

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER Sea Breeze Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3663 15th Ave Vero Beach, FL 32960	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to treat residents in a dignified manner during dining for 2 of 5 residents (Resident #43, Resident #49) and for 2 of 5 residents for medication administration (Resident #95 and Resident #53), and 1 of 5 residents for catheter care (Resident #95). The findings included: Review of the facility's policy titled, Standards and Guidelines: Resident Rights, dated 09/2001 and revised on 01/2024, included the following Standard: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes Maintenance or enhancement of his or her quality of life, recognizing each resident individuality. The facility must protect and promote the rights of the residents. Guideline: Employees shall treat all residents with kindness, respect, and dignity. Procedure 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: b. be treated with respect, kindness, and dignity . 1. Record review revealed Resident #49 was admitted to the facility on [DATE] with a diagnosis to include Hemiplegia, Non-Traumatic Intracranial Hemorrhage, Anxiety Disorder, Pneumonitis Due to Inhalation of Food and Vomit, Dysphagia, Aphasia following Cerebral Infarction, Seizures, Muscle Weakness, Cognitive Communication Deficit. The admission MDS (Minimum data Set) dated 04/23/26 documents his BIMS (Brief Interview for Mental Status) of 13 that his cognition is intact. During a meal observation on 05/04/26 at 9:20 AM, Resident #49 was observed in his room being assisted by Staff O, CNA (Certified Nursing Assistant) with eating his breakfast. The CNA was observed standing over the resident while assisting him with his meal. During an interview on 05/06/26 at 3:20 PM with Staff O, she was asked about her process for assisting a resident with his meals. When asked if she should be standing over a resident while assisting with his meals, she stated, I didn't know he was a feeder and didn't know we shouldn't stand up over them when feeding them. While Staff O was giving report to Staff P, CNA, an Agency CNA, the surveyor mentioned making sure a resident was sitting up for meals. Staff P then stated to the surveyor Is he a feeder? 2. Record review revealed Resident #95 was admitted on [DATE] with a readmission from hospital on [DATE]. His diagnosis included Paresthesia of Skin, Congestive Heart Failure, Hypertension, (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pneumonitis Due to Inhalation of Food and Vomit, Dysphagia, Major Depressive Disorder, Diabetes Type II. Review of the Medicare 5 Day MDS (Minimum Data Set) dated 05/01/26 documents a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition. During an interview with Resident #95 on 05/03/26 at 10:30 AM, Resident #95 stated that his nurse was very rude to him the other day. The resident stated, she (Staff Z, LPN) came into his room and shoved his medication in his mouth. He had asked for assistants to be moved off a sore and have the pillow placed under his back. She seemed mad and told him she didn't have time to assist and walked out of his room. During an interview on 05/04/26 at 1:00 PM with the DON (Director of Nursing), she stated that she found a note about the incident written up by a CNA under her door. This was the first she had heard about it; she stated that the Executive Director ended up suspending the nurse upon further investigation. 3. Record review for Resident #53 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Burkitt Lymphoma in Remission Muscle Weakness (Generalized), and Cognitive Communication Deficit. Review of the Brief Interview of Mental Status assessment dated [DATE] documented a score of 6 indicating severe cognitive impairment. Review of the physician's orders for Resident #53 revealed an order dated 04/22/26 for Testosterone Cypionate Intramuscular Solution 200 MG/ML (Testosterone Cypionate) Inject 0.3 ml intramuscularly one time a day every Sunday for hormone replacement. On 05/03/ 26 at 10:46 AM, an observation was made of Staff A, Licensed Practical Nurse / LPN, in the hallway next to the B-side nursing station giving an intramuscular (IM) injection into Resident #53's left upper arm. The LPN had initially tried to pull up his sleeve, but could not pull it up far enough, so he pulled the resident's shirt and sweater down exposing his left shoulder and administered the injection. During an interview conducted on 05/06/26 at 1:30 PM with the Assistant Director of Nursing / ADON, who was asked about administration of intramuscular injection in the hallway, she said absolutely not, we would take the resident back to their room to provide privacy and administer the injection in the room. 4. On 05/06/26 at 9:50 AM, an observation of catheter care was observed for Resident #95 performed by Staff M Certified Nursing Assistant (CNA) who was assisted by the Director of Nursing. At 9:51 AM the Assistant Director of Nursing barged into the resident's room through the closed door without knocking or introducing herself. During an interview conducted on 05/06/26 at 11:00 AM with Staff N Certified Nursing Assistant who was asked about entering a resident's room that has the door shut, she said you always need to knock and identify yourself and ask permission to enter. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Record review for Resident #43 revealed the resident was admitted to the facility on [DATE] and a readmission on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus; Dysphagia, Oropharyngeal Phase; Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 02, which indicated that he was severely cognitively impaired. Review of Section GG of the same MDS revealed Resident #43 required set-up or clean up assistance from staff for eating. Review of the Physician's Orders showed that Resident #43 had an order dated 11/26/25 for CCHO (Consistent Carbohydrates) diet, Mechanical Soft texture, thin consistency fortified foods; Frozen Nutritional Treat in the evening for 90 Days Supplement starting 03/12/26; House Supplement 60 milliliters (ml), two times a day for weight status for 60 days, Supplement starting on 04/16/26. Review of the Care Plan initiation date 06/13/24 documented Resident #43 has an Activities of Daily Living (ADL) self-care deficit, related to ADL needs and participation vary, Hemiplegia, Limited Mobility. Goals were to not have a decline in ADL functioning through next review date. Interventions were to provide supervision verbal cues and/or touching/steadying of hands to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. During an observation conducted on 05/03/26 at 8:40 AM observed Resident #43 in bed, bed was raised high. Further observation revealed Staff T, Certified Nursing Assistant (CNA), was in the room standing on the right side of the bed assisting Resident #43 to eat his breakfast. The bed was noted to be raised to Staff T's waist. During an interview conducted on 05/05/26 at 7:27 AM with Staff U, CNA, who stated he has worked at the facility for 16 years. He stated dignity is to treat residents with respect, provide privacy, and treat them as if they were family. He also stated they are to sit while assisting with meals, because standing makes the residents feel intimidated. During an interview conducted on 05/06/26 at 9:16 AM with Staff T, CNA, who stated she has worked at the facility for a month. She stated they are not supposed to stand while assisting with meals. Staff T then acknowledged that on Sunday 05/03/26 she was standing and assisting Resident #43 with his breakfast. 6. A lunch dining observation on the A wing of the facility was conducted on 05/03/26 between 12:36 PM and 12:46 PM. During this time, observed three CNAs distributing the lunch trays and overheard Staff K, CNA, talking to another CNA, which was in the hallway, that the lunch tray she had in her hands was for the resident in room (room number stated) and he's a feeder. Then at 12:46 PM, there were some lunch trays left in the tray cart, and Staff U, CNA, stated to another CNA, those trays are feeder trays, while he was standing in the hallway and within range of other residents and family members to hear. During an interview conducted on 05/05/26 at 7:27 AM with Staff U, CNA, who stated he has worked at the facility for 16 years. He stated dignity is to treat residents with respect, provide privacy, and treat them as if they were family. Staff U was then asked about Sunday 05/03/26 and calling residents feeders. He acknowledged calling residents feeders and admitted that he should not call them by that name.		

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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 observations, interviews and record review, the facility failed to ensure an informed consent for psychotropic medication(s) was obtained for residents prescribed psychotropic medications for 2 of 59 residents reviewed, who were receiving psychotropic medications, Resident #109 and Resident 25. The findings included: 1. Record review revealed Resident #109 was admitted to the facility on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Generalized Anxiety Disorder, Major Depressive Disorder, and Brief Psychotic Disorder. Review of the Minimum Data Set (MDS) assessment revealed the Brief Interview of Mental Status assessment (BIMS) dated 05/01/26 documented a score of 9, indicating moderate cognitive impairment. Review of the physician's orders for Resident #109 revealed in part the following: An order dated 04/30/26 for Lorazepam Tablet 1 MG Give 1 mg by mouth every 8 hours as needed with no end date. An order dated 05/01/26 for Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth every 6 hours as needed with no end date. An order dated 04/30/26 for Trazodone HCl Tablet 100 MG Give 1 tablet by mouth at bedtime An order dated 05/04/26 for Trazodone HCl Tablet 50 MG Give 1 tablet by mouth two times a day and was discontinued on 05/04/26. An order dated 05/04/26 for Trazodone HCl Tablet 50 MG Give 2 tablet by mouth two times a day. Record review for Resident #109 revealed no informed consent for psychotropic medications on 04/30/26. On 05/03/26, an observation was made from 8:20 AM to 8:50 AM of Resident #109 in a reclined Geri chair repeatedly calling out help me. During this time, the resident was observed attempting to get out of the chair, but unable to do so. The resident was also observed with a contracted left hand. During the course of the survey from 05/03/26 to 05/06/26, multiple requests were made for informed consent for psychotropic medications from admission with no documentation provided to surveyor. During an interview conducted on 05/03/26 at 8:45 AM, Resident #109 clutched at surveyor's arm and said, help me, I want to get out of this chair. During an interview conducted on 05/06/26 at 11:45 AM, the Director of Nursing (DON) was informed (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was no informed consent for psychotropic medications provided to surveyor for Resident #109. The DON stated medical records told her they do not have the record; admissions did not have the record, and MDS department did not have the record. 2. Record review revealed Resident #25 was admitted to the facility on [DATE] with a diagnosis to include Major Depressive Disorder, Anxiety Disorder, COPD (Chronic Obstructive Pulmonary Disease), Hypertension, and Muscle Weakness. A review of the physician's orders revealed her current orders include the following medications: Trileptal Oral Tablet 150 MG Give 1 tablet by mouth every 12 hours for mood disorder (Active). Fluoxetine HCl Oral Capsule 40 MG Give 1 capsule by mouth one time a day for depression (Active) Start date 12/26/25. Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain (Active). Ondansetron HCl Tablet 4 MG Give 1 tablet by mouth every 6 hours as needed for Nausea and Vomiting (Active). Resident's previous orders included: Chlorpromazine 100MG at bedtime Start date 12/26/25 Trileptal 150 MG twice a day started on 01/08/26 and discontinued on 04/08/26. Trazadone started on 01/08/26 and discontinued on 04/21/26. A review of the document called Psychoactive Medication Informed Consent, revealed it was signed by the resident dated 12/26/25 but nothing else was filled out. The statement of informed consent, of whether she wanted or did not want the medication, was not checked off. It did not list the medications she is taking. A review of a document called Psychotropic Medications Use: Risks vs Benefits is dated 03/04/26. This documents her medications at that time and had a sentence on the third page that the signature of this nurse confirms the above information has been reviewed with the resident and/or resident responsible party. During an interview on 05/06/26 at 1:30 PM with the DON (Director of Nursing), she stated that they do not use the form named Psychoactive Medication Informed Consent They stopped using it on 03/26. They use the Risk & Benefit form for Psychotropic medication, that started in March. So, if this was the case, Resident #25 should have a document in her file listing her medications and informed consent checked off for the original document since she was admitted in December 2025 and had several psychotropic medications added. The DON acknowledged she should have had one for each time a psychotropic medication was added prior to 03/26.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, policy and record review, the facility failed to ensure resident rights were honored for 6 of 7 sampled residents as evidenced by the failure to ensure showers and/or honor shower preferences for Residents #15, #40, #38, #81, #95, and #112. The findings included: Review of the policy, Standards and Guidelines: ADL Care and Services, issued 04/20 and revised on 01/24, in part documented, Appropriate care and services will be provided for resident who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, Hygiene (Bathing/showers, dressing, grooming, nail care, oral care). Review of the facility's policy titled, ADL Care and Services, dated 04/2020 with revised date 01/2024, included the following: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: 4. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, including but not limited to: a. hygiene (baths/showers, dressing, grooming, nail care, oral care); b. Mobility (transfer, ambulation, wheelchair, splint/brace); c. Elimination (toileting, catheter, ostomy) 6. Interventions to improve or minimize a residence's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 1. Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses documented in part as: Acute Systolic Heart Failure, Cardiomegaly, and Presence of Automatic (implantable) Cardiac Defibrillator. