight fluctuations, and suboptimal meal intake. Recommendations include increasing the Nepro supplement to twice a day to aid with meeting estimated needs. This note addressed the significant weight loss 5 days after the weight loss was identified. In an interview conducted on 4/2/25 at 11:57 AM with the facility's Registered Dietitian he stated he only comes to the facility on ce a week in person. When asked about severe/significant weight loss, he said that he may intervene after 7 to 14 days, depending on the timing. He may have 15 weight loss patients and will not be able to do an assessment of all of them, and will wait until the next time he comes in. The majority of his weight losses are followed up within a few days. When asked why Resident #9's weight was not taken on readmission, he did not know. He did not ask Staff to reweight Resident #9 because he assumed that his weight was probably correct due to his fluid fluctuations. He noticed a 12% severe weight loss from 2/15/25 to 3/19/25 and addressed it 5 days later, on 3/24/25. Resident #9's Nepro supplements were increased to twice a day because he likes them. When asked why he did not place Resident #9 back on Med Pass with the Nepro supplements, he said Resident #9 did not like the Med Pass. According to the Registered Dietitian, the Nepro supplements are provided by Nursing and are not brought on the meal tray from the kitchen.

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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** 40153 Based on observations, interviews, and record review, the facility failed to follow the physician's orders for tube feeding and the facility's policy regarding weights, resulting in weight loss for 1 of 1 resident sampled for tube feeding (Resident #5). The findings included: The facility's policy titled, Weighing the Resident, dated 11/30/2014, revealed the following: Resident will be weighted unless ordered otherwise by the physician: Admission/readmission times 3 days. Weekly times 4 weeks. Monthly thereafter. As needed. A record review revealed that Resident #5 was readmitted to the facility on [DATE] with diagnoses of Type 2 Diabetes, Seizures, and Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 has a Brief Interview of Mental Status (BIMS) score of 03 which indicated Resident #5 was severely cognitively impaired. A review of the physician orders showed an order for Glucerna 1.5 (tube feeding formula) at 60 milliliters (ml) an hour for 20 hours to provide 1200ml, off from 9:00 AM to 11 AM and off from 5:00 PM to 7:00 PM which was dated 3/10/25. In an observation conducted on 03/31/25 at 7:59 AM, Resident #5 was in bed with the tube feeding bottle of Glucerna 1.5, which started the day before on 03/30/25 with no start time. The tube feeding bottle was noted at the 250ml mark out of a 1000ml capacity bottle. In an observation conducted on 03/31/25 at 12:31 PM, no tube feeding was running in the room. A full new bottle of tube feeding was noted at the side table at the time of this observation. In an observation conducted on 4/1/25 at 8:40 AM, Resident #5 was in bed with no tube feeding running. A new bottle of tube feeding, dated 04/01/25, was noted beside it. In an observation conducted on 4/1/25 at 1:52 PM, Resident #5 was noted in the room with the tube feeding running. A closer observation showed a bottle of Glucerna 1.5, which was observed earlier, at the 1000ml mark out of a 1000ml bottle. The tube feeding bottle had a start date of 4/1/25 but not a start time. This showed that no tube feeding started from about 8:00 AM this morning to 2 PM for a total of 6 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 4/2/25 at 8:16 AM, Resident #5 was in his room with a tube feeding Glucerna 1.5 at 60ml an hour. The bottle had a start date of 4/1/25 but no start time. The tube-feeding bottle was noted at the 650ml level out of a 1000ml capacity bottle. Assuming this bottle started at 12:00 PM, running at 60ml an hour should have provided 480ml and would have been at the 520ml mark out of a 1000ml capacity bottle. In an interview conducted on 04/02/25 at 11:38 AM, Staff J, Licensed Practical Nurse (LPN), stated that Resident #5 is tolerating his tube feeding. When she arrived here this morning at 7:00 AM, the tube feeding was already running. When asked about Resident #5's tube feeding order, she said he is receiving Glucerna 1.5 at 60ml an hour, stopped at 10:00 AM, and put it back at 2:00 PM. A review of Resident #5's weight showed 184.2 pounds dated 3/5/25, and no new readmission weight was noted for 3/9/25. The Nutrition assessment dated [DATE] revealed the following: the tube feeding Glucerna 1.5 at 60ml an hour for 20 hours provides 1800 calories and 99 grams of protein. Resident #5's Usual Body Weight ranges between 185 pounds and 190 pounds. Estimated daily caloric needs are between 2113 calories and 2563 calories a day. The Resident meets the criteria for malnourished, and the above tube feeding is meeting estimated nutritional needs. In an interview conducted on 04/02/25 at 11:57 AM with the facility's Registered Dietitian (RD), he stated that he