

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Medicana Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 Lake Worth Road Lake Worth, FL 33460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure a completed informed consent for psychotropic medication was obtained for 1 of 5 sampled residents reviewed for unnecessary medication (Resident #1). The findings included: Review of the facility policy titled, Psychotropic Medication Assessment and Monitoring: with a revised date of 08/2023 included in part the following: Procedure: a) Obtain physician's order, b) Psychoactive Medication Consent signed by the resident/resident representative. A psychotropic drug is any drug that affects brain activities associated with mental process and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, the following: Quadriplegia and personal history of Malignant Neoplasm of Bladder, and Major Depressive Disorder Recurrent Severe with Psychotic Symptoms. The Brief Interview of Mental Status evaluation dated 05/01/26 documented a score of 11, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #1 revealed in part, the following: An order dated 03/30/26 for Quetiapine Fumarate (Seroquel) Oral Tablet 25 MG, give 1 tablet by mouth one time only for psychosis for 1 Day. An order dated 03/31/26 for Quetiapine Fumarate Oral Tablet 25 MG, give 1 tablet by mouth at bedtime for psychosis. An order dated 3/13/26 for Buspirone (Buspar) HCL Tablet 5mg, give 1 tablet by mouth every 12 hours for anxiety. Review of the Psychoactive Medication Consent form for Resident #1 for Quetiapine Fumarate tab 25mg 1 tab by mouth for psychosis dated 03/30/26 included in part the following: I DO desire the use of the medication(s) indicated above and DO consent to their use. I understand that once the target behavior is controlled the dose should be gradually decreased to the lowest possible dosage and frequency or discontinued unless contraindicated by my physician. I DO consent to the use of the medication interventions but only on a temporary basis for treatment of life-threatening medical symptoms only. I DO NOT desire, nor consent to the use of medication interventions on a regular or temporary basis. I understand that I may reevaluate the need for medication intervention at any time, and that this will be reviewed at each quarterly Care Planning Meeting. The consent form did not have any of the above options documented, as indicated. During an interview conducted on 05/13/26 at 4:24 PM with Director of Nursing (DON) who was asked about informed consents for psychotropic medications, she stated we need informed consent for psychotropic medications if there is an increase in dosage or change in the medication. When asked where the documentation is kept she said it would be under miscellaneous tab in the residents electronic medical record. She was responsible for obtaining the informed consent for psychotropic medication, she said it is typically obtained by the nurse who received the order for the medication. When asked about Resident #1, she acknowledged there was no informed consent for the psychotropic medications. The DON said the resident was admitted taking Buspirone and since he (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was taking Buspirone prior to being admitted to the facility they did not need to obtain informed consent. During an interview conducted on 05/13/26 at 5:15 PM with Staff N Registered Nurse/Unit Manager (RN/UM) who stated she has worked at the facility for 4 years and only in her current role of RN/UM since January 2026. When asked about informed consent for psychotropic medications she said it is done on admission and if the dose is increased or the medication is changed and a new medication is started. When asked to clarify if the resident was taking the medication at the hospital before admission, would they still obtain an informed consent on admission, she said yes. She said once she obtains the consent (on paper) it goes to medical records who will upload the document to the resident's electronic record. The RN/UM stated it is placed in the cubby for medical records. During an interview conducted on 05/13/26 at 5:20 PM with Staff O HIC (Health Information Clerk) who stated she has worked at the facility for 4 years. When asked how often she picks up the documents from the medical records cubby to upload to the resident's electronic medical record, she said daily. When asked how far behind she is in uploading the documents, she said not far and said it would be within a week or two. When asked about a document that was obtained 03/30/26 and was still not uploaded, she just remained silent and did not answer the surveyor. HIC was then asked to see if she could look for the document and provide a copy to the surveyor. During an interview conducted on 05/13/26 at 5:25 PM with Resident #1 who was asked his full name and he responded appropriately. When asked about his medications if he signed consent for anything, he said no. When asked about the Buspirone he said no but he has been taking it for a while. When asked about the Quetiapine Fumarate also known as Seroquel, he said he did not sign anything but remembers getting the medication pretty quick after he had needed it and he said he is still getting it. On 05/13/26 at 5:30 PM Staff O (HIC) provided the following psychoactive medication consents for Resident #1; the first was dated 03/13/26 for Buspirone 5mg with a check mark next to do desire the use of the medication(s) indicated and do consent to their use. The second one was dated 03/30/26 for Quetiapine Fumarate with no check mark indicating a do desire or do consent, nor was a do not desire or consent to the use of medication intervention on a regular or temporary basis.		