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) score of 10 on a 0-15 scale, indicating moderate cognitive impairment. Review of the Baseline Care Plan dated 02/25/26 revealed Resident #15 required Limited to Extensive assistance with bathing and showering and that the Life Vest should only be removed as ordered when resident is taking a short shower or bath and not to leave resident alone when Life Vest is removed. An initial interview was conducted on 05/03/26 at 11:24 AM and Resident #15 stated that it is difficult to get staff to give him a shower, that he did not have a scheduled day for showers, and that he has only had 1-2 showers during his stay. Resident #15 was asked if he wanted a shower and he stated, Yes. When Resident #15 was asked how he got cleaned he stated he used pre-moistened wipes. Review of the Task for Shower/Bathing Schedule revealed it did not list the days or shift that Resident #15 would be offered a shower/bath. The paper shower schedule in a binder at the nursing station documented Resident #15 shower days as Monday and Thursday during the 3-11 shift. Review of the dates checked off Yes under the shower/bathing task were Sunday 04/08, Friday 04/17, (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monday 04/20, Saturday 04/25, Friday 05/01 and Sunday 05/03/26 and no refusals were checked off in the past 30 days revealing that Resident #15 was only given 6 showers/baths in thirty days and only one shower/bath on his scheduled shower/bathing day. There was another task listed as Bathing for Resident #15 that showed Resident #15 was not given a shower in the past 30 days and was given 4 sponge baths with one refusal on 04/29/26. An interview was conducted on 05/04/26 at 4:23 PM with Staff I, Certified Nursing Assistant (CNA), who has worked at the facility for 1 month. Staff I was asked how she knows what residents are due for showers/baths on her 3-11 shift and she stated the room numbers are listed on the white board at the nursing station and on the computer under the shower/bathing Task. An interview was conducted with Staff H, Licensed Practical Nurse (LPN) Unit Manager, who was asked to show the surveyor where on the white board the list of residents' rooms who get showers was located. He stated that he usually writes it on the board but did not get to it today. He was then asked how a CNA would know what day/shift their residents get showers and he stated that it is listed on the computer under Tasks for shower/bathing. Staff H was asked if the shower/bathing task did not have a day/shift listed what would happen and he replied that may be a problem but then he stated that there is a typed-up schedule in the shower book that is located on the unit that the CNAs can look at. The surveyor could not locate the schedule in the shower binder and Staff H came over and located it in a different binder, not the shower binder. 2. Record review of Resident #38 revealed he was admitted on [DATE] with a diagnosis to include COPD (Chronic Obstructive Pulmonary Disease), Muscle Weakness, Hip Fracture, Hepatic Failure, Hypoglycemia and Myocardial Infarction. Resident's admission MDS (Minimum Data Set) dated 04/18/26 documents his BIMS (Brief Interview for Mental Status) is 15, which means his cognition is intact. Under GG documents for showers and baths he is a Partial/Moderate Assist. His ADL Care Plan documents bathing resident needs limited to extensive assist. based on fatigue, weightbearing and weakness. During an interview on 05/03/26 at 10:55 AM, Resident stated he has not had a shower in weeks and really wants one. 3. Record review of Resident #81 revealed she was admitted on [DATE] with a diagnosis to include Parkinson's Disease, Cervical Spinal Stenosis, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Weakness, Dysphagia, and Essential Hypertension. A review of Resident #81 ADL Care Plan documents for bathing the resident is a limited assist to extensive assist based on fatigue, weightbearing and weakness. A review of her quarterly MDS dated [DATE] documented the BIMS score is 13/15, indicating cognition is intact. A review of the shower task document revealed for the past 30 days 04/06/26 to 04/30/26 Resident #81 has not had any showers or full baths. It shows only 2 sponge baths. During an interview on 05/03/26 at 11:40 AM, Resident #81 stated she has not had a shower in 3 weeks. She stated the CNA told her that she is not on schedule and today told her she would come to tell her what she found out but has not come in yet today. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/04/2026 at 4:00 PM with Staff AA, CNA, she was asked what her process is doing resident showers. She said she keeps a note pad and documents on that. She said most showers are done in the AM and she comes in at 3:00 PM. Asked if she had given this resident a shower today, she stated she just changed her, she has not had one. Most of the time she gives the resident a sponge bath. She said she has only been here 2 weeks and has never given a resident a shower. During an interview with the resident on 05/05/26 at 9:00 AM, Resident #81 was asked if she received a shower yesterday? She stated no and then began to cry. She stated she wants a shower and wants one this morning. She said she had her aide come in and said she would get one at 3:00 PM. She said she wants one after lunch. During an interview on 05/05/26 at 12:25 PM Staff F, Agency CNA, she acknowledged she has this resident today and confirmed she spoke to the resident about a shower. She said she would give her a shower if she had time, but a lot of people give showers. She said the A-beds get a shower on the 7-3 shift and the B beds on the 3-11 shift. She said she documents in the Kardex and documents in real time. During an interview on 05/05/26 at 3:20 PM with Staff BB, CNA, she stated she has this resident and would give her a shower. She documents in the Kardex and will document at about 6-7 PM. The surveyor and the aide went into the room. and the resident stated the other CNA gave her a shower and washed her hair. Resident #81 stated the CNA got mad because I was taking so long but told her I would take my time; I haven't had a shower in 3 weeks. She also wanted to shave her legs. 4. Record review revealed Resident #112 was admitted on [DATE] with a diagnosis to include Hypothyroidism, Coronary Artery Disease, Essential Hypertension, Pulmonary Embolism, Cachexia, Hemiplegia and Hemiparesis following a Cerebral Infarction, Lack of Coordination, Type II Diabetes, COPD (Chronic Obstructive Pulmonary Disease), Sjogren syndrome, Heart Failure and Vascular Dementia. Review of the MDS documents has not been completed yet. Review of the care plan documented that for ADLs for bath and showers, she is dependent on staff including getting in and out of showers. Review of the shower / bath task sheet did not show that this resident has had any showers or baths since she has been here. The shower book documented that B-beds get a shower from 3-11 and her schedule for her room would be Wednesdays and Saturdays. During an interview on 05/03/26 1:00 PM with Resident #112, she was asked if she has had a shower since she has been here if she wants one. She stated, I haven't had a shower since I have been here, I didn't know that was an option. When asked if they sponge bathed her, she said yes but not very good, they did it very quickly. The resident hair was observed to be dirty and greasy. During an interview on 05/06/26 at 8:50 AM, the resident was asked if she had gotten a shower yet. She stated, No. She said she doesn't care when she gets it but wants one. During an interview on 05/06/26 at 8:55 AM, Staff F, Agency CNA, stated she would make sure the resident gets a shower. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview with the resident at 1:30 PM, she was asked again if she got a shower, and responded, no, they told me they were coming between 11:00 AM-1:00 PM but no one came. During an interview on 05/06/26 at 5:30 PM with the resident, she stated she finally got a shower today. She said it felt so good and she feels so much better and clean. The resident's hair looked clean. 5. Record review revealed Resident #95 was admitted on [DATE] with a readmission from hospital on [DATE]. His diagnosis includes Paresthesia of Skin, Congestive Heart Failure, Hypertension, Pneumonitis, Dysphagia, Major Depressive Disorder, and Diabetes Type II. Review of the Medicare 5 Day MDS dated [DATE] documented a BIMS score of 15, indicating intact cognition. Under GG, it documented he needs substantial / Maximal Assist with his showers. His Care Plan for ADL's document for bathing the resident needs Limited to Extensive Assist based on fatigue, weightbearing and weakness. Review of the shower tasks for shower days documented: Tuesday & Fridays 3-11 shift, resident prefers showers. The review showed for the last 30 days 04/07/26 to 05/05/26 documented 1 shower on 04/04/14/26 and 2 partial sponge baths on 04/07/26 and 04/17/26. There were no full sponge-baths documented. During an interview on 05/06/26 at 5:00 PM with the resident, he stated he had never been offered or given a shower prior to him going to the hospital. He stated he had a temporary plasma port but that was ok to get wet. When he came back from the hospital, he could not get the permanent plasma port wet so he couldn't have any showers. 6. During an interview conducted on 05/03/26 at 11:00 AM with Resident #40's family member, who stated that everything is okay at the facility except Resident #40 is not getting showers. He stated he has brought up the concern during the care plan meetings. However, she sometimes goes for 3 weeks without showers or change of clothing. He stated he knows this because he does her laundry and during that time there were no dirty clothes to take home for laundry. He keeps asking them to provide showers at least 2 days a week; he would prefer 3 times a week, but they told him No just 2 times a week, which he understands but they are not even doing that. Resident #40's family member also stated they told him she does get showers; however, he knows she is not getting them. He is further concerned because he knows they (Certified Nursing Assistants (CNA)) come in and ask if she wants a shower now, and she usually will say not know; however, he has asked them to come in and let her know that today is shower day and she will go and get a shower. He then stated again, he has let them know but still she's not getting two showers a week. During an observation conducted on 05/03/26 at 11:00 AM of Resident #40, who was in bed wearing her pajamas; her hair was undone and appeared oily and unclear. Record review for Resident #40 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Ischemic Cardiomyopathy; Chronic Systolic (Congestive) Heart Failure; Major Depressive Disorder; Anxiety Disorder; Mood [Affective] Disorder; Paranoid Schizophrenia. Review of Quarterly MDS dated [DATE] revealed that Resident #40 had a BIMS score of 14, which indicated that she was cognitively intact. Review of Section GG of the same MDS documented Resident #40 requires (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sea Breeze Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3663 15th Ave Vero Beach, FL 32960	
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	set-up or clean-up assistance from staff for showers/bathe self. Review of the annual MDS dated [DATE], Section F revealed Resident #40's preferences for choosing a tub bath, shower, bed bath, or sponge bath as 'very important'. Review of the Care Plan initiated on 06/13/24 documented Resident #40 had an Activities of Daily Living (ADL), self-care deficit related to chronic medical conditions. Goals were maintained and/or improve ADL functioning through next review date. Interventions were to Shower/Bed Bath per preference on Showers days and encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. Review of the Certified Nursing Assistant (CNA) Tasks for Shower Tuesday/Thursday Day 3-11 as needed and per request dated 04/06/26 &ndash; 05/04/26 documented Resident #40 received a shower only 5 times during those dates, 2 full bed baths and 12 checks marks noted as Not Applicable (the activity did not occur). In addition, there was a 2-week gap (04/16/26 and 04/30/26) when Resident #40 did not receive a shower. No documentation was found of Resident #40 refusing showers. Further review of the Shower task documented Resident #40 received a shower on 05/04/26 at 2:31 AM. During an interview conducted on 05/04/26 at 6:11 PM, Resident #40 was observed in bed wearing the same pajamas she was wearing on 05/03/26, hair was still oily-like and appeared uncleaned. She stated she did not receive a shower today. She then confirmed that today was Monday and she is scheduled for showers on Tuesdays and Thursdays. She stated she would prefer the showers in the morning, but she is scheduled for the late afternoons. An interview was conducted on 05/05/26 at 9:41 AM with the MDS coordinator, who stated she has been with the facility for 4 months. She stated the last care plan meeting for Resident #40 was held on 04/29/26 at 10:30 AM. Review of the care plan meeting minutes with the MDS coordinator revealed the resident and family member attended the meeting. Further review revealed there were no concerns at this time. During an interview conducted on 05/05/26 at 10:55 AM, Staff H, Licensed Practical Nurse (LPN), Unit Manager of Wing A, stated he has worked at the facility for 5 months. He stated the shower schedule is set up by room numbers and the staff are aware to ask the residents that day if they want a shower. He then stated if the residents request a different day or time then the generic schedule is changed and MDS will let them know. If the resident refuses on their shower day, then the CNA will make him or the incoming CNA aware of the change and when the resident prefers a shower. Staff H stated that normally the CNA task is changed to the times and days the resident requested and the system will remove the older task. Staff H explained that the Not applicable option in the CNAs' Task represents the activity did not occur. During an interview conducted on 05/05/26 at 11:16 AM with Staff W, CNA from an Agency, who has worked at the facility for about 2 months, 2 times a week depending on eligibility, she stated there's a book with the shower schedules by room or she can ask the nurse or another CNA who gets showers. She stated she is able to document who she gave a shower to in the Point Click Care (POC) system. Staff W stated there are no showers scheduled during the 11PM-7AM shift. Staff W was then asked (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why she documented that she provided Resident #40 with a shower at 2:31 AM on 05/04/26 and acknowledged that she made a mistake and did not give a shower to the resident that day. Staff W also explained Not applicable option in task means the task was not done. On 05/05/26 at 12:04 PM, the MDS coordinator provided the surveyor with a copy of the MDS Care Plan Communication Log dated 04/29/26 documenting that the family member of Resident #40 was concerned that she was not getting enough showers. There were no follow-up details. 7. Record review revealed Resident #29 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses that included: Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris; Type 1 Diabetes Mellitus with Ketoacidosis without Coma; Atrial Fibrillation; Muscle Wasting and Atrophy. Review of Quarterly MDS dated [DATE] revealed that Resident #29 had a BIMS score of 14, which indicated that she was cognitively intact. Review of Section GG of the same MDS revealed Resident #29 was dependent on staff for toileting hygiene and for putting on/off clothing or shoes. Review of the care plan initiated on 08/06/25 documented Resident #29 was at risk for skin impairment related to Anemia, Incontinence, use of anticoagulant/antiplatelet medications, and weakness/decreased mobility. Goals were to be free from any new skin impairment through the review date. Interventions were to provide incontinence care promptly should any episodes of incontinence occur. Review of CNAs Tasks for bladder Continence from 04/06/26 to 05/05/26 documented Resident #29 is bladder incontinent and peri care with Barrier Cream applied was conducted 3 times a day on 04/06/26, 04/07, 04/08, 04/12, 04/15, 04/17, 04/18, 04/19, 04/22, 04/23, 04/25, 04/26, 04/27, 04/28, 04/29, 05/03/26; For all other days it was documented only 2 times or one time a day. There was documentation of Resident #29 refusing incontinence care. During an interview conducted on 05/03/2026 at 10:24 AM, Resident #29, who was in bed wearing a hospital gown, she stated she needed to be changed; but they (staff) had told her in the past that their policy is to change them every two hours; and right now she needs to get changed but she's not due until 11:00 AM and therefore she must wait. She stated she has called (activated the call light system) to be changed but they come in, turn off the call light and tell her to wait. On 05/05/26 at 12:40 PM, another interview was conducted with Resident #29, who stated the staff is still lacking in assisting her when she needs it. During an interview conducted on 05/06/26 at 9:16 AM, Staff T, CNA, stated she has worked at the facility for a month. She stated she has 13 to 14 residents scheduled to her care today, and they all are total-assistance care except for one. Staff T stated they are to check and provide care to the residents every two hours or when the resident requests assistance but again depends on if they are busy.		