comes into the facility on ce a week. The Resident's weights are taken the first 3 days from admission, weekly for 4 weeks, and monthly thereafter. Two Restorative Certified Nursing Assistants take the weights on all residents, and he provides them with the list of the monthly weights. He stated that he does not provide them with the weekly weights, and they know themselves on which residents need admission weights, and which ones need weekly weights. He is given The list of weights to enter into the electronic system every week. According to the Registered Dietitian, tube feeding running for only 18 hours a day would only provide 1620 calories, which meets 76% of Resident #5's lower estimated needs (2113). Interview was conducted with the Assistant Director of Nursing (ADON) on 4/2/25 at 12:29 PM. They have assigned two Restorative Certified Nursing Assistants to take the weights on all residents, and they are supposed to do it in a timely manner. In an interview on 4/2/25 at 12:39 PM with Staff K, Restorative Certified Nursing Assistant stated getting the list from the RD on the residents who need their monthly weights and weekly weights taken. After the weights are taken, the list is given back to the RD, and he puts them in the electronic system. They are also given a list of all the new residents who have been admitted to the facility. In this interview, this Surveyor requested a new weight be taken on Resident #5. Using a Hoyer lift, Resident #5's new weight was recorded at 176 pounds, which showed a 4.45% weight loss in one month from 184.2 pounds to 176 pounds.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to provide the correct fluid restrictions as per the Physician ' s order for 1 of 1 sampled Resident on Dialysis (Resident #27). The findings included: A record review revealed Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Type 2 Diabetes, Severe Chronic Kidney Disease, and Anemia. The Annual Minimum Data Set (MDS) dated [DATE] revealed that Resident #27 had a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. The Physician ' s order dated 1/2/2025 showed the following: Fluid restriction: 1000 milliliters (ml) a day. Dietary 420ml a day, Breakfast coffee 180ml, Lunch apple juice 120ml, Dinner 120ml and Nursing 580ml. In an interview conducted on 3/31/25 at 12:00 PM, Resident #27 stated she goes to dialysis three times a week and is on fluid restriction. She said, I think I am allowed 32 ounces of fluids daily. The former Clinical Dietitian visited her but she had only seen the new Clinical Dietitian once or twice. In an observation conducted on 04/01/25 at 7:45 AM, Resident #27 was in her room getting ready to go to her dialysis treatment. Her Breakfast tray was noted at the side table with the following: 6 ounces of grits, 2 cups of coffee (8 ounces each), 1 slice of toast, 1 diet jelly, and 1 pack of margarine. The meal ticket was noted with the following: fluid restrictions of 1000ml per day, 6 ounces only for breakfast coffee, no orange juice, no bananas, and no oranges. This showed that Resident #27 was provided with 16 ounces of coffee and not 6 ounces of coffee as per Physician ' s orders. In an observation conducted on 04/2/25 at 8:34 AM, Resident #27 was in her room eating her Breakfast meal. The meal ticket noted 2 cups of coffee, a fluid restriction of 1000ml a day, and 6 ounces of coffee only at breakfast. The Breakfast meal tray noted 2 cups of coffee, 8 ounces each. This showed Resident #27 was provided with 16 ounces of liquids and not the necessary 6 ounces as per the Physician ' s order. The Care plan dated 3/3/25 showed the following: Resident #27 is at risk for altered nutrition and hydration related to obesity, abnormal labs, and need for 1000ml fluids. The Resident is non-compliant with diets and tends to hide snacks and food that are inappropriate for diet in her room. Resident #27 has been educated by nursing, former Registered Dietitian (RD), Renal RD, and current RD on diet compliance in relation to managing End Stage Renal Disease. Resident #27 will tolerate and follow the recommended diet and fluid restrictions. Follow fluid restriction as ordered and see Medication Administration Record (MAR) for dietary/nursing breakdown. Encourage compliance with fluid restrictions for fluid volume management. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 4/3/25 at 12:48 PM with the Kitchen Manager, he stated that the tray line has a staff member who checks the trays to ensure the correct food items and correct fluids are placed on the meal trays. The coffee cups on the trays come from the kitchen and are provided by Dietary. The clinical dietitian calculates the exact amount of fluids for each meal, and it will show on the meal ticket for staff to follow with a breakdown of how many fluids are needed per meal. The Kitchen Manager was asked why Resident #27 ' s meal ticket showed 6 ounces of coffee only on the meal ticket and 2 cups of coffee was served. He said Resident #27 requested two cups of coffee, and he was trying to honor Resident #27 ' s preferences.