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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** Based on interviews, and record review, the facility failed to provide nutritional interventions in a timely manner to prevent weight changes including significant weight loss and/or gain for 5 of 6 sampled residents reviewed for nutrition (Resident #30, Resident #27, Resident #36, Resident #49, and Resident #20).The findings included: Review of the facility's policy titled, Weight Measurements, dated 08/2023, included the following: Body weight is a value used to monitor the nutritional status of the resident.Frequency of measurements & Calculations:Residents are weighed weekly, monthly, or according to physician orders. Residents should be weighed at the same time of day, in similar clothing, and using the same scale. Any significant or progressive weight loss or gain is noted and reported to the resident's attending physician, family, or responsible party, and document in the medical record.Note all new admits are weighed weekly for 30 days. 1. Record review for Resident #30 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Sequelae of Cerebral Infarction, Dementia, Type 2 Diabetes Mellitus with Hyperglycemia and Adjustment Disorder with Anxiety. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #30 had a Brief Interview of Mental Status (BIMS) score of 10 which indicated he is moderate cognitively impaired. Review of Section GG revealed Resident #30 was independent for eating. Review of Resident #30's Weight and Vitals Summary report revealed his admission [DATE]) weight was 160.9 pounds and on 02/04/26 he was 151.3 pounds. This showed a significant percent weight loss of 5.96 % in three weeks. Further review revealed Resident #30 was not weighed weekly for 30 days as a newly admitted resident, as per the facility's policy. Record review revealed a Mini Nutritional Assessment (MNA) was conducted on 02/03/26 for Resident #30, who was found to be At Risk for Malnutrition; however, no interventions were implemented at this time. Further review of Resident #30's Weight and Vitals Summary report revealed he was weighed monthly and on 04/02/26 his weight was 144.6 pounds. This showed a severe percent weight loss of 10.13% in three months. Review of the Nutrition Comprehensive Evaluation/Risk Screen with description of significant change conducted by the Licensed Dietitian (LD) dated 04/23/26 revealed the following: Weight history reviewed: -3.7% x 30 days, -4.3% x 90 days, -10% x 180 days. Resident #30's intake of meals is between 51% to 75% average. Resident #30 was reviewed with the team during weekly focus. Current oral intake may not be sufficient to meet needs. Recommendation: weekly weights to monitor trends and add ready care 2.0 120 ml two times daily (nutrition support drink). Review of the Physician's Orders showed Resident #30 had an order dated 04/23/26 for Med Pass 2.0/Ready Care 2.0 for nutrition support give 120 ml by mouth two times a day; and on 04/29/26 a physician order was added for weekly weights, one time a day every Wednesday. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2026 and May 2026 Medication Administration Record documented Resident #30 consumed 90-100% of the Med Pass 2.0 (nutrition shake) since it was ordered on 04/23/26. Review of Resident #30's Weight and Vitals Summary report revealed on 04/30/26 his weight was 142.2 pounds and on 05/06/26 he was 143.0 pounds, indicating he has gained weight. On 05/11/26 at 1:30 PM an interview was conducted with Resident #30. He was pleasantly confused and stated he was doing okay but continued to have his own conversation. During an interview conducted on 05/13/26 at 9:25 AM with Staff A, CNA, (Certified Nursing Assistant) who stated she has worked at the facility for 10 years. She stated she is provided with a list of residents that need to be weighed on her shift, then she gives the list with the weights back to the nurse. She confirmed residents are weighed monthly. During an interview conducted on 05/14/26 at 2:54 PM with the LD, who stated she is a contracted employee, has worked at the facility for 8 years and works about 12 hours a week, usually Tuesdays and Thursdays. She stated she assesses new admissions, which means she conducts the MNA, then risk screens and if the resident screens low in the risk screen she will conduct a full evaluation to estimate nutritional needs. She stated new admitted residents will be weighed upon admission, then weekly for 4 weeks, then monthly if no concerns. She stated the interdisciplinary team (IDT) meetings are held every Thursday in which weights are discussed or if any resident had a change of weight. She stated she prints the weight loss reports weekly and weights are done by nursing. Then weights are reviewed monthly by her and the IDT team to identify weight loss or gain to address the changes as soon as possible. She stated significant weight loss is 5% in a month, 7.5 % in 3 months and 10% in 6 months; if she feels the weight is incorrect, she will try to get the resident re-weighted. The LD was asked to review Resident #30's records and interpret the weights. She stated Resident #30 was not weighed weekly as per policy and between 01/17/26 and 02/04/26 Resident #30 weight loss was 5.9% and she acknowledged to be a significant weight loss. She stated she or the team would enter the orders for weekly weights and Resident #30 did not trigger any concerns with nutrition during the admission period or the MNA. She stated she missed the MNA conducted on 02/03/26 which documented Resident #30 was at risk for malnutrition. She was then asked when she conducted the Nutrition Comprehensive Evaluation/Risk Screen with description of significant change dated 04/23/26 which weights was she using to calculate the percentages; she provided a confusing answer and when the weights were reviewed, she simply stated she missed it and is doing the best for the residents. 