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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** Based on observations and interviews, the facility failed to ensure residents' rooms were maintained in a safe, clean, homelike environment for 13 of 60 rooms, Rooms 210, 202, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, and 128. The findings included: 1. On 05/03/2026 10: 30 AM, an observation of the window to the outside in room [ROOM NUMBER] was covered with dark matter. During a side-by-side observation conducted on 05/05/26 at 8:30 AM, the Assistant Director of Nursing acknowledged the window was dirty in room [ROOM NUMBER] 2. On 05/03/2026 at 12:20 PM, an observation made in room [ROOM NUMBER] of the bathroom wall on the side revealed the toilet tissue holder with bubbling paint and exposure of a crumbling wall with no paint along the entire length of the wall. There was an observation in the room of an unused oxygen concentrator with the plug running under the bathroom door and plugged in to an electrical outlet in the bathroom. On the oxygen concentrator there was a tag attached with a string to the top handle of the concentrator that read Read other side! Do Not Use! Removed from Service. Turn Tag Over.; and on the other side of the tag, it read Removed From Service!!! Do Not Use! Low Max O2 81%. Removed March 2026. During a side-by-side observation conducted on 05/05/26 at 8:30 AM, the Assistant Director of Nursing acknowledged the unused concentrator with the tag attached Do Not Use dated March 2026. She said the oxygen concentrator should have been removed back in March. 3. An interview was conducted on 05/03/26 at 11:17 AM with the resident who resides in room [ROOM NUMBER]-B. The resident stated there is some type of leak coming from the ceiling in the bathroom and that is why there is a grey bucket on top of the toilet, and I emptied the bucket 3 days ago. Observation revealed there was a discolored ceiling tile, a vent above the toilet and the floors and walls in the bathroom were stained. Photographic Evidence Obtained. On 05/06/26 at 10:28 AM, a tour of the bathroom was conducted with the Housekeeping District Manager and the Facilities Housekeeping Manager who observed the discoloration around the toilet and the stained walls in room [ROOM NUMBER]. They alerted the Maintenance Director about the ceiling tile and bucket on the toilet. 4. During the tour that was conducted on 05/06/26 at 10:28 AM, the Housekeeping District Manager and the facilities Housekeeping Manager were shown the floors on the unit that included rooms 100-110, as follows: the stained tile floors, some flooring located inside residents rooms was sticky when walking on them and the molding around the doors were damaged and missing areas of paint. They were advised of a strong foul odor in room [ROOM NUMBER] that they were aware of as they mentioned the residents' name when the surveyor brought up the concerns with room [ROOM NUMBER]. At 10:40 AM, Staff S, Maintenance Assistant, stated that there is new flooring in the 200 (continued on next page)		

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit and that he was told that new flooring for the 100 unit had been approved but had not heard anything recently about having the tile replaced.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, interview and record review, the facility failed to implement their Grievance-Resident Rights policy for 3 of 3 sampled residents as evidenced by the failure to provide timely response to grievances for Residents #60, #25, and #95. The findings included: Review of the policy, Grievances-Resident Rights, issued 04/2017 and revised 07/2024, in part, documented, Guideline: The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative, and #8. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. 1. Record review revealed Resident #60 was admitted to the facility on [DATE] with diagnoses documented, in part, Obesity, Unilateral Primary Osteoarthritis, and Generalized Anxiety Disorder. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented that Resident #60 had a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale, indicating the resident had intact cognition. Review of the Medication Administration Record (MAR) for January, February, and March 2026 revealed Resident #60 had received Tirzepatide Subcutaneous Solution Auto-injector 5 MG/0.5ML every Friday on the following dates (01/23, 01/30, 02/06, 02/13, 02/20); Resident #60 received Tirzepatide-Weight Management Subcutaneous Solution 10 MG/0.5ML (Inject 0.5 mg subcutaneously one time a day every Friday for weight loss until 03/27/26, on the following dates: 03/06, 03/14, and 03/20; and did not receive the prescribed dose of Tirzepatide on 03/27/26. An initial interview was conducted on 05/03/26 at 1:34 PM with Resident #60 who stated she had been waiting for her weight loss medication that had disappeared on 03/27/26. Resident #60 was asked who she told and stated that many nurses know, including Staff T, Registered Nurse (RN), since she was the nurse that was working on 03/27/26 and who was unable to find my prescribed dose on 03/27/26. At 1:30 PM, Staff T came into Resident #60's room and was asked what she knew about the missing weight loss medication. Staff T stated that she had told the Social Services Director (SSD) and that she is not sure what is going on about the medication but agreed to go talk to the SSD when she left the resident's room. An interview was conducted on 05/04/26 at 8:26 AM with the Social Services Director (SSD) who stated the first time she heard the medication that was prescribed to Resident #60 was missing was on 05/03/26. The SSD stated that she had asked Staff H, Licensed Practical Nurse (LPN) Unit Manager, about the missing medication for Resident #60 and was told that the weight loss medication was Resident #60's personal medication. An interview was conducted on 05/04/26 at 8:52AM with Staff G, Licensed Practical Nurse (LPN), who is employed by an agency and has worked at the facility before and is assigned different units as needed. Staff G was asked about Resident #60, and she stated that Resident #60 frequently has complaints, and that she made sure to pass Resident #60's complaints to facility staff. Staff G stated (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a few weeks ago, Resident #60 had an issue and said that she did not have her weight loss medication, and someone had told her that a CNA may have thrown it away. Staff G was told the weight loss medication was not in the refrigerator where it had been stored and there had been a new dose and old dose; and possibly, they were supposed to throw out the old vial but mistakenly threw both out. Staff G was asked who she told about Resident #60's complaint and she stated that she told Staff H, Licensed Practical Nurse (LPN) Unit Manager. An interview was conducted on 05/04/26 at 9:00 AM with Staff H who stated that he never saw the weight loss medication and that when he checked there was an order for it and then it was discontinued. An interview was conducted on 05/05/26 at 1:08 PM with the SSD who stated the Attending Physician agreed to write an order for the weight loss medication if Resident #60 wanted to start taking it again. The SSD stated that she spoke to Staff H who stated that the order was discontinued and that may be why someone threw it out and the Administrator is going to pay for the medication that was in the refrigerator. The SSD again stated the first time she heard about the missing medication was on 05/03/26. The SSD was then asked about the lack of communication with staff to have this issue from March being addressed now and she stated that she was not sure if the grievance process was followed. The SSD was asked what process should have been followed and stated the moment the medication was discontinued, staff should have called the physician and checked before disposing of the medication. The SSD stated that they initiated a grievance and submitted it to the Administrator today. A follow-up interview was conducted on 05/06/26 at 11:01 AM with the SSD about the process for filing a grievance. She stated that anyone can write or assist a resident with writing a grievance and the forms are located in various areas around the building, such as in the conference room, with the Manager on Duty, in the human resources office, and the business office. The SSD stated the manager on duty is encouraged to write up the grievance or to let the SSD know and she would write it up. The SSD was asked what type of training staff are given about grievances and stated they get training on it during orientation and that she talks during the orientation about the grievance process and about where the forms are in located the building. An interview was conducted on 05/06/26 at 11:00 AM with Staff K, Certified Nursing Assistant (CNA), who stated that she had worked in the facility since February 2026, she went through orientation, she thinks the grievance forms are located by the front entrance, she would tell the nurse if a resident had a complaint / grievance, and fill out the form if the nurse directed her to do it. An interview was conducted on 05/06/26 at 11:18 AM with Staff L, Registered Nurse (RN), who was just hired and was asked if she went through orientation and she stated, somewhat. Staff L was asked what she would do if a resident had a grievance. She stated she would go to the Assistant Director of Nursing (ADON) and find out if the forms are online or on paper. She was then asked if she had ever seen a grievance form and she stated, no, and that she did not know where the Grievance forms were located in the building. Review of the Grievance Form that was initiated after surveyor intervention, dated 05/04/26 for (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #60, with the date the grievance occurred as 03/27/26, and the form was completed by the SSD and was pending investigation. 2. Record review revealed Resident #25 was admitted to the facility on [DATE] with a diagnosis to include Major Depressive Disorder, Anxiety Disorder, COPD (Chronic Obstructive Pulmonary Disease), Hypertension, and Muscle Weakness. Review of Resident #25's admission MDS (Minimum Data Set) dated 12/31/25 documented the BIMS (Brief Interview for Mental Status) score as 15, indicating cognition is intact. A review of the Grievance log revealed that only one grievance was found for Resident #25 dated 05/01/26 written by the Social Service Director (SSD) from the daughter who informed the SSD that [Resident #25] was missing her Febreze spray bottle in her room which was taken to a nursing cart and lost. The follow up response on 05/02/26 was that aerosols are prohibited in the rooms. The SSD will reimburse residents for the Febreze. No other grievances were found for Resident #25 until 05/04/26 after the surveyors were in the building. On 05/04/26, a grievance was written for Resident #25 that her vase in her room was broken by a Certified Nursing Assistant (CNA) while trying to turn the light off. Another grievance dated 05/04/26 documented Resident #25 did not go to the preferred outing to get cigarettes but went to another store which did not have cigarettes. During an interview on 04/29/26 at 12:43 PM with Resident #25's relative, she stated she had made multiple verbal grievances with the SSD. She stated on 04/21/26 she talked to the SSD about the Febreze missing from the room. On 04/22/26, she filed a grievance about her vase being broken. On 04/24/26, she filed a grievance in reference to her Psychotropic consent form not being filled out. 3. Record review revealed Resident #95 was admitted on [DATE] with a readmission from hospital on [DATE]. His diagnosis included Paresthesia of Skin, Congestive Heart Failure, Hypertension, Pneumonitis, Dysphagia, Major Depressive Disorder, and Diabetes Type II. Review of the Medicare 5 Day MDS assessment dated [DATE] documented the BIMS score of a 15, indicating intact cognition. A review of a Grievance dated 05/04/26 documented Resident #95 informed the SSD that a nurse [name provided / Staff Z] shoved meds in his mouth and when he asked to be pulled up in the bed, she stated she did not have time for that and left room. The follow up to the grievance documented the Executive Director spoke with the resident's nurse (Staff Z) and the nurse was suspended pending investigation. A review of the letter / email dated 04/30/26 documented Staff DD wrote about the concern on 04/27/26 was never submitted until 05/04/26 by putting it under DON (Director of Nursing) door. The grievance documents the following: On 04/27/26 I had just finished providing care to my assigned residents between 12:30 AM-1:00 AM I went inside the conference room on B side to have a sip of water. While standing in their [Staff Z], LPN (Licensed Practical Nurse), the Nurse asked me am I CNA (Certified Nursing Assistant) for ----. I said yes. [Staff Z], LPN then told me that room ---- asked for a pillow under him. I responded, He has pillows on the window Staff Z, LPN responded I know, he wants it under him I stated you were just in his room and couldn't place a pillow under him? [Staff Z], LPN responded I am busy and I have been changing people. I responded too busy to care for your resident is ridiculous when you were just in his room and it only takes 3 seconds to put a pillow under (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him I walked directly to the resident's room and noticed that his call light was on. While positioning the resident on his side he stated he was very uncomfortable and in pain. I apologized to resident while asking if the position of pillow helped and carefully position pillow under his side until he told me he was comfortable. Resident began to cry and apologize. He then said he does not mean to be a bother, but he has a wound and it hurts. I responded you are not a bother and if this doesn't make you feel better let me know so I can tell the nurse. Shortly after I left room, he put his light on again. I went to check on him. He was crying and asked me can I see if the nurse was still busy because he really needed to be pulled up. I responded, I will go find someone and be right back. I seen another CNA and asked her to help me. She said yes We pulled resident up to his comfort and placed another pillow on his side due to resident stating that his buttocks was hurting and he cannot lay on the wound. Resident complained about the nurse not helping him when he asked her [Staff Z, LPN]. We made sure the resident was comfortable before leaving out. Resident stated, If she has enough time to pop a spoon in my mouth, then she should have had time to pop a pillow under me. During an interview with Resident #95 on 05/03/26 at 10:30 AM, Resident #95 stated that his nurse was very rude to him the other day. The resident stated she (Staff Z) came into his room and shoved his medication in his mouth. He had asked for assistants to be moved off a sore and have the pillow placed under his back. She was mad and told him she didn't have time to assist and walked out of his room. Resident #95 said that Staff DD, CNA, came in and wrote a grievance up. During an interview on 05/04/26 at 1:00 PM, the DON (Director of Nursing) stated she found a note about the incident written up by a CNA under her door. This was the first she had heard about it; and the Administrator ended up suspending the nurse upon further investigation. During an interview on 05/06/26 at 4:00 PM, the SSW she was asked about grievances. She stated that she didn't hear anything about the grievance until the surveyor informed her yesterday. The SSW stated the first time I saw the grievance was from the DON who stated Staff DD stuck it under her door.		