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staffing to 4 of 22 sampled residents (Resident #2, #6, #36 and #52) as evidenced by failure to provide two nursing staff to provide assistance with repositioning/ turning a total dependent care resident (Resident #2); failure to provide personal care in a timely manner (Resident #6); failure to provide incontinent care in a timely manner (Resident #36) and failure to assist a resident during dining in a timely manner (Resident #52). This had the potential to affect 75 residents in the facility at the time of the survey. The findings included: 1) Review of Resident #2's clinical record documented an admission on 02/10/22 with a readmission on 07/11/24. The resident's diagnoses included Cerebral Infarction, Diabetes Mellitus Type 2, Acute Hematogenous Osteomyelitis, Cerebral Vascular Disease, Peripheral Vascular Disease, Anxiety Disorder, Morbid Obesity and Apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked). Review of Resident #2's Minimum Data Set (MDS) significant change assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had no cognition impairment. The assessment documented that the resident was dependent on the staff to complete activities of daily living including bathing, toileting, personal hygiene and roll left to right. The assessment documented under Functional Limitation in Range of Motion that the resident had upper and lower impairment on one side. On 03/31/25 at 7:47 AM, an interview was conducted with Resident #2 who stated they had an electric storm and it affected her arthritis, added she has left side paralyzed and stated, I was in pain. The resident stated this morning, at 5:00 AM, Staff D, Certified Nursing Assistant (CNA) was asking her to turn to her left side which she could not do, kept jerking her left side, and asked Staff D to stop and she responded it was her job, that a lot of residents had arthritis like her. Resident #2 stated Staff D had done the same thing about a month ago, she was pushing my leg and asked her to stop and she did not. The resident stated she did not want to report it because she was afraid it would get worse. The resident added there are some residents that yelled and added I don't yell and don't call for help. Resident #2 stated she could turn over to her left side but could not turn over to her right side because her left side was paralyzed. On 03/31/25 at 8:17 AM, an interview was conducted with Staff E, RN who stated she worked 7:00 PM to 7:00 AM shift (last night) and Staff D, CNA was assigned to Resident #2. Staff E stated she helped Staff D to turn residents that yell but did not ask her to help with Resident #2. On 03/31/25 at 8:59 AM, an interview was conducted with the Administrator, who was informed of Resident #2's allegation. On 04/01/25 at 1:42 PM, an interview was conducted with the Director of Nursing (DON) who stated she was aware of Resident #2's allegations. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/25 at 2:25 PM, an interview was conducted with Resident #2's attending physician who stated the resident was on hospice services, has severe arthritis. The physician stated he just talked to the Resident regarding the resident incident with the CNA and she was perfectly alert, oriented x 3 (person, place and time). The physician stated the resident would not lie, able to recognized him and knew his full name. The physician stated Resident #2 told him that she screamed, and described the aide (CNA) was rough, and that she asked the aide to stop. The physician added Resident #2's roommate confirmed the incident. On 04/01/25 at 3:26 PM, a telephone interview was conducted with Staff D, CNA, who stated she was a fulltime, working 11:00-7:00 AM shift. Staff D stated she was assigned to Resident #2 over the weekend and stated the resident was total care and was supposed to have two people assist to turn the resident towards the window over to her right side, from her weak left side. Staff D stated the resident thinks she was going to fall out of bed, and added turning her toward the window is very difficult. The CNA was asked if she asked for help and replied, you don't have help, everybody is doing their own. Staff D stated Resident #2 is scared that she fall out of bed, added the resident did not complain of pain or asked her to stop. Staff D stated next time she will ask for help. Review of Staff D, CNA's personnel file revealed a skills competency assessment dated [DATE] regarding positioning a resident with a passing score. On 04/02/25 at 8:49 AM, an interview was conducted with the Hospice Nurse who stated Resident #2 was on pain symptom management due to neck and generalized pain, had an accident years ago and broke her neck, had a stroke and had Morbid obesity. The hospice nurse was asked regarding the aide visits and stated two aides come to the facility, except on Tuesdays and stated Resident #2 needs two person assist and the two hospice aides do her care together. The hospice nurse stated Resident #2 was care plan for two person assist. Consequently, a side by side review of the hospice RN-Initial Comprehensive Assessment note dated 02/28/25 documented Pt (patient) requires