2. Record review for Resident #49 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux, Depression, Anxiety, and Osteoarthritis of Right Ankle and Foot with Absence of Right Toe. Review of the Significant Change Minimum Data Set (MDS) assessment for Resident #49 dated 04/26/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Record review revealed Resident #49's weights in her Electronic Health Record (EHR) were as (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follows: 10/17/25 128 pounds (lbs.) 11/13/25 129.5 lbs. 12/03/25 119.0 lbs. 01/02/26 118.6 lbs. The resident was not weighed weekly upon admission for 30 days as per policy. Record review revealed from 11/13/25 to 12/03/25 the resident was noted with a 10.5 lb. weight loss in 20 days which was a severe weight loss at 8.1%. A reweight was not taken to confirm the weight loss. Further record review revealed on 12/04/25 Staff Z, Dietetic Technician Registered (DTR), who is no longer employed by the facility, wrote a progress note titled weight review, where the weight loss was addressed. Staff Z wrote the resident ate small portions, declined supplements, and was at risk for unavoidable weight loss due to post-op toe amputation. Staff Z did not recommend weekly weights to monitor the resident. 3. Record review for Resident #36 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Dementia, Mild Protein-Calorie Malnutrition, and Chronic Kidney Disease. Review of the Significant Change Minimum Data Set (MDS) for Resident #36 dated 04/16/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident had severe cognitive impairment. Resident #36's weights in her EHR were as follows: 01/08/26 115.6 lbs. 01/09/26 116.2 lbs. 01/15/26 117.2 lbs. 02/05/26 116.0 lbs. 03/05/26 110.5 lbs. 04/05/26 107.1 lbs. 05/05/26 105.6 lbs. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/11/26 108.4 lbs. The resident was not weighed weekly for 30 days upon admission as per policy. From 02/05/26 to 03/05/26 the resident lost 5.5 lbs. which was a 4.7% weight loss in one month. From 02/05/26 to 04/05/26 the resident lost 8.9 lbs. which was a 7.7% weight loss in 2 months. This was a severe weight loss. Further record review revealed weight loss was not addressed when it began to occur in March 2025. Reweights were never attained to confirm the weight losses. The severe weight loss was addressed 23 days after it was identified when a comprehensive assessment dated [DATE] was completed by the Licensed Dietitian (LD). The comprehensive assessment was completed because of the Significant Change MDS. Weekly weights were initiated in May 2026, a month after severe weight loss occurred and 2 months after the initial weight loss had begun. 4. Record review for Resident #27 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Diabetes, Cachexia, Protein-Calorie Malnutrition, and Dementia. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #27 dated 03/19/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #27's weights in his EHR were as follows: 04/03/26 147.9 lbs. 05/03/26 157.8 lbs. The resident experienced a significant 9.9 lb. weight gain which was 6.7% in one month. As of 05/14/26, 11 days, a reweight had not been taken to confirm the significant weight change and it had not been addressed. On 05/14/26 at 02:50 PM an interview was conducted with the LD, whose employment of 8 years was contracted by the facility through the company she worked for. She stated residents who were admitted to facility were weighed weekly for a month. There was otherwise no policy for weights and addressing significant weight changes provided by the facility or the contracted company she was employed by. Weights were taken by Certified Nursing Assistants (CNAs) and entered in the EHRs by the nurses. All the residents' weights were in the EHR including weekly weights and reweights. If a resident refused to get weighed, she would document it in the resident's care plan and in a progress note. The LD stated she ran a weekly report that identified significant weight changes and she tries to address them as soon as possible. She stated an acceptable time frame to address an identified significant weight change would be by the following week since she was at the facility twice a week, usually Tuesdays and Thursdays. A resident who lost 4.5% or more would also be assessed because it (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected a trend. Interventions for a resident who had experienced a significant weight change would include weekly weights until stable. If a significant weight change was identified, a reweight to confirm the change would be preferably attained