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure PRN (as needed) orders for antipsychotic medications were limited to 14 days for 1 of 3 sampled residents receiving PRN psychotropic medications, Resident #109; and 1 of 5 sampled residents reviewed for unnecessary medications, Resident #39. The findings included: 1. Record review revealed Resident #109 was admitted to the facility on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Generalized Anxiety Disorder, Major Depressive Disorder Recurrent Moderate, Brief Psychotic Disorder. Brief Interview of Mental Status assessment dated [DATE] documented a score of 9 indicating moderate cognitive impairment. Review of the physician's orders for Resident #109 revealed in part the following: An order dated 04/30/26 for Lorazepam Tablet 1 MG give 1 mg by mouth every 8 hours as needed with no end date. An order dated 05/01/26 for Lorazepam Oral Tablet 1 MG (Lorazepam) give 1 tablet by mouth every 6 hours as needed with no end date. On 05/03/26, an observation was made from 8:20 AM to 8:50 AM of Resident #109 in a reclined Geri chair repeatedly calling out help me. During this time the resident was observed attempting to get out of the chair but was unable to do so. The resident was also observed with a contracted left hand. Several staff were observed during this time walking past the resident without acknowledging her. During an interview conducted on 05/04/26 at 3:38 PM, Staff C Licensed Practical Nurse (LPN) was asked about the 'as needed' (PRN) psychotropic medications orders. She stated 'I am pretty sure they need an end date, and they are typically only for 14 days'. During an interview conducted on 05/05/26 at 10:18 AM, the Medical Director was asked about the psychotropic medications being ordered as needed (PRN). He stated the pharmacy will only send a 14-day supply and he did not believe they needed an end date for PRN psychotropic medications. 2. Record review revealed Resident #39 was admitted to the facility on [DATE] with a diagnosis to include Paraplegia, Colostomy, Hypertension, Major Depressive Disorder, Anxiety Disorder and Chronic Kidney Disease. Review of the Medicare 5-day MDS (Minimum Data Set) assessment dated [DATE] documented the BIMS (Brief Interview for Mental Status) score as 15/15 indicating intact cognition. A review of the physician orders documented Resident #39 had an order for Alprazolam Oral Tablet 0.25 MG to give 1 tablet by mouth every 8 hours as needed for Anxiety. This medication was (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued on 05/01/26. Resident #39 also prescribed Temazepam PRN (as needed) which was discontinued on 05/01/26. A review of the Pharmacy Reviews for March 2026 dated 03/30/26 documented the Pharmacist consultant recommended that the current order of Alprazolam PRN and Temazepam PRN did not have a specified stop date. The physician agreed with the Pharmacist's findings, signed it on 03/30/26, did not put a stop date, and didn't discontinue the medication until 05/01/26. In the April 2026 Pharmacy reviews dated 04/10/26, the Pharmacist recommended again that the Alprazolam PRN have a stop date. Again, the Physician agreed with the findings on 04/22/26, did not add a stop date and did not discontinue the medication until 05/01/26.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure resident's fingernails were cut and cleaned for 2 of 3 sampled residents reviewed for Activities of Daily Living (ADL) care, Residents #98 and #21. The findings included: Review of the policy, Standards and Guidelines: ADL Care and Services, issued 04/20 and revised on 01/24, in part states, Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with Hygiene (Bathing/showers, dressing, grooming, nail care, oral care). 1. Record review revealed Resident #98 was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Fracture of the Lower End of Left Radius Subsequent Encounter for Closed Fracture with Routine Healing, Muscle Weakness (Generalized), and Cognitive Communication Deficit. The Brief Interview of Mental Status Evaluation dated 03/24/26 documented a score of 12 indicating moderate cognitive impairment. Review of the care plan for Resident #98 dated 03/22/26 with a focus on the resident has a potential for ADL selfcare deficit r/t (related to) inability to complete ADL tasks without weight-bearing assistance from staff/caregiver, pain, depression, weight-bearing status left arm, ADL needs and participation vary, Fatigue, chronic medical conditions. On 05/03/26 at 12:53 PM, an observation was made of Resident #98 with fingernails untrimmed and jagged extending about 1/2 inch past the edge of the nails with brownish-yellow substance under the nails. He had a splint on his left wrist/forearm that wrapped around his thumb, he was missing the tip of his ring finger. During an interview conducted on 05/03/26 at 12:53 PM, Resident #98 was asked about his fingernails. He stated he really needs them cut, smoothed out and cleaned but he cannot do it and no staff has offered to do it for him. During an interview conducted on 05/05/26 at , Staff F, Certified Nursing Assistant (CNA), was asked about fingernail care. She stated they don't really like us to cut nails, CNAs can clean their fingernails and cut them if they are not diabetic, and if they are diabetic, we can clean the fingernails, but the nurse need to cut the fingernails. When asked about Resident #98's fingernails, she looked at them and said those are way too long and very dirty. They need to be cleaned and definitely cut. 2. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses documented in part as: Essential Hypertension, Acute Kidney Failure, and History of Falling. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) score of 10 on a 0-15 scale, indicating moderate cognitive impairment. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/03/26 at 10:57 AM with Resident #21 who was in bed with a gown on and had a scab on the right side of his nose. Resident #21 was asked what happened to his nose and he was unsure of how he cut his nose and then fell asleep during the interview. An interview was conducted on 05/04/26 at 8:51 AM and Resident #21 was in bed eating breakfast and was asked what happened to his nose and he did not have an answer. It was observed that his nails were about a quarter (1/4) of an inch past his fingertips and had discoloration under the nails. Resident #21 stated that they took away his fingernail clippers and that is why his nails were long. An interview was conducted on 05/04/26 at 9:03 AM with Staff H, Licensed Practical Nurse (LPN) Unit Manager, who was asked about the cut on Resident #21's nose and he stated he did not know that Resident #21 had a cut on his nose but suggested that maybe Resident #21 scratched his nose. An interview was conducted on 05/04/26 at 9:15 AM with Staff J, Certified Nursing Assistant, who was asked if she knew what happened to Resident #21's nose and she stated that Resident #21 scratched his nose causing it to bleed and that she showed the nurse about two weeks ago and that Resident #21 keeps scratching the scab and it opens up again. Staff J was asked if Resident #21's nails needed to be trimmed, and she stated that Resident #21 cuts his own nails and that they are not that long. The surveyor and Staff J went to see Resident #21 and Staff J agreed that his nails were too long. Staff J stated she offered to cut Resident #21's nails last week but Resident #21 wanted to clip them himself and said he lost his clippers. Staff J went to get a new pair of clippers, but she could not get into the storage room and the staff in charge of the supplies was not available at that time. Staff J stated there is no excuse, I should have clipped his nails last week or made sure he got the clippers. An interview was conducted on 05/04/26 at 4:41PM with Resident #21 who had a small pink basin, a nail cleaner and nail clippers on his bedside table. Resident #21 stated that he trimmed and cleaned his nails himself.		

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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** Based on observation, record review and interview, the facility failed to ensure wound care orders were clarified and wound care was documented for 1 of 3 sampled residents reviewed for skin conditions, Resident #57; failed to ensure skin assessments were completed weekly for 1 of 3 sampled residents, Resident #3; failed to follow pharmacy review recommendation of not crushing medications for 1 of 5 sampled residents, Resident #3; and failed to give medication in timely manner for 3 of 3 sampled residents, Residents #38, #81 and #39. The findings included: 1. Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses to include: Hemiplegia and Hemiparesis, Type II Diabetes Mellitus, Chronic Respiratory Failure, Absence of Left Leg Above the Knee, Aphasia, Dysphagia, Bipolar Disorder, and Major Depressive Disorder. A review of the annual MDS (Minimum Data Set) assessment dated [DATE] revealed the BIMS (Brief Interview for Mental Status) score was 12/15, indicating moderate cognitive impairment. There was no current physician orders noted that had to do with the resident's left arm. A review of Resident #3 care plan for skin documented a skin infection dated 04/27/26 with a revision 04/30/26. The interventions included: to obtain labs/diagnostics per physician orders and report results as indicated; Report any significant changes in mental status/cognition to nurse/physician; Administer antibiotic as per MD orders; A review of the weekly skin checks documented for 03/22/26, the resident had a reopened area to left shoulder; and on 03/25/26, the last skin check was documented that the resident had a fall. A review of the current physicians orders documented the resident is taking Tamsulosin HCl Oral Capsule 0.4 MG, Give 1 capsule by mouth one time a day for BPH [Benign prostatic hyperplasia] (Active); Ferrous Sulfate Oral Tablet Give 325 mg by mouth one time a day for anemia (Active); and Pantoprazole Sodium Oral Tablet Delayed Release 40 MG Give 40 mg by mouth in the morning for Ulcer (Active). A review of the Pharmacy Consultant reports dated 04/10/26 documented the resident: 'is currently taking Ferrous Sulfate 325 MG tabs which should not be crushed. Currently requires medications crushed. Consider switching to Ferrous Sulfate liquid 7.5 ml.' The Physician response was that he agrees with the recommendation, but the physician order was never changed. The Pharmacy consultant documented that the resident is: 'currently taking Tamsulosin (Flomax) 0.4 MG which should not be crushed, chewed or opened with order to crush medications. Consider either discontinuing if no longer needed or witch to Silodosin (Rapaflo) 8 MG daily after dinner.' The Physician agreed with recommendation, but the medication was never discontinued or switched. The Pharmacy consultant documented the resident is: 'currently on Pantoprazole 40 MG tabs daily with order to crush. Pharmacy consult recommended that medication not to be crushed since it is an enteric coated product and recommended to switch to Omeprazole 20 MG daily since it is a capsule and can be opened and administered with applesauce.' The Physician response was that he agrees (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the recommendation, but the physician order was never changed. During an interview on 05/06/26 at 9:30 AM, Staff L, RN (Registered Nurse), was asked about this resident's left arm. She said that he scratches his arms. She said she hasn't done anything yet this AM (morning) because he is sleeping on the left shoulder but normally, would spray the wound with wound spray, rinse with saline, put a 4x4 on it and wrap in Kling. She said when she got report they said the resident was in a bad mood this morning, so she hasn't gone in there yet. The surveyor asked if there was an order for medication or skin care. Staff L stated that she doesn't see any order from the physician that has to do with his left arm. During a secondary interview on 05/06/26 at 10:40 AM, Staff L was asked if she gave Resident #3 his morning medications. She stated yes and then was asked if she crushed any of the resident's morning medications that included the Ferrous Sulfate and Tamsulosin. She stated she did crush his Ferrous Sulfate and Flomax this morning and put it in applesauce. Staff L stated the Pantoprazole is given at 6:00 AM, the night nurse gives that medication and she wouldn't know. She stated, the order does not say not to crush it. 2. Record review revealed Resident #38 was admitted on [DATE] with a diagnosis to include: COPD (Chronic Obstructive Pulmonary Disease), Muscle Weakness, Hip Fracture, Hepatic Failure, Hypoglycemia and Myocardial Infarction. Review of the resident's admission MDS (Minimum Data Set) assessment dated [DATE] documented the BIMS (Brief Interview for Mental Status) score was 15/15, indicating intact cognition. A review of the physician's orders documented the following medications that Resident #38 was ordered and not administered timely: Toprol XL Oral Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for Hypertension. Senokot Oral Tablet 8.6 MG Give 2 tablet by mouth every 12 hours as needed for constipation. Polyethylene Glycol 3350 Powder Give 17 gram by mouth every morning and at bedtime for constipation Mix with 4-8oz of liquid. Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. Fluticasone-Salmeterol 250-50 MCGVACT Aerosol Powder, breath activated Give 1 inhalation by mouth every morning and at bedtime for shortness of breath. Aspirin EC Oral Tablet Delayed Release 81 MG Give 1 tablet by mouth every morning and at bedtime for Anticoagulant V Hematological Agent Use. Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCGVACT 2 puff inhale orally every 6 hours as needed for wheezing V shortness of breath unsupervised self-administration Resident (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may self-administer the medication. Review of the MAR (Medication Administration Record) and the time stamp for each of the medications when scheduled to be given and the actual given times documented the following medications were outside the one hour before and one hour after parameters for giving the medications: a. On 04/10/26, scheduled for 9:00 AM, given at 11:27 AM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. b. On 04/10/26, scheduled for 9:00 AM, given at 11:26 AM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. c. On 04/10/26, scheduled for 9:00 AM, given at 11:26 AM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. d. On 04/11/26, scheduled for 9:00 AM, given at 12:08 PM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. e. On 04/11/26, scheduled for 9:00 AM, given at 12:08 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. f. On 04/11/26, scheduled for 9:00 AM, given at 12:08 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. g. On 04/21/26, scheduled for 9:00 AM, given at 10:59 AM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. h. On 04/22/26, scheduled for 9:00 AM, given at 11:08 AM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. i. On 04/22/26, scheduled for 9:00 AM, given at 11:08 AM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. j. On 04/22/26, scheduled for 9:00 AM, given at 11:07 AM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. k. On 04/22/26, scheduled for 9:00 AM, given at 11:08 AM: Prednisone oral tablet 20 MG. Give 1 tablet by mouth in the morning for wheezing for 5 days. l. On 04/23/26, scheduled for 9:00 AM, given at 12:18 PM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. On 04/23/26, scheduled for 9:00 AM, given at 12:22 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. n. On 04/23/26, scheduled for 9:00 AM, given at 12:20 PM: Prednisone oral tablet 20 MG. Give 1 tablet by mouth in the morning for wheezing for 5 days. o. On 04/23/26, scheduled for 9:00 AM, given at 12:30 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. p. On 04/25/26, scheduled for 9:00 AM, given at 12:00 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. q. On 04/25/26, scheduled for 9:00 AM, given at 12:01 PM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. r. On 04/25/26, scheduled for 9:00 AM, given at 12:00 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. s. On 04/25/26, scheduled for 9:00 AM, given at 12:00 PM: Prednisone oral tablet 20 MG. Give 1 tablet by mouth in the morning for wheezing for 5 days. t. On 04/26/26, scheduled for 9:00 AM, given at 10:43 AM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. u. On 04/26/26, scheduled for 9:00 AM, given at 10:44 AM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. v. On 04/26/26, scheduled for 9:00 AM, given at 10:43 AM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. w. On 04/28/26, scheduled for 9:00 AM, given at 1:15 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. x. On 04/28/26, scheduled for 9:00 AM, given at 1:16 PM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. y. On 04/28/26, scheduled for 9:00 AM, given at 1:15 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. z. On 04/29/26, scheduled for 9:00 AM, given at 1:44 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of breath. aa. On 04/29/26, scheduled for 9:00 AM, given at 1:44 PM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. bb. On 04/29/26, scheduled for 9:00 AM, given at 1:44 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. cc. On 04/30/26, scheduled for 9:00 AM, given at 11:49 AM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. dd. On 04/30/26, scheduled for 9:00 AM, given at 11:49 AM: Toprol XL Oral Tablet Extended Release 24-hour 25 MG 1 tablet by Mouth one time a day for Hypertension. ee. On 04/30/26, scheduled for 9:00 AM, given at 1:49 AM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. ff. On 05/02/26, scheduled for 9:00 AM, given at 12:25 PM: Toprol XL Oral Tablet Extended Release 24 hour 25 MG 1 tablet by Mouth one time a day for Hypertension. gg. On 05/02/26, scheduled for 9:00 AM, given at 4:14 PM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. hh. On 05/02/26, scheduled for 9:00 AM, given at 4:13 PM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. ii. On 05/03/26, scheduled for 9:00 AM, given at 11:01 AM: Toprol XL Oral Tablet Extended Release 24 hour 25 MG 1 tablet by Mouth one time a day for Hypertension. jj. On 05/03/26, scheduled for 9:00 AM, given at 11:05 AM: Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated. Give 1 inhalation by mouth every morning and at bedtime for short of breath. kk. On 05/03/26, scheduled for 9:00 AM, given at 11:04 AM: Aspirin EC Oral tablet Delayed release 81 MG. Give 1 tablet by mouth every morning and at bedtime for anticoagulant/Hematological Agent use. During an interview on 05/06/26 at 7:15 AM with the DON (Director of Nursing), she acknowledged that medications were being administered outside the 2-hour perimeter for medication administration and not given in a timely manner. 