assist 2 (two) person assist to provide care .consulted with staff before and after visit . Continue side by side review of the hospice nurse documentation Nursing-Updated Comprehensive Assessment note dated 03/28/25 documented 2 pxs (person) assist with ADL (activities of daily living) needs .consulted with staff before and after visit . On 04/02/25 at 11:31 AM, an interview and a side by side review of Resident # 2's MDS significant change assessment dated [DATE] was conducted with the MDS Coordinator who stated the resident was placed on hospice services. The MDS Coordinator stated the resident had no cognition impairment and was dependent on the staff for personal hygiene, toileting, shower, and always complained of shoulder pain had left sided paralysis. The MDS coordinator stated the resident could not turn by herself, needed help, like to have something to hold on to it because the resident was afraid of falling, was on an air mattress and did not have bed rails. The MDS Coordinator stated if a resident is dependent they will need two people and because Resident #2 was afraid there should be two people. The MDS Coordinator added turning the resident require two people and the CNA will see it on the CNA Kardex (tasks) plan. Subsequently, a side by side of Resident #2's CNA's Kardex was conducted with the Coordinator and revealed the lack of written documentation of Resident #2's needs for two person turning/reposition required. The MDS Coordinator was apprised that Resident #2's Hospice nurse notes documented the resident needed two person assist for the care. On 04/02/25 at 1:59 PM, an interview was conducted with Staff H, CNA assigned to Resident #2 stated sometimes she uses help to do the resident's care, and sometimes does it by herself. Staff H added when it is rainy the resident's pain is worse, she tells her stop and will get somebody to help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/25 at 11:06 AM, observation revealed Resident #2 being bathe by two hospice aide. Consequently, an interview was conducted with the hospice's aides who both stated the hospice nurse wants two aide to do the resident's care. On 04/03/25 at 11:09 AM, an interview was conducted with Staff J, Licensed Practical Nurse (LPN) who stated Resident #2 needs two CNA to turn and to do her care. Staff J stated she had not had any CNA asking for help with Resident #2. On 04/03/25 at 12:59 PM, an interview was conducted with Staff C, CNA who stated Resident #2 needs two person to turn her because of her weak side. 40153 2. A record review revealed Resident #52 was readmitted on [DATE] with diagnoses of Type 2 Diabetes, Anemia, and Intracerebral Hemorrhage. The Quarterly Minimum Data Set (MDS) dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 15. A record review revealed Resident #9 was readmitted on [DATE] with diagnoses of Anxiety, Depression and Psychosis. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #9 had a Brief Interview of Mental Status (BIMS) score of 15 which is cognitively intact. In an observation conducted on 03/31/25 at 8:08 AM, Resident #9 received his breakfast tray. At 8:21 AM, Resident #9 ' s roommate, Resident # 52, received his breakfast tray 13 minutes later. In this observation, Resident #52 said, It is kind of bothersome to wait for my meal while my roommate is eating. In an observation conducted on 4/1/25 at 8:21 AM, Resident #9 was noted in his room eating his Breakfast tray with no staff present. He then asked this Surveyor to help him open the carton of milk and said, I can only use my right hand. Resident #52 was still waiting on his Breakfast tray. In an observation conducted on 04/01/25 at 8:35 AM, Resident #52 tray was noted inside the meal cart located in the hallway. The Breakfast meal was brought to Resident #52 by Staff M, a Certified Nursing Assistant, at 8:39 AM, 18 minutes later. In this observation, Resident #52 said, I could feel better; I am hungry and a little annoyed while waiting on his breakfast tray. In an interview conducted on 04/1/25 at 8:41 AM, Staff M stated that she left Resident #52 ' s breakfast tray for last because he needed assistance with his meal and could not eat on his own. She waits until she passes all the trays before coming into the room to help him with his meals. 51663 3. A record review showed that Resident #36 was admitted on [DATE] and readmitted on [DATE] with diagnosis of Pneumonia and Hypothyroidism. The entry Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 13, which indicates mild cognitive impairment. In an interview conducted on 03/31/2025 at 9:00 AM, Resident #6 stated that they are short of staff. Her roommate and her have to wait a couple of hours before someone comes when they ring. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. A record review showed that Resident #6 was admitted on [DATE] and readmitted on [DATE] with diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy and Local Infection of the skin and subcutaneous tissue. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairment. In an interview conducted on 03/31/2025 at 8:45 AM, Resident #36 stated that one night she had to wait 5 hours to get her brief changed, she doesn't understand why they don't hire enough people.