by the next day if not the next week. The weights and dietary notes for Resident #49 were reviewed with the LD. She confirmed the resident was not weighed weekly upon admission as per facility policy and the doctor did not order weekly weights when a significant weight loss was identified. She did not comment when the doctor's note stating unavoidable weight loss was due to post toe amputation was brought to her attention. The weights and dietary notes for Resident #36 were reviewed with the LD. She confirmed reweight was not taken and the weight losses were not addressed and monitored in a timely manner. The weights for Resident #27 were reviewed with the LD. She agreed that a reweight should have already been taken to confirm if the resident had a significant weight gain. Bottom of Form		

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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** Based on observations, interviews and record review the facility failed to ensure tube feeding administered as ordered and ensure the tube feeding bottle was labeled with a time started for 1 of 2 sampled residents reviewed for tube feeding (Resident #6). The findings included: Review of the facility's policy titled, Person-Centered Medication Administration Schedule with a revised date of 08/14/24 included in part the following: Medications shall be administered according to established schedules. Medications may be administered one hour before to one hour after the prescribed times. A physician's order for specific times supersedes any routine schedule. Review of the facility's policy titled, Enteral Feeding: Ready-to-Hang with a revised date of 08/2023 included in part, the following: Fill in information on label (resident's name, room, date, start time and rate. Record review for Resident #6 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Vascular Dementia, and Gastrostomy Status. The Brief Interview of Mental Status evaluation dated 05/07/26 documented a score of 99 indicating the interview was not able to be completed. Review of the Physician's Orders for Resident #6 revealed an order dated 02/17/26 in the morning for Feeding turn off at 10:00am, turn tube feed on at 2:00pm (1000 ml/24 hours) Nepro 1.8 carbsteady continuous at 50 ml per hour for 20 hours and in the afternoon for Feeding turn on at 2:00pm (100 ml/24 hours) Nepro 1.8 carbsteady continuous at 50 ml per hour for 20 hours. Turn tube feed off at 10:00am. Review of the actual medication administration times for enteral feed order for Resident #6 from 05/04/26 to 05/13/26 documented the following: On 05/04/26 the tube feeding was documented as being turned on at 3:21 PM (1 hour and 21 minutes late). On 05/05/26 the tube feeding was documented as being turned off at 11:22 AM (1 hour and 22 minutes late). On 05/05/26 the tube feeding was documented as being turned on at 3:19 PM (1 hour and 19 minutes late). On 5/06/26 the tube feeding was documented as being turned on at 11:03 AM (1 hour and 3 minutes late). On 05/07/26 the tube feeding was documented as being turned off at 11:07 AM (1 hour and 7 minutes late). On 05/07/26 the tube feeding was documented as being turned on at 3:32 PM (1 hour and 32 minutes late). On 05/08/26 the tube feeding was documented as being turned off at 11:06 AM (1 hour and 6 minutes late). On 05/08/26 the tube feeding was documented as being turned on at 3:36 PM (1 hour and 36 minutes late). On 05/09/26 the tube feeding was documented as being turned off at 11:50 AM (1 hour and 50 minutes late). On 05/09/26 the tube feeding was documented as being turned on at 3:38 PM (1 hour and 38 minutes late). On 05/10/26 the tube feeding was documented as being turned off at 11:21 AM (1 hour and 21 minutes late). On 05/12/26 the tube feeding was documented as being turned on at 3:48 PM (1 hour and 48 minutes late). On 05/11/2026 10:45 AM, observation was made of Resident #6 out of bed in a Geri chair with no tube feeding. Review of the nursing progress notes for Resident #6 from 05/04/26 to 05/14/26 revealed no documentation of issues with tube feeding or that the tube feeding was not administered as ordered. On 05/12/26 at 9:55 AM, an observation was made of Resident #6 sitting up in bed sleeping with a bottle of Nepro 1.8 carbsteady infusing at 50 ml per hour via pump. The bottle was dated with a start of 05/11/26 at 1900 (7:00 PM). the bottle had 550 ml out of a 1,000 ml capacity bottle (The bottle should have had 250 ml of Nepro). On 05/13/26 at 8:45 AM an observation was made of Resident #6 sitting up in bed sleeping with a bottle of Nepro 1.8 carbsteady infusing at 50 ml per hour via pump. The bottle was dated with a start of 05/12/26 with no time documented on the label. The bottle had 400 ml out of a 1,000 ml capacity bottle of Nepro. On (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/13/26 at 6:40 PM an observation was made of Resident #6 sitting up in bed sleeping with a bottle of Nepro 1.8 carbsteady infusing at 50 ml per hour via pump. The bottle was dated with a start of 05/12/26 with no time documented on the label. The bottle had 200 ml out of a 1,000 ml capacity bottle of Nepro. On 05/14/26 at 7:00 AM an observation was made of Resident #6 sitting up in bed sleeping with a bottle of Nepro 1.8 carbsteady infusing at 50 ml per hour via