3. Record review revealed Resident #81 was admitted on [DATE] with a diagnosis to include: Parkinson's Disease, Cervical Spinal Stenosis, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Weakness, Dysphagia, and Essential Hypertension. A review of her quarterly MDS (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Minimum Data Set) assessment dated [DATE] documented the BIMS score was 13/15, indicating intact cognition. A review of the physicians' orders documented Resident #81 is on the following medications: Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for mild pain. Trileptal Oral Tablet 150 MG Give 2 tablet by mouth three times a day for mood disorder. traZODone HCl Oral Tablet 150 MG Give 1 tablet by mouth at bedtime for Insomnia. MiraLax Oral Packet 17 GM Give 1 packet by mouth one time a day for constipation. Lisinopril Oral Tablet 5 MG Give 1 tablet by mouth one time a day for Hypertension. Lidocaine External Patch 4 % Apply to left sacroiliac joint topically in the morning for left sacroiliac pain and low back pain and remove per schedule. Laxative Rectal Suppository 10 MG Insert 1 suppository rectally every 24 hours as needed for constipation. HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. Duloxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth one time a day for Major Depressive Disorder. Diclofeno External Gel 1.6 % Apply to neck topically every 8 hours as needed for StiffnessVPain. Diclofenac Sodium External Gel 1 % Apply to dorsum of R foot topically four times a day for right foot pain. Clonazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for generalized anxiety disorder. Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's disease. buspirone HCl Oral Tablet 7.5 MG Give 1 tablet by mouth three times a day for general anxiety disorder. Review of Resident #81's MAR and the time stamps of when the medication is scheduled to be given and when the medications were actually administered revealed that the following medications were given outside the two-hour parameter of one hour before scheduled time and 1 hour after the scheduled times: (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Sea Breeze Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3663 15th Ave Vero Beach, FL 32960	
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 04/18/26, scheduled for 9:00 AM, given at 1:34 PM: Venlafaxine HCL ER Oral tablet extended release 24-hour 75 MG Give 3 tablet by mouth one time a day for Major Depressive Disorder. b. On 04/20/26, scheduled for 9:00 AM, given at 1:14 PM: Lisinopril oral tablet 5 MG give 1 tablet by mouth one time a day for hypertension. c. On 04/20/26, scheduled for 9:00 AM, given at 1:20 PM: Venlafaxine HCL ER Oral tablet extended release 24-hour 75 MG Give 3 tablet by mouth one time a day for Major Depressive Disorder. d. On 04/20/26, scheduled for 9:00 AM, given at 3:25 PM: Lidocaine External Patch 4 %. Apply to right shoulder topically in the morning for right shoulder pain and remove per schedule. e. On 04/20/26, scheduled for 9:00 AM, given at 3:16 PM: Diclofenac Sodium External Gel 1% Sodium (Topical) Apply to dorsum of right foot topically four times a day for right foot pain. f. On 04/20/26, scheduled for 1:00 PM, given at 3:17 PM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. g. On 04/20/26, scheduled for 1:00 PM, given at 3:17 PM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. h. On 04/22/26, scheduled for 9:00 AM, given at 11:26 AM: Venlafaxine HCL ER Oral tablet extended release 24-hour 75 MG Give 3 tablet by mouth one time a day for Major Depressive Disorder. i. On 04/22/26, scheduled for 9:00 AM, given at 11:26 AM: Trileptal Oral tablet 150 MG. Give 2 tablets by mouth three times a day for Mood Disorder. j. On 04/22/26, scheduled for 9:00 AM, given at 4:50 PM: Lidocaine External Patch 4 %. Apply to right shoulder topically in the morning for right shoulder pain and remove per schedule. k. On 04/23/26, scheduled for 9:00 AM, given at 12:44 PM: Venlafaxine HCL ER Oral tablet extended release 24 hour 75 MG Give 3 tablet by mouth one time a day for Major Depressive Disorder. l. On 04/23/26, scheduled for 9:00 AM, given at 12:50 PM: Trileptal Oral tablet 150 MG. Give 2 tablets by mouth three times a day for Mood Disorder. m. On 04/23/26, scheduled for 9:00 AM, given at 12:49 PM: Lidocaine External Patch 4 %. Apply to right shoulder topically in the morning for right shoulder pain and remove per schedule. n. On 04/23/26, scheduled for 9:00 AM, given at 12:49 PM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. o. On 04/23/26, scheduled for 9:00 AM, given at 12:49 PM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p. On 04/23/26, scheduled for 9:00 AM, given at 12:49 PM: Clonazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for Generalized Anxiety Disorder. q. On 04/23/26, scheduled for 9:00 AM, given at 12:50 PM: Lisinopril oral tablet 5 MG give 1 tablet by mouth one time a day for hypertension. r. On 04/23/26, scheduled for 5:00 PM, given at 7:13 PM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. s. On 04/23/26, scheduled for 5:00 AM, given at 7:15 PM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. t. On 04/23/26, scheduled for 5:00 AM, given at 7:18 PM: Clonazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for Generalized Anxiety Disorder. u. On 04/28/26, scheduled for 9:00 AM, given at 2:12 PM: Lidocaine External Patch 4 %. Apply to right shoulder topically in the morning for right shoulder pain and remove per schedule. v. On 04/28/26, scheduled for 9:00 AM, given at 2:12 PM: Diclofenac Sodium External Gel 1% Sodium (Topical) Apply to dorsum of right foot topically four times a day for right foot pain. w. On 04/28/26 scheduled for 9:00 AM, given at 2:11 PM Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. x. On 04/29/26 scheduled for 1:00 PM, given at 3:18 PM Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. y. On 04/28/26 scheduled for 1:00 PM, given at 3:21 PM Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. z. On 05/01/26 scheduled for 9:00 AM, given at 10:57 AM Trileptal Oral tablet 150 MG. Give 2 tablets by mouth three times a day for Mood Disorder. aa. On 05/01/26 scheduled for 9:00 AM, given at 10:56 AM: Duloxetine HCL Capsule Delayed Release Particles 30 MG. Give 1 capsule by mouth one time a day for Major Depressive Disorder. bb. On 05/01/26 scheduled for 9:00 AM, given at 10:56 AM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. cc. On 05/01/26 scheduled for 9:00 AM, given at 10:57 AM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. dd. On 05/01/26 scheduled for 9:00 AM, given at 10:58 AM: Lisinopril oral tablet 5 MG give 1 tablet by mouth one time a day for hypertension. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ee. On 05/01/26 scheduled for 9:00 AM, given at 10:57 AM: Clonazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for Generalized Anxiety Disorder. ff. On 05/02/26 scheduled for 1:00 PM, given at 5:12 PM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. gg. On 05/02/26 scheduled for 1:00 PM, given at 5:12 PM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. hh. On 05/03/26 scheduled for 1:00 PM, given at 3:54 PM: Carbidopa-Levodopa-Entacapone Oral Tablet 50-200-200 MG Give 1 tablet by mouth three times a day for Parkinson's Disease. ii. On 05/03/26 scheduled for 1:00 PM, given at 3:54 PM: Buspirone HCL Oral tablet 7.5 MG. Give 1 tablet by mouth three times a day for General Anxiety Disorder. During an interview on 05/06/26 at 7:15 AM with the DON (Director of Nursing), she acknowledged that medications were being administered outside the 2-hour perimeter for medication administration and not given in a timely manner. 4. Record review revealed Resident #39 was admitted to the facility on [DATE] with a diagnosis to include Paraplegia, Colostomy, Hypertension, Major Depressive Disorder, Anxiety Disorder, and Chronic Kidney Disease. Review of the Medicare 5-day MDS assessment dated [DATE] documented the BIMS score as 15/15, indicating intact cognition. A review of the physicians orders documented the resident is currently taking the following medications: Trazadone HCl Oral Tablet Give 150 mg by mouth at bedtime for MDD 3 tabs for 150 mg) Rosuvastatin Calcium Tablet 10 MG Give 1 tablet by mouth at bedtime for lipid control Polyethylene Glycol 3350 Powder Give 17 gram by mouth one time a day for Bowel Management Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth every 8 hours as needed for hypotension Give for SBP <90, hold for SBP greater than 130 Lisinopril Oral Tablet 10 MG Give 1 tablet by mouth one time a day for hypertension hold if SBP is < 110 Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Neuropathy Escitalopram Oxalate Tablet 10 MG Give 1 tablet by mouth one time a day for Depression (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MAR and time stamps of when the medication is scheduled and the actual time it was administered revealed that this resident was not getting his medications within the 2-hour parameters, as follows: a. On 04/28/26, scheduled for 9:00 AM given at 1:26 PM Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Neuropathy. b. On 04/28/26 scheduled for 09:00 AM given at 1:23 PM Escitalopram Oxalate Tablet 10 MG. Give 1 tablet by mouth one time a day for depression. c. On 04/28/26 scheduled for 09:00 AM given at 1:27 PM Lisinopril Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for hypertension. d. On 04/29/26 Scheduled for 9:00 AM given at 2:05 PM Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Neuropathy. e. On 04/29/26 scheduled for 9:00 AM given at 2:07 PM Lisinopril Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for hypertension. f. On 04/29/26 scheduled for 9:00 AM given at 2:05 PM Escitalopram Oxalate Tablet 10 MG. Give 1 tablet by mouth one time a day for depression. g. On 04/29/26 Scheduled for 1:00 AM given at 3:34 PM Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Neuropathy. h. On 05/02/26 scheduled for 9:00 AM given at 12:38 PM Escitalopram Oxalate Tablet 10 MG. Give 1 tablet by mouth one time a day for depression. i. On 05/02/26 scheduled for 9:00 AM given at 12:38 PM Lisinopril Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for hypertension. j. On 05/02/26 Scheduled for 9:00 AM given at 12:38 PM Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Neuropathy. During an interview on 05/06/26 at 7:15 AM with the DON (Director of Nursing), she acknowledged that medications were being administered outside the 2-hour perimeter for medication administration and not given in a timely manner. 5. Record review revealed Resident #57 was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Encounter for Orthopedic Aftercare Following Surgical Amputation, Acquired Absence of Right Leg Above Knee, and Peripheral Vascular Disease. Review of the BIMS assessment for Resident #57 dated 04/02/26 documented a score of 15 indicating the resident was cognitively intact. Review of the physician's orders for Resident #57 revealed an order dated 04/08/26 for: Treatment: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Soak Wound with Dakins 0.25 % Solution for 10 minutes and then rinse with normal saline, wet to dry dressings every day shift. There was no indication where the wound was located on the body. Review of the Treatment Administration Record (TAR) for Resident #57 from 04/09/26 to 05/04/26 documented in part the following: On 04/15/26, 04/28/26 and 05/01/26, there was no documentation of the above treatment having been performed or administered. On 05/04/26, the nurse documented the code 9 indicating, Other/See Nurse Notes. Review of the Nursing Progress Notes for Resident #57 on 05/04/26 revealed no documentation. Review of the Care Plan for Resident #57 with an initiated date of 04/29/26 with a focus on: The resident has infection - Left foot Wound infection. The goals were to Minimize risk for electrolyte imbalance; resident will verbalize an acceptable level of comfort and resident will receive antibiotics per physician orders. The interventions included: Administer antibiotic as per MD orders. Administer treatment per physician orders. Monitor resident vital signs as indicate. On 05/03/26 at 11:10 AM, an observation was made of Resident #57 sitting up in bed with an amputated right leg and an undated bandage on his left foot. During an interview conducted on 05/03/26 at 11:10 AM, Resident #57 was asked about the staff taking care of his wound on his left foot. He said sometimes they take care of it but mostly he has to do it himself. On 05/04/26 at 10:30 AM, an observation was made of Resident #57 lying uncovered on his bed with his left foot with no bandage on it. The great left toe had a jagged edge that was lifting from the skin and had a dark brown area at the end of the nail and partially under the nail. During an interview conducted on 05/04/26 at 3:38 PM, Staff C, Licensed Practical Nurse (LPN), was asked about following the physician's orders. She stated, 'yes, the MAR/TAR are like the Bible, and you follow the orders to the T (meaning exactly)'. When asked if there is any concern about an order or it is unclear what she would do, she stated, call the doctor to clarify the order. When asked about wound care, she said we follow the physician's orders and document the care when it is completed. During an interview conducted on 05/05/26 at 7:56 AM, the Assistant Director of Nursing was asked about wound care orders for Resident #57. She looked up the order in the resident's Electronic Medical Record. She acknowledged it did not say where the location of the wound was, it was an incomplete order, and it should have been clarified. She also acknowledged the wound care documentation was not recorded for several days.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure it followed physicians' catheter care orders or discontinue orders after catheter was removed for 2 of 2 sampled residents reviewed for catheter care, Resident #11 and Resident #95. The findings included: 1. Record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses that included in part the following: Urinary Tract Infection, Obstructive and Reflux Uropathy. Review of the Brief Interview of Mental Status (BIMS) assessment dated [DATE] documented a score of 15 indicating an intact cognitive response. Review of the Physician's Orders for Resident #11 revealed in part the following: An order dated 03/18/26 for an indwelling urinary catheter: Monitor every shift. Notify the physician of changes in urinary appearance (color, consistency, odor, etc.) and/or no urinary output every shift. An order dated 03/18/26 for indwelling urinary catheter care every shift and as needed. Review of the Treatment Administration Record (TAR) from 04/01/26 to 05/04/26 revealed on 04/07/26 on the 11:00 PM to 7:00 AM shift and on 04/10/26 on the 7:00 AM to 3:00 PM shift, there was no documentation of monitoring or providing catheter care. From 05/01/26 to 05/04/26 on all three shifts (7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM), with exception to 05/02/26 on the 3:00 PM to 11:00 PM shift, documented monitoring and providing catheter care despite the catheter having been removed on 04/30/26. On 05/03/26 at 9:40 AM, an observation was made of Resident #11 sitting up in bed. There was no indwelling urinary catheter present. During an interview conducted on 05/03/26 at 9:40 AM, Resident #11 was asked if she had had an indwelling urinary catheter. She responded she did, but they had removed her catheter last week on Thursday. During an interview conducted on 05/04/26 at 3:38 PM, Staff C, Licensed Practical Nurse (LPN), was asked about an indwelling urinary catheter and if they need an order. She said yes and they would follow the orders for catheter care as well. When asked if the catheter was removed, would they need to document the removal. She said yes in a progress note. When asked if a urinary drainage bag needs a privacy cover, she said yes always. When asked about wound care, she said, we follow the physician's orders and document the care when it is completed. During an interview conducted on 05/05/26 at 8:45 AM, the Assistant Director of Nursing (ADON) was asked about the indwelling urinary catheter for Resident #11. She acknowledged the resident did have an active / current order for catheter care and monitoring, and it was not documented as having been done in a couple of days. During a side-by-side observation of Resident #11, she acknowledged the resident did not have an indwelling catheter and Resident #11 informed her that it was taken out last Thursday. 