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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. 40153 Based on observations, interviews, and record review, the facility failed to follow its own menu portions for a Regular diet. This has the potential to affect 39 out of 75 residents currently on a Regular diet. The findings included: A review of the facility ' s menu, week 1 lunch Day 4 showed the following: open-faced roast pork 1 sandwich 2 ounces portion with brown gravy, mashed potatoes, buttered noodles, and herb green beans. In an interview conducted on 4/2/25 at 11:30 AM with the Dietary Manager, he stated the portion for the pork today is 2 ounces on the regular diet. In an observation of the lunch tray line conducted on 4/2/25 at 11:35 AM, Staff I, the Account Manager, noted plating 3 plates with roast pork for the regular diet consistency. The weight of the first slice of pork was taken using a facility ' s scale, which showed that it was 1 ounce. The weight of the second slice of pork was taken using a facility ' s scale, which showed that it was 1.5 ounces. Both lunch plates contained less than the required 2 ounces of pork as per the facility ' s menu. In an interview conducted on 4/2/25 at 11:40 AM with the facility ' s Account Manager, she stated that the portion size for the pork needed to be 2 ounces, and she weighed the pork slices before placing them on the trayline to ensure they were 2 ounces.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide food that meets residents' preferences, for 2 out of 65 sampled residents observed during dining. (Resident #78, Resident #77) The findings included: 1. A record review showed that Resident #78 was admitted on [DATE] with diagnosis of malignant neoplasm of lower respiratory tract. The Admission Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 05, which indicates severe cognitive impairment. During an observation conducted on 03/31/2025 at 8:40 AM this surveyor observed that Resident #78 meal ticket consisted of: #8 Scoop of Pureed French Toast, 1 Margarine, 1 Syrup, #16 Scoop of Ground Sausage Patty, 2 ounces (oz) of [NAME] Gravy, #6 Scoop of Pureed Hot Cereal, 8oz of Honey Thickened Milk, 4oz of Honey Thickened Orange Juice and 6oz of Honey Thickened Coffee or Hot Tea. Resident #78's tray did not have the margarine, the syrup, and the 2 ounces of [NAME] Gravy. 2. A record review showed that Resident #77 was admitted on [DATE] with diagnosis of Benign Intracranial Hypertension and Diabetes Mellitus due to underlying condition with hyperglycemia. The Medicare 5 Day Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 13, which indicates mild cognitive impairment. During an observation conducted on 03/31/2025 at 8:50 AM this surveyor observed that Resident #77 meal ticket consisted of: 2 slices of French Toast, 1 Margarine, 1 Syrup, 2 slices of Bacon, 6oz of Hot Cereal, 8oz of Milk, 4oz of Orange Juice and 6oz of Coffee or Hot Tea. Resident #77's tray only had one slice of Bacon. In an interview conducted on 04/03/2025 at 12:55 PM, the Kitchen Manager (KM) stated that they have two people on the tray line to check the meal tickets and the trays. The first person is the one calling all the meals to the cook, so the cook knows what to plate. And the second person is the checker, that will make sure everything that needs to be on the tray is on it. They are both in the kitchen. The kitchen manager further stated that the tray should have two slices of bacon and never one regarding Resident #77. The Kitchen Manager acknowledged the missing items on Residents #78 tray.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40153 Based on observation, interview and record review, the facility failed to keep food safety requirements in accordance with professional standard of food service safety, for 1 of 2 visits to the main kitchen. The findings included: A review of the State Operations Manual Appendix PP (Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22) showed the following: Food handling risks associated with food stored on the units may include but are not limited to: Food stored in a manner (open containers, without covers, spillage from one food item onto another, etc.) that allows cross-contamination. Machine Washing and Sanitizing-Dishwashing machines use either heat or chemical sanitization methods. The following are general recommendations for each method according to the U.S. Department of Health and Human Services, Public Health Services, and Food and Drug Administration Food Code. High Temperature Dishwasher (heat sanitization): Wash - 150-165 degrees Fahrenheit. Final Rinse - 180 degrees Fahrenheit. In a tour of the main kitchen conducted on 03/31/25 at 7:21 AM accompanied by the Dietary Manager, the following were noted: A round garbage can with no lid was noted in the food production area. In this observation, the Dietary Manager stated they ordered the garbage cans, which had no lids. The walk-in refrigerator was noted to have an opened bag of boiled eggs. The walk-in refrigerator was noted to have an opened bag of grapes. The walk-in refrigerator noted an opened bag of cucumbers with white spots and a moldlike substance around the cucumbers. The walk-in refrigerator was noted to have an opened bag of raw chicken pieces. The walk-in refrigerator was noted to have an opened bag of raw fish pieces. The walk-in refrigerator was noted with a bag of raw meals that was not dated or labeled. The walk-in refrigerator was noted to have an opened box of raw bacon. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continued observation at 7:30 AM of the hot temperature dishwasher machine revealed that the rinse cycle was at 150 degrees Fahrenheit, and the wash cycle was noted at 160 degrees Fahrenheit. At 7:33 AM, the rinse cycle was at 150 degrees Fahrenheit, and the wash cycle was noted at 150 degrees Fahrenheit. At 7:37, the rinse cycle was at 150 degrees Fahrenheit, and the wash cycle was noted at 145 degrees Fahrenheit. This showed that the facility did not have the necessary high-temperature ranges, as shown above. In this observation, the kitchen manager said that maintenance just looked at the dishwasher last Friday. He further said he would have maintenance look at the dishwasher machine again.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 40153 Based on observation, interviews, and record review, the facility failed to dispose of refuse in a sanitary manner. The findings included: A review of the facility ' s policy titled Solid Waste management dated 11/30/2014 showed the following: solid waste shall be handled and disposed of in a manner that shall ensure a safer and sanitary facility environment. In an observation conducted on 03/31/25 at 8:18 AM, the garbage area near the back of the main kitchen was noted with debris consistent with dirty gloves, food debris, cans of soda, bottled water, medicine cups, supplements, and other debris. In an observation conducted on 04/1/25 at 8:44 AM, the garbage refuse area in the back of the facility was noted with 3 round garbage bins with overflowing garbage bags. Closer observation revealed dirty gloves and other debris around the main dumpster area. In an interview conducted on 4/1/25 at 10:50 AM with the Kitchen Manager, he stated checking the back area dumpster every other day will pick up any stuff he sees and will clean around. When asked who was responsible for ensuring that the garbage area was cleaned and contained, he did not know. In an interview conducted on 04/1/25 at 11:00 AM with the Administrator, he was told of the findings.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40153 Based on observations, interviews and record review, the facility failed to ensure that Quality Assurance Performance Improvement (QAPI) meetings were conducted quarterly, and that the necessary staff members attended those meetings for 3 of 6 months reviewed during QAPI review. The findings included: A review of the facility ' s policy titled Quality Assurance Performance Improvement Program, dated 11/30/2014, showed that the Quality Assessment and Assurance Committee (QAA) meetings are at least quarterly but may be held more frequently as appropriate. The QAA committee members include, but are not limited to, the Executive Director, Medical Director, Director of Nursing, and Infection Preventionist. A review of records revealed the last QAPI meeting was held on December 18, 2024. Further review did not show that a QAPI meeting was conducted in March 2025 or the sign-in sheet with all the necessary staff members. In an interview conducted on 4/3/25 at 5:00 PM with the facility ' s Administrator, he started in this facility in March of this year and had one QAPI meeting with the committee on 03/20/25. He further said the Director of Nursing, Activities, Maintenance, Rehab, Social Services, Admission, and Housekeeping attended the meeting but not the Medical Director. When this surveyor asked for the sign-in sheet from all the necessary members for the QAPI meeting held on 3/20/25, he could not provide it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews and record review; the facility failed to follow infection control guidelines by failing to wear a disposable gown during personal care and wound care for Resident #36, failing to have PPE (Personal Protective Equipent) readily accessible for residents on Enhanced Barrier Precautions, failing to wear a disposable gown during medication administration to a resident on Enhanced Barrier Precaution for Resident #71, and failing to provide contact precautions per Physician order for Resident #31. This had the potential to affect 12 residents on Enhanced Barrier Precautions and 1 resident on Contact Precautions. The findings included: Review of the facility's policy titled Standard Precautions: revised on October 2018 documented .hand hygiene after .removing PPE (Personal Protective Equipment) .gloves .after gloves are removed, wash hands immediately to avoid transfer of microorganism to other resident or environment . Review of the facility's policy titled Enhanced Barrier Precautions revised on August 2022 documented Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organism to residents. EBPs employ targeted gown and glove use during high contact resident care activities .examples of high-contact resident care activities requiring the use of gown and glove include: dressing, bathing .providing hygiene .changing briefs or assisting with toileting . device care or use (urinary catheter, feeding tube .and wound care (any skin opening requiring a dressing) . staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms . 1) Resident #31 was initially admitted to the facility on [DATE] with the most recent admission on 02/25/25. Diagnoses included Spinal Stenosis, Trach Status, Paraplegia, and Paralysis of Vocal Cords and Larynx. A Brief Interview for Mental Status (BIMS) revealed a score of 15 per the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/25/25. This indicated the resident was cognitively intact. A urine culture received 02/22/25 and reported on 02/25/25 revealed escherichia coli and Extended-spectrum beta-lactamase (ESBL) confirmation test positive. He was on Invanz Injection solution reconstituted 1 gram use 1 gram intravenously one time a day. This was given 03/01/25-03/07/25. Invanz is a antibiotic used to treat bacterial infections. On 04/01/25 at 10:00 AM an observation was made of Resident #31's room. On the door to his room there was a sign indicating he was on Enhanced Barrier Precautions. A review of the resident's Physician Orders revealed an order dated 03/03/25 for contact precautions. There was no stop date on this order. 04/03/25 at 8:54 AM a phone call was placed to Resident #31's primary physician. The Physician stated he should still be on contact precautions until a repeat urine culture was done. There was no repeat urine culture noted in the resident's electronic health record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This was discussed with the Director of Nursing on 04/03/25 at 5:30 PM who stated he had another culture but this was not documented and she acknowledged that the contact precaution order was not discontinued. 36057 2) On 03/31/25 during multiple tour to the facility first and second floor units revealed multiple resident's door with an Enhanced Barrier Precautions (EBPs) sign and Personal Protective Equipment (PPE) not readily accessible, no PPE carts outside of the residents room or nearby. On 04/01/25 from 8:41 AM to 4:41 PM, observation revealed the facility's first and second floor continues to revealed multiple resident's door with an Enhanced Barrier Precautions (EBPs) sign and Personal Protective Equipment (PPE) not readily accessible, no PPE carts outside of the residents room or nearby. On 04/01/25 at 4:41 PM, an interview was conducted with Staff A, LPN who was asked when she will wear a gown and stated if the resident was on isolation or contact precautions. She was asked if she will use a gown while administering medications to a resident with PEG(feeding tube) and stated No. Staff A stated the gowns were in central supplies room. The central supplies room was located 90-100 feet from the residents assigned to Staff A. Observation revealed resident's room hallway on the first and second floor revealed no PPE readily accessible for staff to use. Photographic evidence obtained. On 04/02/25 at 8:30 AM, observation revealed multiple PPE cart on both floor hallways. On 04/02/25 at 9:01 AM, an interview was conducted with the Central Supplies Clerk who stated he was instructed to placed PPE carts in the resident's hallways today. On 04/03/25 at 5:02 PM, an interview was conducted with the DON/Infection Preventionist who stated that on 03/14/25 she did a skills fair, and EBP was included. The DON stated resident on EBP had a sign on the door. The DON was apprised that Resident #36 who had a wound did not have a EBP sign, was not listed on the facility's list of residents with an EBP sign and the staff did not wear a gown during personal and wound care. The DON was apprised there was not PPE readily accessible to the staff on 03/31/25 and 04/01/25 on either floor. 3) On 04/01/25 at 10:12 AM, medication administration for Resident #71 performed by Staff N, LPN started. At 10:30 AM, Staff N entered the room, performed hand hygiene, donned gloves, and with gloved hands picked up the resident' floor matt from the floor and repositioned it. Staff N did not change the gloves and continue to stopped the resident's feeding machine, retrieved the feeding syringe, and flushed the resident's tube feeding. Staff N then proceed to administer the resident's medication through the feeding tube. Staff N did not wear a gown during the high contact activity with Resident #71. Staff N continue with the same gloves and pulled a test strip from the bottle, and proceeded to performed a glucose fingerstick. During the medication administration, the resident's feeding syringe fell on the floor, Staff N picked up the syringe placed on top of the table and after approximately 5-7 minutes, Staff N rinsed the syringe with plain water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/25 at 4:26 PM, during an interview, Staff N was asked about handwashing policy and stated she had to perform hand hygiene before and after contact with the resident. Staff N was apprised of infection control concerns observed during Resident #71's medication observation such as no changing gloves after she touched the floor mat and then proceeded to administer the resident's medication via the feeding tube and rinsing of the syringe with plain water after it fell on the floor. 