pump. The bottle was dated with a start of 05/13/26 at 10:40 PM. The bottle had 800 ml out of a 1,000 ml capacity bottle (The bottle should have had 575 to 600 ml of Nepro). During an interview conducted on 05/14/26 at 9:00 AM with Staff D Licensed Practical Nurse (LPN) who was asked about the tube feeding order for Resident #6, the LPN stated it is for Nepro 1.8 carbsteady to infuse at 50ml per hour, it is turned on at 2:00 PM and turned off at 10:00 AM. When asked about the 1000ml/24 hours and the 100ml/24 hours she stated that she would need to call the physician to clarify the order. When asked if there was any report of the tube feeding not being given over the night shift she said no. When asked if the tube feeding bottle started at 05/13/26 at 10:40 PM and ran for 50ml per hour until 05/14/26 at 9:00 AM (10 hours and 15 minutes) how much should be left in the 1000 ml capacity bottle, she said it should be about 500ml. When asked where they document the tube feeding being turned on and off, she said it is on the Medication Administration Record. On 05/14/26 at 9:05 AM a side-by-side observation with Staff D LPN was made of Resident #6 sitting up in bed sleeping with a bottle of Nepro 1.8 carbsteady infusing at 50 ml per hour via pump. The bottle was dated with a start of 05/13/26 at 10:40 PM. The bottle had 700 ml out of a 1,000 ml capacity bottle. She acknowledged the amount left in the bottle should have been closer to 500ml. During an interview conducted on 05/14/26 at 1:00 PM with the Director of Nursing who acknowledged the tube feeding order was not clear. After reviewing the actual medication administration times for enteral feed order for Resident #6, she also acknowledged the enteral feeding (medication) was more than 1 hour late from the prescribed time to turn the tube feeding on and off several times in the month of May 2026.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement physician response to pharmacy recommendations for 1 of 5 sampled residents reviewed for Medication Regimen Review. (Resident #3).The findings included:Review of the facility's policy titled, Medication Regimen Review (MRR), dated 06/01/24, included the following: 9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing act upon the recommendations contained in the MRR.Record review for Resident # 3 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Atherosclerotic Heart Disease of native coronary artery without angina pectoris, a condition where plaque builds up in the heart that restricts oxygen flow, and Gastro-esophageal reflux disease without esophagitis, a chronic digestive condition where stomach acid or contents flow back into the throat.Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident # 3 had a Brief Interview for Mental Status of 13, which indicated that he was cognitively intact.Review of the Physician's Orders showed that Resident #3 had an order dated 02/17/26 for Metoclopramide HCL oral tablet. Given by mouth three times a day for nausea/vomiting. The order to discontinue the medication was dated 05/01/26 and the last administration was on 05/08/2026.Review of the Care Plan dated 02/17/26 documented that Resident #3 had an alteration in gastro-intestinal status, episodes of nausea, vomiting and abdominal pain. Goals were to have decreased risk of discomfort, complications or signs and symptoms related to gastro-intestinal alterations through the review date. Interventions were to med as ordered for nausea, observe medications for side effects.Review of the Pharmacy Consultation Report dated 03/30/26 documented Resident #3 received Metoclopramide which may cause involuntary movements including tardive dyskinesia, but an abnormal involuntary movement scale (AIMS), Dyskinesia Identification System: Condensed User Scale (DISCUS), or other appropriate assessment was not documented in the medical record. The recommendation included monitoring involuntary movements using a clinically validated scale at baseline, 3 months after initiation or a dose increase, at least every 6 months thereafter and as clinically indicated for the drug Metoclopramide. Early detection of symptoms and discontinuation of the offending agent may help to avoid tardive dyskinesia (involuntary movements).During an interview on 05/14/26 at 11:40 AM, the March 2026 recommendations were reviewed for Resident #3. The DON stated that the medical director reviewed the document on 04/02/26 and made recommendations to the provider. The order was reviewed by the facility provider on 05/01/26 and the DON stated that she put in a stop date of 05/01/26. She stated that this medication is not a psychotropic drug , it is an anti-emetic and does not need behavior monitoring. During a speaker phone interview on 05/14/26 at 2:23PM with the Medical Director, the March 2026 pharmacy consultation report for Resident #3 was reviewed. She stated that she accepted the recommendations for behavioral monitoring and added a recommendation to the primary care physician to consider weaning off the Reglan (Metoclopramide) and verified that she signed the document on 04/02/26.Resident #3 was not monitored for behaviors while receiving Metoclopramide, as recommended from the period of 04/02/26 when the recommendation was accepted and the date of discontinuation on 05/08/26.		