2. Record review revealed Resident #95 was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Acute or Chronic Diastolic (Congestive) Heart Failure, Dysphagia, Disease of the Pericardium, and Venous Insufficiency (Chronic) (Peripheral). Review of the BIMS assessment dated [DATE] documented a score of 15 indicating an intact cognitive response. Review of the Physician's Orders for Resident #95 revealed in part the following: An order dated 03/20/26 for Indwelling Urinary Catheter care every shift and as needed. Review of the Care Plan for Resident #95 dated 03/22/26 with a focus on the resident having a risk for injury / infection r/t [related to] presence of catheter secondary to BPH (benign prostatic hyperplasia) with obstructive uropathy. The goal was for the resident to be free of complications related to catheter use through next review. The interventions included in part the following: Provide catheter care per orders. Review of the Treatment Administration Record from 04/01/26 to 05/04/26 (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documentation of catheter care having been performed on the 7:00 AM to 3:00 PM shift on 04/08/26, 04/14/26, 05/02/26 and 05/03/26 or on the 11:00 PM to 7:00 AM shift on 04/10/26. On 05/03/26 at 10:35 AM, an observation was made of Resident #95 sitting up in bed with an indwelling urinary catheter drainage bag suspended from side of bed facing the open door to the room. The bag was more than half full of yellow liquid with no privacy cover in place. On 05/03/26 at 11:30 AM, a second observation was conducted of Resident #95 sitting up in bed with an indwelling urinary catheter drainage bag suspended from side of bed facing the open door to the room. The bag was more than half full of yellow liquid with no privacy cover in place. During an interview conducted on 05/04/26 at 3:38 PM, Staff C, Licensed Practical Nurse (LPN), was asked about an indwelling urinary catheter drainage bag and if it needed a privacy cover. She stated yes always. During an interview conducted on 05/05/26 7:56 AM, the Assistant Director of Nursing acknowledged there were dates the catheter care was not documented as performed for Resident #95.		

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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 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 physician's orders for tube feeding were follow and updated orders accordingly for 1 of 1 sampled resident reviewed for tube feeding, Resident #95. The findings included:Record review for Resident #95 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Acute On Chronic Diastolic (Congestive) Hear Failure, Dysphagia, Disease of the Pericardium, and Venous Insufficiency (Chronic) (Peripheral). The Brief Interview of Mental Status (BIMS) assessment dated [DATE] documented a score of 15 indicating an intact cognitive response.Review of the Care Plan for Resident #95 dated 03/22/26 with a focus on the resident requires tube feeding related to dysphagia. The goals were for the resident will maintain adequate nutritional and hydration status and the resident will remain free of side effects or complications related to tube feeding through review date. The interventions included in part the following: Follow physician orders regarding nutrition order and flushes. NPO as ordered, with the exception of thin liquid drinks at bedside. Patient may use straw.Review of the physician's orders for Resident #95 revealed in part the following: An order dated 03/26/26 for every shift for Enteral Nutrition (tube feeding) Jevity 1.5 (formulary type) at 65ml/hr [hour], continuously for total volume of 1300mL, 150ml water flush every 4hrs [hours] via pump.Review of the Medication Administration Record (MAR) for Resident #95 from 04/01/26 to 05/03/26 revealed no documentation for tube feeding on the 3:00 PM to 11:00 PM shift on 05/02/26, 05/03/26 and 05/04/26 and the 11:00 PM to 7:00 AM shift on 05/04/26. On 04/28/26 on 7:00 AM to 3:00 PM shift, a code was documented: 12 indicating the medication was on order from the pharmacy and MD [physician] was aware. On 7:00 AM to 3:00 PM shift on 05/02/26 and 05/03/26, it documented a code 5 indicating Hold/See nurse notes. On 11:00 PM to 7:00 AM shift on 05/02/26 and 05/03/26, it documented a code 2 indicating 'drug refused'. Review of the Nursing Progress Notes for Resident #95 from 04/28/26 to 06/03/26 revealed no documentation regarding tube feeding in any manner. During an interview conducted on 05/04/26 at 3:38 PM, Staff C, Licensed Practical Nurse (LPN), was asked about tube feeding orders. She stated we follow the tube feeding orders and if it is not given according to orders then we notify the physician and document this in the nurse progress notes. During an interview conducted on 05/05/26 at 7:56 AM, the Assistant Director of Nursing (ADON) was asked about tube feeding for Resident #95. She stated as far as she was aware he was still on tube feeding and verified this by looking at the resident's electronic medical record. When the ADON did a side-by-side observation with surveyor in the resident's room, she acknowledged there was no tube feeding hung or being administered. The resident said to her he has not had any tube feeding since Friday because he is now eating by mouth.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure they obtained an assessment for bed rails, physician orders, a consent and a care plan for the bed rails was completed for 6 of 6 sampled residents reviewed for bed rails, Residents #3, #39, #49, #81, #95, and #112. The findings included:1. Record review revealed Resident #3 was admitted to the facility on [DATE] with a diagnosis to include: Hemiplegia and Hemiparesis following a Cerebral Infarction, Type II Diabetes Mellitus, Chronic Respiratory Failure, Acquired Absence of Left Leg Above the Knee (AKA), Aphasia, Dysphagia, Bipolar Disorder, and Major Depressive Disorder. A review of the annual MDS (Minimum Data Set) assessment dated [DATE] revealed the BIMS (Brief Interview for Mental Status) was 12 of 15 indicating moderate cognitive impairment. A review of the Resident's care plan documented under resident has a potential for Activities of Daily Living (ADL) selfcare deficit r/t (related to) ADL needs and participation vary, fatigue, chronic medical conditions, AKA RLE (right lower extremity). The interventions included: Side rails as ordered to promote functional bed mobility. Date Initiated: 07/16/2025.Observations made on 05/04/26 at 11:44 AM of Resident #3 bed, showing he has bed rails in the up position on each side of the bed.Review of the reentry Nursing assessment dated [DATE] documents that side rails are not necessary at this time. Resident is dependent for transfers and mobility. further review revealed that questions #3 Would the resident benefit from the use of side rails to promote increased independence for transfers/mobility. Is not answered/ it is left blank; and for #4 the resident/representative understands the risk/benefits of the side rail and consents the use of it, is left blank and not answered. The resident had signed a consent, dated 05/01/26. 2. Record review revealed Resident #39 was admitted on [DATE] with a diagnosis to include Colostomy, Paraplegia, Hypertension, Major Depressive Disorder, Chronic Kidney Disease, Lack of Coordination, Muscle Weakness, Abnormalities of Gait and Mobility, and Anxiety Disorder. Review of the Medicare 5-day MDS dated [DATE] documents the BIMS score is 15 of 15 indicating intact cognition. Review of the ADL Care Plan documented the resident has a potential for ADL selfcare deficit related to inability to complete ADLs without weight-bearing assistance, impaired mobility d/t (due to) paraplegia, pain, depression, wound vac, ADL needs and participation vary, fatigue, and chronic medical conditions. Side rails as ordered to promote functional bed mobility. Observations on 05/04/26 at 12:04 PM of Resident #39's bed revealed that he has bed enablers on each side of his bed.Review of Resident #39 Nursing Admissions Assessment for bed rails dated 03/27/26 documents that resident needs side rails to promote independence. The alternatives tried is bed in the lowest position. His consent was signed the day on 05/03/26 (the surveyors entered the building). there were no physician's orders for the siderails. 3. Record review revealed Resident #81 was admitted on [DATE] with a diagnosis to include Parkinson's Disease, Cervical Spinal Stenosis, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Weakness, Dysphagia, and Essential Hypertension.A review of Resident #81's ADL Care Plan documents for bathing the resident is a limited assist to extensive assist based on fatigue, weightbearing and weakness. A review of her quarterly MDS (Minimum Data Set) dated 03/19/26 documents the BIMS score is 13 of 15, indicating intact cognition. Observations were made on 05/04/2026 at 12:48 PM of the Resident #81 bed having bed enablers on each side of the bed.A review of the Nursing admission assessment dated [DATE] for bed rails documents that resident can have side rails; The alternatives that they tried were bed in lowest position.There wsa no consent or (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders for the bed rails. 4. Record review revealed Resident #112 was admitted on [DATE] with a diagnosis to include Hypothyroidism, Coronary Artery Disease, Essential Hypertension, Pulmonary Embolism, Cachexia, Hemiplegia and Hemiparesis following a Cerebral Infarction, Lack of Coordination, Type II Diabetes, COPD (Chronic Obstructive Pulmonary Disease), Sjogren syndrome, Heart Failure and Vascular Dementia. Review of the MDS documents it had not been completed yet. Observations were made on 05/04/26 at 11:24 AM for Resident #112, who was observed with bed enablers on each side of the bed. Review of the Nursing Admissions assessment dated [DATE] that documents bed rails revealed that questions #3, Would the resident benefit from the use of side rails to promote increased independence for transfers/mobility, is not answered and is left blank; and #4, resident/representative understands the risk/benefits of the side rail and consents the use of it. Is left blank, is not answered; #5, the alternatives trialed prior to implementation of the bed rails, document bed in lowest position and frequent rounding are checked off. The intervention #1 documents that side rails are not necessary at this time. She has a consent that was signed 05/01/26. There were no physician orders for the bed rails. 5. Record review revealed Resident #95 was admitted on [DATE] with a readmission from hospital on [DATE] with diagnoses to include: Paresthesia of Skin, Congestive Heart Failure, Hypertension, Pneumonitis, Dysphagia, Major Depressive Disorder, and Diabetes Type II. Review of the Medicare 5-Day MDS assessment dated [DATE] documents a BIMS score of 15, indicating intact cognition. Under GG, it documents he needs substantial/Maximal Assist with his showers. Review of the care plan for ADL's documents for bathing that the resident needs Limited to Extensive Assist based on fatigue, weightbearing and weakness. Observations on 05/04/2026 at 1:13 PM of Resident #95's bed revealed that he has bed rails on each side of his bed. Review of the initial Nursing assessment dated [DATE] documents under questions #3, Would the resident benefit from the use of side rails to promote increased independence for transfers/mobility, is not answered and is left blank; and #4, the resident/representative understands the risk/benefits of the side rail and consents the use of it, is left blank and is not answered. The alternatives that were tried were bed in lowest position. Under interventions #1 documents side rails are not necessary at this time. 6. Record review revealed Resident #49 was admitted to the facility on [DATE] with a diagnosis to include Hemiplegia, Non-Traumatic Intracranial Hemorrhage, Anxiety Disorder, Pneumonitis Due to Inhalation of Food and Vomit, Dysphagia, Aphasia following Cerebral Infarction, Seizures, Muscle Weakness, Cognitive Communication Deficit. Review of the admission MDS assessment dated [DATE] documents the BIMS score of 13 indicating intact cognition. Observations on 05/04/26 at 12:14 PM of Resident #49's bed revealed that this resident has 2 bed rails on his bed. Review of the Admissions Nursing Assessment for bed rails dated 04/17/26 documents this resident would benefit from enablers. Further review of the assessment revealed that the alternatives that were tried were bed/bolster/wedges though this was the day he came in. The consent was signed and dated 05/01/26. There are no physician orders for the siderails. There were no care plans for the use of the siderails. During an interview on 05/05/26 at 1:10 PM, the Maintenance Director was asked about the bed rails and if they put them on the beds. He stated that we don't put them on unless there is a care plan in place. He was asked if he read each care plan and stated no. The nurse puts a work order in for us to put the siderails on the beds. During an interview on 05/05/26 at 1:15 PM, Staff G, LPN (Licensed Practical Nurse), stated she has worked for the facility as an agency nurse for 3 months. She was asked if she does admission assessments? she stated yes she says we go over the bed rails with the patient and or representative about the pros and cons. We see what the resident can do. If patient requests them we have therapy/Administration do an assessment. We don't have the bed rails (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go up right away. The resident has to be safe, which enabler is right for them to use. During an interview on 05/05/26 at 1:20 AM, the Director of Rehab stated she started working here on Monday. She called her Regional Director of Rehab and stated that they only do a side rail assessment on the residents that they feel will need one. If they need an assessment, then Nursing will send a referral to us. Otherwise, they are done on admission by nursing. During an interview on 05/5/26 at 2:00 PM, the DON (Director of Nursing) was asked about the bed enablers and the policy. She stated if the resident wants them they can have them. She was asked about the residents that were assessed for not having them but have them on their beds. She didn't say anything. She was asked about consents in which she replied I have a whole stack here They were either signed 05/01/26 or 05/03/26 on the day the surveyors entered the building. She was asked if the enablers are off beds when before residents are p[placed in them and she stated yes. The surveyor looked at the beds and saw 6 rooms, Rooms 221-A, 222-B, 226-B, 277-A, 231- and 228-B, with no residents in those beds and they have been discharged . All beds were observed to have enablers on them. During an interview on 05/05/26 at 2:30 PM, Staff F, Assistant Maintenance, was going around taking the bed rail enablers off the beds that had no residents in them. When asked if they take them off every time when someone is discharged , he said only when we get a list which isn't very often.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 2 sampled residents reviewed for controlled substance reconciliation, Resident #87. The findings included: Record review revealed Resident #87 was admitted on [DATE] with diagnoses that included in part the following: Displaced Intertrochanteric Fracture of Right Femur. Review of the physician's orders for Resident #87 revealed an order dated 04/17/26 for Tramadol HCl tablet 50 MG give 1 tablet by mouth every 6 hours as needed for moderate and severe pain. Review of the Medication Monitoring Control Record for Resident #87 for Tramadol documented the medication (med) was signed out on 04/26/26. Review of the Medication Administration Record for Resident #87 revealed no documentation for Tramadol having been administered on 04/26/26. During an interview conducted on 05/06/26 at 5:00 PM, Staff CC, Licensed Practical Nurse, was asked about the controlled medications being documented. She stated when a narcotic is removed from the med cart it is signed out on the Medication Monitoring Control Record, and once it is given, it is signed off on the MAR.		