4) On 04/01/25 at 11:19 AM, observation of insulin administration for Resident #2's performed by Staff A was conducted. Staff A, LPN donned gloves, administer the resident's insulin, removed gloves, left the resident's room without performing hand hygiene. Staff A proceeded to the medication cart to document the insulin administration. Observation revealed Staff A did not perform hand hygiene at the medication cart. On 04/01/25 04:05 PM, an interview was conducted with Staff A, LPN who was asked when she will do handwashing. Staff A stated she will do handwashing or uses the hand sanitizer when going into the resident's room, when coming out of the room. Staff A was asked if she had to do hand hygiene after removal of gloves and stated 'Yes. Staff A was apprised she did not do hand hygiene after Resident #2's glucose fingerstick and the removal of her gloves. 5) Review of Resident #71 clinical record documented an admission on 01/14/25. The resident's March 2025 Medication Administration Record (MAR) documented that the medications were administered via PEG tube. On 04/01/25 at 10:12 AM, medication administration for Resident #71 performed by Staff N, LPN started. At 10:30 AM, Staff N entered the room, performed hand hygiene, donned gloves and proceeded to administered the resident medications via PEG tube. Staff N did not wear a gown during the administration of the medications via PEG tube, a high contact activity. On 04/01/25 at 4:26 PM, an interview was conducted with Staff N, LPN who was asked when she will use a gown and replied her understanding was for residents with PEG (a feeding tube) tube she will wear gloves, not a gown and stated she will check with the DON about it. Staff N was asked to review EBP signage on Resident #71's door. Staff N confirmed she needed to wear a gown during Resident #71's medication administration and she did not. Staff N was asked for the location of the disposable gowns and stated the gowns were upstairs (second floor), none on the first floor. Resident #71 was on the first floor. 6) Review of Resident #36's clinical record documented an admission on 09/24/24 with a readmission on 03/11/25. The resident's diagnoses included Pneumonia, PU (pressure ulcer) stage 2, Dementia and Neuromuscular Scoliosis. Review of Resident #36's MDS 5 days admission assessment dated [DATE] documented the resident had a pressure ulcer. Review of Resident #36's care plan titled Resident has pressure injury . initiated on 11/07/24 revealed revised interventions did not include EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105258	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Pompano Beach	2401 NE 2nd Street Pompano Beach, FL 33062

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 10:26 AM, observation revealed Resident #36 in bed and Staff C, CNA at the bedside and donning gloves. Observation revealed a basin with water next to the resident's bed. An interview was conducted with Staff C who stated she was going to do Resident #36's personal care. Further observation revealed Staff C did not have a gown on. On 04/02/25 at 10:30 AM, observation revealed Staff C with a wash cloths and soapy water, Resident #36's upper body was uncovered. On 04/02/25 at 10:27 AM, an interview was conducted with the Wound Care Nurse(WCN) who stated Resident #36 had a stage four (4) Midback- Pressure Ulcer since January 2025. The WCN stated the wound last measurement on 03/25/25 was 10 x 7.5 x 0.7 centimeters (cm) On 04/02/25 at 10:40 AM, entered Resident # 36's room and observed the resident was undressed wearing an adult brief. Observation revealed Staff C was dressing the resident, Staff C did not put a gown on during high contact activities with Resident #36 such as bathing and dressing. On 04/02/25 at 10:46 AM, Wound Care observation for Resident #36 performed by the WCN started. The WCN entered the resident's room, performed hand washing, placed supplies by the resident's bedside, donned gloves, removed the mid-back old dressing. Observation revealed the WCN did not wear a gown during the high contact activity such as wound care. During an interview, the WCN was asked if he wears a gown during resident wound care and stated he will only use the gown when the resident were on isolation precautions. On 04/02/25 at 11:13 AM, an interview was conducted with Staff C, CNA who was asked when she will wear a gown (PPE) and stated she will wear a gown when she sees a yellow sign on the door. Staff C was asked if she needed to wear a gown while providing care to Resident #36 and stated she will not need to use a gown during Resident # 36's care and had not heard from the DON/Infection Preventionist or the nurse that she needed to use a gown.