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NAME OF PROVIDER OR SUPPLIER Medicana Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 Lake Worth Road Lake Worth, FL 33460	
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 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** Based on observations, interviews, and record review, the facility failed to adequately monitor side effects for psychotropic medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #5). The findings included: Review of the facility's policy titled, Psychotropic Medication Assessment & Monitoring, revised date 8/2023, included the following: Purpose: that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. The center implements gradual dose reduction (GDR) and non-pharmaceutical interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medications; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Procedure: c. The internal disciplinary team assesses and monitors the appropriateness, effectiveness, and side effects associated with psychotropic medications for each resident via the MSDS process. The resident, and when indicated the family or responsible person, will be included in this process. The consultant pharmacist reviews the use of the psychotropic medication order as part of each drug regimen review and monitors for: Timely completion of reassessment; Reassessment for trial reduction in dose as per acceptable standards of practice, if there is a change in behavior or clinical status. e. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when use: a) In excessive dose; or b) for excessive duration; or c) without adequate monitoring; or d) without adequate indications of its use; or e) in the presence of adverse consequences which indicate the dose should be reduced or discontinued. Record review for Resident #5 revealed the resident was admitted to the facility on [DATE] with a readmission date of 06/23/25 with diagnoses that included: End Stage Renal Disease; Type 2 Diabetes Mellitus with Diabetic Nephropathy; Dementia; Anxiety Disorder; and Major Depressive Disorder, Recurrent, Moderate. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) of 15, which indicated he was cognitively intact. Review of Section N revealed Resident #5 is on the following medications: antidepressant, opioid, hypoglycemic, anticonvulsant medications. Review of the Physician's Orders showed Resident #5 had an order dated 01/26/26 for Pregabalin 25 milligram (mg) capsule, 1 capsule by mouth two times a day for Convulsive; on 02/07/26 an order for Fluoxetine HCl 20 mg capsule, 1 capsule by mouth in the morning for Depression. Further review of Resident #5's physician's orders showed an order dated 02/28/26 to monitor for side effects/adverse reactions related to use of psychoactive medications: anticholinergic effects, irregular heartbeat, drowsiness, unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal idealizations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Review of the Care Plan dated 02/06/26 documented that Resident #5 uses psychotropic medication therapy related to diagnoses of depression and anxiety. Goals were to have decreased risk of discomfort or adverse reactions related to psychotropic therapy through the review date. Interventions were to observe for side effects and adverse reactions of psychoactive medications: anticholinergic effects, irregular heartbeat, drowsiness, unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal idealizations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Review of the psychiatry consultations (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 02/11/26 and 04/15/26 recommended for Resident #5 to be monitored for medication side effects as part of his treatment plans. Review of the May 2026 Medication Administration Record (MAR) showed Resident #5 has not been monitored for side effects as per physician orders. During an interview conducted on 05/13/26 at 5:27 PM with Staff D, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 1 month. She stated residents on psychotropic medications are monitored for behaviors and side effects which she would document in the MAR. Staff D was asked to pull up Resident #5's MAR and show where she would document for side effects. She then stated Resident #5 does not have an order in the MAR for monitoring side effects. During an interview conducted on 05/14/26 at 12:25 PM with the Director of Nursing (DON), who stated she has worked at the facility since February. She stated there's an order for monitoring side effects of psychoactive medications in the system; and the nurses are to check for side effects and document in the MAR. A side-by-side review of Resident #5's MAR was conducted with the DON, and she was unable to find the order for monitoring of the side effects. She stated she would have to investigate it. At 2:56 PM, the DON stated that it looks like the schedule for the order was not filled out.		

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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** Based on observations, interviews and record review, the facility failed to provide the correct fluid consistency ordered for 1 of 1 sampled resident. (Residents #44) The findings included: Record review for Resident #44 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Parkinson's Disease, Dementia, Dysphagia, Chronic Respiratory Failure, and Atelectasis. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #44 dated 02/20/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Review of the Physician's Orders for Resident #44 revealed an order dated 11/03/25 for a Pureed texture, Honey Thick consistency Diet. Review of the Care Plan for Resident #44 initiated on 08/15/11 with a focus on Nutritional Status was observed with a goal stating, Diet as ordered. During an observation on 05/11/26 at 12:58 PM, Resident #44 was observed in the dining room, during the second seating. Her meal ticket read, Regular Pureed, Honey Thick Liquids, House Shake Honey Thick. The shake on the tray was observed to have a nectar thick consistency. During an observation on 05/13/26 at 08:35 AM, Resident #44's breakfast tray was in the meal cart. The house shake on the tray was of nectar thick consistency. The tray was brought into the room, and the resident was fed by Staff A, Certified Nursing Assistant (CNA), who had been employed by the facility for 10 years. The shake was poured into a cup and was observed to be of nectar thick consistency. Staff A confirmed she had not added anything to the shake to thicken it. Photographic evidence was obtained. On 05/14/26 at 10:04 AM an interview was conducted with the Director of Therapy, who had been the Director since the year 2017. The Director stated he knew Resident #44 well and she had a diagnosis of Parkinson's along with chronic respiratory issues. She had been declining during the past 5 years and was dependent on staff when eating and drinking. The Director further stated the resident had a lot of swallowing issues and had bouts of pneumonia recently. The last time she had pneumonia was in January 2026 when she was already on Honey Thick Liquid Consistency. He stated if the resident drank a beverage that was nectar thick or not honey thick, she would be at risk for aspiration. The Director was then shown the photographic evidence obtained from the resident's trays. An interview was conducted on 05/14/26 at 02:50 PM with the Licensed Dietitian (LD), who had worked at the facility as a contractor for 8 years. She stated the kitchen provided all beverages at the appropriate consistency on the meal trays. Thickening of beverages was performed by kitchen staff only.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This was observed during 1 of 2 visits conducted in the Main Kitchen. The findings included: A tour of the Main Kitchen was conducted on 05/11/26 at 8:48 AM with the Dietary Manager (DM). The following was observed: The facility had a large reach-in refrigerator with multiple glass doors, 5 in total. a. A [NAME] Brand, Nectar thick Beverage, 32 ounce carton was found open in the reach-in refrigerator with a handwritten date in black of 04/26/26. The side panel of the carton stated the product could be kept under refrigeration for up to 7 days once opened. The DM stated it was the date the item was received and could not determine how many days it had been opened. b. A Silk Soy Brand, 32-ounce carton, was found open in the reach-in refrigerator. There was no opened date identified on the carton and the label read stays fresh 7-10 days after opening. The DM was unable to determine the date it was opened. c. Sitting water was observed on the lids of 2 5-pound cottage cheese containers. The stickers placed on them by the facility had dissolved in the water and were unreadable. Right above the cottage cheese containers on the top shelf was a large gallon-sized container of sauerkraut which was stored under one of the refrigerator fans. When the container was pulled off the shelf, water sitting on the lid poured onto this surveyor. d. The walk-in freezer was observed with 2 evaporator fans on the back wall. Under the left fan, 4 Chef [NAME] Brand, dessert pies were observed with a significant amount of ice accumulation. The top pie, which was out of the box and wrapped with plastic wrap, was observed with the most ice buildup. Water dripped and froze over the side of the pie and onto the others so that they were all stuck together. The fan cover of the evaporator fan above the pies had a frost like build up and towards the bottom of the cover, there was some ice build up from an accumulation of water. Photographic evidence was obtained.		

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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** Based on observations, interviews and record review the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) during care provided for 1 of 19 residents on EBP (Enhanced Barrier Precautions), (Resident #6) and 1 of 1 sampled residents observed for wound care (Resident #48). The findings included: Review of the facility's policy titled, Enhanced Barrier Precautions with a revised date of 06/13/24 documented in part the following: To ensure understanding of Enhanced Barrier Precautions by staff when caring for residents. Enhanced Barrier Precautions are indicated: wounds, and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (Multidrug-resistant organism). Review of the Enhanced Barrier Precautions signage issued by the U.S. Department of Health and Human Services Center for Disease Control and Prevention with no date that the facility used to post on the residents' door included in part the following: Enhanced Barrier Precautions & Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities: Transferring, Changing briefs or assisting with toileting, wound care: any skin opening requiring a dressing. 1). Record review for Resident #6 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Vascular Dementia, and Gastrostomy Status. The Brief Interview of Mental Status evaluation dated 05/07/26 documented a score of 99, indicating the interview was not able to be completed. Review of the Physician's Orders for Resident #6 revealed in part the following: An order dated 01/29/26 for every shift Check g-tube placement q shift, before administration of meds and flushes. An order dated 02/13/26 for Enhanced Barrier Precautions every 24 hours. On 05/11/26 at 1:55 PM an observation was made of Resident #6 assisted back to her bed from Geri chair via Hoyer lift by Staff M, Certified Nursing Assistant (CNA) and Staff L, Certified Nursing Assistant (CNA). Once Resident #6 was in bed, they proceeded to change her brief. Neither staff member wore a gown during the transfer or during the incontinence care provided. The resident had a Peg tube in place and there was an Enhanced Barrier Precaution sign on the outside of the resident's door. During an interview conducted on 05/14/26 at 9:25 AM with Staff D Licensed Practical Nurse (LPN), who was asked about when someone has a wound or Peg tube when do you need to wear gown and gloves, she said whenever you provide care for the wound or Peg tube or when transferring the resident or providing incontinence care such as changing briefs. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2). Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] with a readmission On 01/14/22 with diagnoses that included: Cerebral Infarction due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery; Chronic Obstructive Pulmonary Disease; Type 2 Diabetes Mellitus with Severe Non-Proliferative Diabetic Retinopathy with Macular Edema, Bilateral. The MDS dated [DATE] revealed Resident #48 had a BIMS of 01, which indicated that she was severely cognitively impaired. Further review revealed Resident #48 had pressure reducing device for chair, for bed, and has Nutrition or Hydration intervention to manage skin problems. Review of the Physician's Orders showed Resident #48 had an order dated 02/19/26 to cleanse sacrum with wound cleanser; pat dry; apply skin prep to peri-wound. Then apply Calcium Alginate & cover with border gauze. Offer the resident pain medications 30-60mins prior to treatment and as needed for wound care. During an interview conducted on 05/14/26 at 10:25 AM with the Wound Care Licensed Practical Nurse (WCLPN), who stated Resident #48 had a sacral wound before and it had healed; however, the wound came back, she's not sure why, but it is getting better and it is expected to resolve within 2-3 weeks. During a wound care observation conducted on 05/14/26 at 10:30 AM with the WCLPN, who had pulled all the supplies for the treatment and had cleaned the surface of the bedside table for Resident #48. She was assisted by Staff G, Certified Nursing Assistant (CNA), who was wearing a gown and gloves (PPE) and had already positioned Resident #48 on her right side. The WCLPN washed her hands in Resident 48's room don clean gloves; then removed the soiled dressing, discarded the dressing and gloves, used hand sanitizer don clean gloves and followed Resident #48's physician order for the wound treatment. She removed her gloves and used hand sanitizer to clean her hands, then she realized and stated that she forgot to put on the gown. The WCLPN acknowledged she knows she is to wear a gown while providing wound care.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews, and record review, the facility failed to document the census for 2 out of 4 days (05/13/24 and 05/14/26) reviewed for daily nurse staffing data. The findings included: During an observation conducted on 05/13/26 at 9:00 AM, it was revealed that the daily nursing staffing data was posted on the main hallway, near the nurses station. Further observation revealed the daily nursing staffing data posted, did not include documentation of the facility census. During a second observation on 05/14/26 at 7:47 AM the daily nursing staff posted was dated 05/13/26 and did not have the census documented. A third observation was conducted on 05/14/26 at 10:12 AM. The daily nurse staffing post was dated 05/14/26 but the facility census was not documented on the form. Photographic Evidence Obtained. During an interview conducted on 05/14/26 at 10:20 AM with the Human Resource Manager (HRM) she stated that she was responsible for entering the information on the form and posting the form. She stated that the scheduler provides the information for the staffing hours. When asked how she determines what census number to enter on the form she stated that it is midnight census. During a side-by-side review of the staffing sheets for 05/11/26, 05/12/26, and 05/13/26 it showed that the census for 05/11/26 and 05/12/26 were typed on the form. The census for 05/13/2026 was written by hand. When asked why the census was for 05/13/2026 written, she explained that she sometimes includes the census when she first generates the form but if not, she will fill it in when the form is taken down the following day when she reviews the form and makes any needed corrections since it will be used to calculate the two-week staffing.		

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an accurate medical record for 1 of 18 sampled residents reviewed for Resident Records (Resident #3).The findings included:Review of the facility's policy titled, Medical Record Management, dated 04/20/26, included the following: Medical records will be complete and accurate.Record review for Resident # 3 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Atherosclerotic Heart Disease of native coronary artery without angina pectoris, a condition where plaque builds up in the heart that restricts oxygen flow.Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #3 had a Brief Interview for Mental Status Score of 13, which indicated that he was cognitively intact. Review of Section O of the MDS dated [DATE] revealed that Resident #3 was under Hospice care.Review of the Care Plan dated 02/17/26 documented that Resident #3 was readmitted on hospice services for atherosclerotic heart disease. Goals were decreased risk of signs and symptoms of cardiac complications. Interventions were to observe for shortness of breath.Review of the medical record dated 03/02/26 titled Hospice Physician Telephone Order revealed six documents scanned as part of the file but only the first document was for Resident #3.During an interview conducted on 05/13/26 at 5:22PM, Staff O, Health Information Clerk stated that she is responsible for uploading the scanned documents to the resident's medical record. She stated that she verified the name of the resident on each document if she is scanning multiple documents. In addition, she does not shred the hard copy documents until she ensured that the documents were successfully scanned to the resident record.During a follow-up interview on 05/14/26 at 11:39AM a side-by-side review of Resident #3's medical record showed that several medical records for other residents were included in the document scanned for Resident #3 on 03/02/26 under Hospice Physician Telephone Order. The residents included were Resident #88, Resident #74, Resident #51, Resident #37 and Resident #23. Staff O acknowledged that she did not number and identify each document for each resident prior to scanning which created the error and all documents were scanned under the first resident, Resident #3.		