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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 respond to the pharmacist's recommendations for Lidocaine patch to have a removal time and to specify the site of administration for 1 of 5 sampled residents identified for medication regimen review, Resident #4. The findings included: Review of the facility's policy titled, Medication Regimen Reviews, dated April 2007, included the following: The Consultant Pharmacist Shall review the medication regimen of each resident at least monthly. Policy Interpretation and Implementation: 5. The primary purpose of this review is to help the facility maintain each resident's highest practical level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. Record review revealed Resident #4 was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Chronic Systolic (Congestive) Heart Failure; Type 2 Diabetes Mellitus with Diabetic Neuropathy; and Primary Generalized (Osteo) Arthritis. Record Review of the Medication Regimen Review (MRR) for Resident #4 revealed the following: On 01/15/26, the pharmacist recommended to please clarify the order for Lidocaine patch by adding a specific site to avoid medication error; also recommended clarification of the Lidocaine patch order to be applied once daily for 12 hours then remove for 12 hours to avoid tachyphylaxis (a sudden decrease in response to a drug/medication). On 03/20/26, the pharmacist again asked for the Lidocaine patch order to be clarified for specific site to avoid medication errors; and to apply the Lidocaine patch once daily for 12 hours then remove for 12 hours to avoid tachyphylaxis. On 05/04/26, the physician signed and agreed with the pharmacist's recommendations. Review of the Physician's Orders showed that Resident #4 had an active order dated 01/15/26 for Lidocaine External Patch 4 % to apply to affected area topically one time a day for pain. Review of Resident #4's Medication Administration Record (MAR) for the month of May revealed nurses had signed that the Lidocaine External Patch 4 % was applied to affected area topically one time a day for pain. During an interview conducted on 05/05/26 at 10:18 AM, the Medical Director was asked about pharmacy review/recommendations. He stated he reviews them when they are given to him. When asked how often he comes to the facility, he stated 3 to 4 times a week. When asked about pharmacy review/recommendations from December 2025 not reviewed and signed until May, he stated they (facility) had misplaced a lot of the original recommendations. During an interview conducted on 05/06/26 at 11:30 AM, the Director of Nursing (DON) stated she has worked at the facility for 2 months. She stated she had a difficult time finding the pharmacy's medication regimen reviews, as some of the MRR documents were signed and stored in the binder and some she had to ask the pharmacist to resend. The DON stated she is not sure what happened and acknowledged the discrepancy with the MRR.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to monitor for behaviors and side effects for residents receiving psychotropic medications for 2 of 59 sampled residents receiving psychotropic medications, Residents #12 and #109. The findings included: 1. Record review revealed Resident #109 was admitted to the facility on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Generalized Anxiety Disorder, Major Depressive, and Brief Psychotic Disorder. Review of the Brief Interview of Mental Status (BIMS) assessment dated [DATE] documented a score of 9 indicating moderate cognitive impairment. Review of the physician's orders for Resident #109 revealed in part the following: An order dated 04/30/26 for Lorazepam (a psychotropic medication) tablet 1 MG give 1 mg by mouth every 8 hours as needed with no end date. An order dated 05/01/26 for Lorazepam (a psychotropic medication) tablet 1 MG give 1 tablet by mouth every 6 hours as needed with no end date. An order dated 04/30/26 for Trazodone HCl (a psychotropic medication) tablet 100 MG give 1 tablet by mouth at bedtime An order dated 05/04/26 for Trazodone HCL (a psychotropic medication) tablet 50 MG give 1 tablet by mouth two times a day and was discontinued on 05/04/26. An order dated 05/04/26 for Trazodone HCl (a psychotropic medication) tablet 50 MG give 2 tablet by mouth two times a day. An order dated 05/03/26 for BEHAVIOR: Enter # in Supplementary Documentation: 0 No behaviors; 1 Aggressiveness 2 Wandering; 3 Agitated; 4 Angry Comments; 5 Anxiety; 6 Avoidance/Resisting Care; 7 Compulsive Actions; 8 Crying; 9 Delusion/Paranoia; 10 Depressed/Withdrawn; 11 Fear/Panic; 12 Hallucinations; 13 Insomnia; 14 Jittery/Nervous; 15 Mood Changes; 16 Noisy/Yelling; 17 Pacing; 18 Pulling Tube (NG, Cath, IV); 19 Other enter note every shift for Use of Psychoactive Medication NON-PHARM INTERVE: 0 Not applicable; 1 1:1; 2 Activity; 3 Back-rub/Touch; 4 Change Position; 5 Change Environment 6 Give Fluids; 7 Food; 8 Redirect; 9 Toilet; 10 Other &ndash; enter nurses note. Effectiveness I Improved, NC No Change, W Worse An order dated 05/03/26 for Side Effects of psychotropic Medications - Including: Sedation, Insomnia, increased agitation, dry mouth, increased thirst every shift for Medication Side Effects Observations Select N if monitored and none of observed Select Y if monitored and side effect were observed. Select chart code Medication Side Effects Observation' and document behaviors in progress note. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documentation of behaviors or side effects for psychotropic medications. Review of the Behavior Symptoms Tasks for Resident #109 from 04/30/26 to 05/03/26 documented no behaviors on 05/03/26 on the 7:00 AM to 3:00 PM shift. During an interview conducted on 05/03/26 at 8:45 AM, Resident #109 clutched at the surveyor's arm and said, help me, I want to get out of this chair. During an interview conducted on 05/03/26 at 10:20 AM, Staff A, Licensed Practical Nurse, was asked if Resident #109 has been seen by psychiatry He stated he does not see anything in the chart. On 05/03/26, an observation was made from 8:20 AM to 8:50 AM of Resident #109 in a reclined Geri chair repeatedly calling out help me. During this time, the resident was observed attempting to get out of the chair but was unable to do so. Several staff were observed during this time just walking past the resident without acknowledging her. On 05/03/26 at 12:00 PM, an observation was made of Resident #109 and Staff B, Certified Nursing Assistant (CNA), who was in the room with the resident. Staff B stated she was just watching the resident; she is on 1:1 observation. Resident #109 continued to be in reclined Geri chair. On 05/04/26 at 7:10 AM, an observation was made of Resident #109 reclined in a Geri chair located in the day room next to the B-side nursing station with Staff D, CNA present. The resident was trying to get out of the chair and very restless. The CNA stated she has been with her all night, and she has been on 1:1. She stated the resident has been like this all night and she kept trying to undress herself as well. She said she is so agitated. 2. Record review revealed Resident #12 was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus with Hyperglycemia; Major Depressive Disorder; Dementia; Anxiety Disorder; Suicidal Ideations; and Adult Failure to Thrive. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of Section N of the same MDS revealed Resident #12 was on an antipsychotic, antianxiety, antidepressant, antiplatelet, insulin, and anticonvulsant medications. Review of the Care Plan dated 08/08/25 documented that Resident #12 has a mood problem. Goals were to have improved mood state (happier, calmer appearance, no sign or symptoms of depression, anxiety or sadness) through the review date. Interventions were to monitor/record/report to the physician as needed for acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Review of the physician's orders showed Resident #12 had orders dated 09/08/25 for monitoring side effects of psychotropic medications every shift - Including: Sedation, Insomnia, increased agitation, dry mouth, increased thirst; Select Y if monitored and none of observed, select N if monitored and side effect WERE observed, document behaviors in progress note. Review of the May 2026 Medication (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record (MAR) documented Resident #12 received all her medications without any refusal. Further review revealed from 05/01/26 to 05/05/26, nurses had entered N on the 7-3 Day shift and the 11-7 shift for monitoring of side effects; during the 3-11 PM shift on 05/01/26, 05/04/26, Y was entered, and on 05/02/26, 05/03/26, and 05/05/26, N was entered. Review of nurses' progress notes dated 05/01/26 to 05/05/26 revealed no documentation of Resident #12 having any side effects or that the physician was contacted due to any significant changes. During an interview conducted on 05/06/26 at 2:06 PM, Staff V, Licensed Practical Nurse (LPN), stated she has worked at the facility for 2 weeks. She stated for residents with psychotropic medications, she monitors side effects usually after she administers the medications and checks back in 15-30 minutes to ensure no side effects. She stated there's a physician order for monitoring side effects and the nurses are to answer the question yes or no. Staff V stated she is to document concerns in the progress notes and contact the doctor. On 05/06/26 at 11:30 AM, the Director of Nursing (DON) was made aware of the above concerns.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the medication error rate was not 5% or greater. The medication error rate was 34.48% with 10 medication errors identified while observing a total of 29 opportunities, affecting Residents #95 and #78. The findings included: 1. Record review revealed Resident #95 was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Acute On Chronic Diastolic (Congestive) Heart Failure, Dysphagia, Disease of the Pericardium, and Venous Insufficiency (Chronic) (Peripheral). Review of the Brief Interview of Mental Status (BIMS) assessment dated [DATE] documented a score of 15 indicating an intact cognitive response. Review of the physician's orders for Resident #95 revealed in part the following: An order dated 03/31/26 for Effer K (Klor-Con) EF25 meq [milliequivalent] give via G-tube every morning and at bedtime. An order dated 03/21/26 for multivitamin with minerals give 1 tablet via Peg tube three times a day. An order dated 04/28/26 for midodrine hydrochloride 2.5 MG give 3 tablets enterally (via feeding tube e.g. G-tube or Peg tube) three times a day. An order dated 04/28/26 for thiamine 100 MG give 1 tablet enterally(via feeding tube e.g. G-tube or Peg tube) one time a day. An order dated 05/04/26 for apixaban 2.5 MG give 1 tablet by mouth two times a day. An order dated 03/21/26 for aspirin 81 MG chewable give 1 tablet give 1 tablet via PEG tube in the morning An order dated 03/21/26 for cholecalciferol 5,000 unit capsule give 1 cap via PEG tube one time a day. An order dated 04/29/26 for Saccharomyces boulardii Capsule 250 MG give 1 capsule via Peg tube two times a day. During a medication (med) pass observation conducted for Resident #95 on 05/04/26 at 8:23 AM, performed by Staff C, Licensed Practical Nurse, included in part the following observations: Effer K tab 25meq EF was administered via the wrong route (given orally). Multivitamin with minerals was administered via the wrong route (given orally). Midodrine hydrochloride 2.5 MG was administered via the wrong route (given orally). (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Thiamine 100 MG was administered via the wrong route (given orally). During a med pass observation conducted for Resident #95 on 05/04/26 at 12:20 PM performed by Staff C, Licensed Practical Nurse, included in part the following observations: Apixaban 2.5 MG was administered via the wrong route (given orally). Aspirin 81 MG Oral Tablet chewable was omitted (not administered). Cholecalciferol 5,000 unit capsule was omitted (not administered). Saccharomyces boulardii Capsule 250 MG was omitted (not administered). During an interview conducted on 05/04/26 at 3:38 PM, Staff C was asked about when a medication was considered given too early or too late. She stated you have one hour before and one hour after the scheduled time or it would be considered given too early or too late. When asked when do you document the medication administered, she said right after you administer the medication. When asked if a medication is not given, do they document that it was not given, she stated, 'yes, you document on the MAR no and put in a progress note for the reason why it was not given and notify the physician or nurse practitioner'. When asked about following the physician's orders, she stated, 'yes, the MAR/TAR are like the Bible, and you follow the orders to the T (meaning exactly)'. When asked if there is any concern about an order or if it is unclear what she would do, she stated, 'call the doctor to clarify the order'. When asked if this includes the correct route, she stated, 'of course'. When asked if a medication is ordered to be given enterally or via G-tube or Peg-tube, could be given orally, she stated, 'no, not without the order being changed.' 2. Record review revealed Resident #78 was admitted to the facility on [DATE] and a readmission on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus (DM2) without Complications; Muscle Weakness (Generalized); Depression; Hypertension; Muscle Wasting and Atrophy. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #78 had a BIMS score of 14 indicating intact cognition. Review of the Physician's Orders showed that Resident #78 had an order dated 08/16/25 for Metformin HCl 500 milligram (mg) tablet to give 1 tablet by mouth one time a day for DM2 with breakfast. Review of Resident #78's May 2026 Medication Administration Record (MAR) revealed medication was to be given at 7:30 AM. Review of the Physician's Orders showed that Resident #78 had an order dated 11/22/25 for Cyanocobalamin (Vitamin B-12) 250 microgram (mcg) tablet to give by mouth one time a day for supplement. On 05/04/26 at 9:28 AM, a medication (med) administration observation was conducted for Resident #78 with Staff V, Licensed Practical Nurse (LPN). Staff V stated she has worked at the facility for 2 weeks. Resident #78 was observed in his room and had finished his breakfast. Staff V prepared 11 medications for Resident #78 which did not include Metformin 500 mg that was not in the medication cart. She then stated that someone had ordered the medication on 04/29/26 and she was surprised the medication was not in the cart. Further review of the resident's electronic chart revealed Metformin 500 mg was showing in red and overdue (7:30 AM). She then placed Cyanocobalamin (Vitamin B-12) 100 mcg and the rest of the medications in a small cup and stated she would contact (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sea Breeze Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3663 15th Ave Vero Beach, FL 32960	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the pharmacy after she was done with the medication pass. On 05/04/26 at 10:05 AM, an interview was conducted with Staff V. She reassured the surveyor that she would contact the pharmacy soon. She was asked if she should contact anyone else since the medication is past due and not available. She stated yes, the doctor. On 05/04/26, a reconciliation of the medications was conducted of the administered medications and the physician's orders that revealed that the Metformin 500 mg tablet was not administered on 05/02/26 and 05/04/26, but the documentation showed he had received the medication on 05/03/26. There was no documentation that the pharmacy or the provider were contacted about Metformin 500 mg not being available for Resident #78 on those days. Further review revealed Resident #78 received the wrong dose for Cyanocobalamin (Vitamin B-12), which should have been 250 mcg, not the 100 mcg the resident received. During an interview conducted on 05/05/26 at 10:18 AM, the Medical Director was asked if a resident did not receive medication for any reason, would he expect to be notified. He stated yes. When asked about the Metformin for Resident #78, he stated he would check his text messages to see if he was notified, he was not sure and couldn't explain why he would be notified one day and not the next.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure medications were secure at all times for 4 of 6 medication (med) carts, and 3 of 5 medication pass observations, Residents #95 and #29, and for 1 of 98 sampled residents, Resident #38. The findings included: 1. On 05/03/26 at 8:36 AM, an observation was made of the medication (med) cart (B1) next to B-side nursing station. The med cart was left unlocked and unattended with 2 residents and 1 visitor in the hallway. During an interview conducted on 05/03/26 at 8:43 AM, Staff A, Licensed Practical Nurse (LPN), was asked about the unlocked and unattended med carts. He stated they should be locked at all times. 2. On 05/04/26 at 6:55 AM, an observation was made of the med cart (B1) next to B-side nursing station. The med cart was left unlocked and unattended with a set of keys on top of the med cart. During an interview conducted on 05/04/26 at 7:05 AM with Staff R, Registered Nurse (RN), was asked about the unlocked and unattended with a set of keys on top of the med cart. She stated the doctor called her and she just walked away for a moment. 3. On 05/04/26 at 8:06 AM, an observation was made of med cart (B3) next to B-side nursing station. The med cart was left unlocked and unattended. During an interview conducted on 05/04/26 at 8:16 AM, Staff C, LPN, was asked about the unlocked and unattended med cart. She stated she must have forgotten to lock it. 4. During an observation of med pass for Resident #95 conducted on 05/04/26 at 8:16 AM, Staff C left the med cart unlocked and unattended. The med cart was not within sight of the LPN while she administered medications to the resident in the resident's room. 5. During an observation of med pass for Resident #95 conducted on 05/04/26 at 12:20 PM, Staff C Licensed Practical Nurse left a bottle of Senna (medication) on the counter next to the sink in the resident's room while she stepped out of the room to get gloves. During an interview conducted on 05/04/26 at 3:38 PM, Staff C was asked when the med carts need to be locked. She stated, 'all of the time unless the nurse is working on the cart'. When asked about leaving meds unattended in a resident's room, she said you should never leave the meds unattended. 6. Record review revealed Resident #29 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses that included: Type 1 Diabetes Mellitus with Ketoacidosis without Coma. Resident #29 had a physician's order dated 12/09/25 for Insulin Glargine Solution 100 Unit/ml inject (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11 units subcutaneously two times a day for Diabetes, scheduled for 9:00 AM and 1700 (5:00 PM). During a medication administration observation conducted on 05/04/26 at 9:46 AM, Staff V, LPN, stated Resident #29 was due for an Accu-Chek (Blood Glucose test). She removed the following supplies from the medication cart: Glucometer, reading strip, a lancet and gloves. Staff V then locked the medication cart and was about to enter Resident 29's room when she noticed one of the residents coming out of the bathroom with his briefs by his ankle from his bathroom. She placed the glucometer and the other supplies on top of the medication cart and went into the room to assist the resident back to the bathroom. In the meantime, the glucometer and lancet were exposed on top of med cart out of her line of vision. Staff V returned to the medication cart, used hand sanitizer and opened the cart to retrieve alcohol wipes and more gloves. Then she entered Resident #29, but she did not lock the medication cart. She performed the Accu-Chek and when she returned to the medication cart, she realized she had left the cart unlocked. 7. Record review of Resident #38 revealed he was admitted on [DATE] with a diagnosis to include COPD (Chronic Obstructive Pulmonary Disease), Muscle Weakness, Hip Fracture, Hepatic Failure, Hypoglycemia and Myocardial Infarction. Review of the admission MDS (Minimum Data Set) assessment dated [DATE] documented the BIMS (Brief Interview for Mental Status) was 15 indicating intact cognition. On 05/03/26 the resident had a roommate but he was later discharged . Observations were made on 05/03/26 at 10:50 AM in Resident #38 room. It was observed on the over-bed table, the resident's Albuterol inhaler. The medication was not locked or attended by nursing staff. The resident stated he always needs it next to him. Observations were made on 05/05/26 at 3:45 PM in Resident #38 room. The resident's Albuterol inhaler was still observed on the over-bed table. Observations were made on 05/06/26 at 2:56 PM in Resident's #38 room on his side table. The medication, Fluticasone Propionate/Salmeterol Diskus Inhalation Powder 250 mcg/50mcg, was observed in a box at his bedside table. A locked box was observed on the over-bed table. During an interview on 05/06/26 at 3:00 PM, Resident #38 stated he just got back from a doctor's visit. He revealed his Albuterol was in his pocket but he knows it has to be locked up as well as the other medication.		

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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 reviews, the facility failed to follow their policy for cleaning and disinfecting resident-care equipment after obtaining blood pressure (BP) readings, affecting Resident #78; and after use of a Glucometer to test blood sugar levels, affecting Resident #29, during 2 of 5 medication administration observations; and failed to ensure hand hygiene was performed during medication administration for 2 of 5 medication administration observations, affecting Residents #31 and #78. The findings included: Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 12/28/25, included the following: Resident care equipment can be a source of indirect transmission of pathogens. Reusable resident care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Definitions: Cleaning is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection refers to thermal or chemical destruction of pathogenic and other types of microorganisms. Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators. Policy Explanation and Compliance Guidelines: 1. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include: b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. d. Multiple-resident use equipment shall be cleaned and disinfected after each use. h. Use only EPA-registered disinfectants with kill claims for the common organisms found in the facility. If the equipment is exposed to residents on transmission-based precautions, verify that disinfectants are registered for use with the relevant Organism. j. Follow manufacturer recommendations for cleaning equipment. Review of the EVENCARE ProView Meter manufacturer's recommendations: Cleaning and Disinfecting Procedures for the Meter: The EVENCARE ProView Meter should be cleaned and disinfected between each patient. Disinfection instruction: Step 1. Before disinfecting, clean the meter as described. Step 2. Wash hands with soap and water, put on single-use medical protective gloves. Step 3. Prepare the CaviWipes towelette or other EPA-registered disinfecting wipe. Take out a wipe from the container and follow the instructions on the package. Step 4. Wipe the glucose meter thoroughly including the front, back and size, and take care not to get any liquid in the test strip port and serial port. Do not wrap the meter in the wipe. Step 5. If using the CaviWipes towelette, allow to remain wet for two minutes. Dispose of wipe when finished. Step 6. After disinfection, user should take off gloves and wash hands thoroughly with soap and water before proceeding to the next patient. 1. Record review for Resident #78 revealed an initial admission dated 12/30/23 with a re-admission dated 08/15/25 with diagnoses that included: Essential (Primary) Hypertension (HTN); Hyperlipidemia; Type 2 Diabetes Mellitus. Physician's Orders showed that Resident #78 had an order for Amlodipine Besylate 10 milligram (mg) tablet to give by mouth one time a day for HTN, start date 08/16/25; and Metoprolol Succinate Extended Release (ER) 24 Hour 25 mg tablet to give 1 by mouth one time a day for HTN, Hold for Heart Rate (HR) less than 60, start date 08/20/25. During a medication administration observation conducted on 05/04/26 at 9:28 AM, Staff V, Licensed Practical Nurse (LPN) stated she needs to get Resident #78's blood pressure (BP) and heart rate HR prior to administering the medications. She gathered the BP wrist cuff, entered Resident #78's room and obtained the BP and HR. Staff V then returned to the medication cart with the BP cuff and placed it on top of the cart without properly (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning it. She then dispensed Resident 78's medications. She did not clean the equipment after returning to the med cart. 2. Record review revealed Resident #29 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses that included: Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris; Type 1 Diabetes Mellitus with Ketoacidosis without Coma; Atrial Fibrillation. Physician's Orders showed that Resident #29 had an order dated 12/09/25 for Insulin Glargine Solution 100 Unit/milliliters (ml) to inject 11 Units subcutaneously two times daily for Diabetes. During an Accu-Chek (blood sugar level testing) observation for Resident #29 conducted on 05/04/26 at 9:46 AM, Staff V, LPN, stated she has been working at the facility for 2 weeks. She gathered the supplies including the multi-resident use Glucometer, alcohol wipes and entered Resident #29's room. Staff V performed hand hygiene, donned on clean gloves and performed the Accu-Chek. She then discarded the sharps in the proper container and washed her hands. Staff V grabbed an alcohol wipe and used it to clean the Glucometer, then returned and stored it in the medication cart. She was then asked what the facility's protocol was for cleaning the Glucometer. Staff V stated that she cleaned the glucometer prior to storing it and should clean it after each use. Staff V did not follow the correct method to clean and disinfect the blood sugar testing unit. 3. Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side; Cerebral Infarction due to Unspecified Occlusion or Stenosis of Left Middle Cerebral Artery; Persistent Mood Disorders and Metabolic Encephalopathy. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. On 05/04/26 at 9:04 AM, a medication administration observation was conducted with Staff V, LPN, for Resident #31. She was observed preparing the following medications for the resident without performing hand hygiene: 1. Aspirin 81mg Chewable tablet to give 1 tablet by mouth one time a day for Deep Venous Thrombosis (DVT) prophylaxis. 2. Clopidogrel Bisulfate 75 mg tablet to give 1 tablet by mouth one time a day for blood clot prevention. 3. Multivitamin-Minerals tablet, give 1 tablet by mouth one time a day for supplementation. 4. Probiotic (Saccharomyces boulardii) capsule to give 1 capsule by mouth one time a day. 5. Trileptal Oral Suspension (Oxcarbazepine) 300 mg/5ml to give 2.5 ml by mouth two times a day for Mood Disorder. Staff V stated Resident #31 gets her medications crushed. She crushed the medications individually except for the Probiotic capsule, which she stated she cannot crush and would open the capsule. Then, without washing her hands or using the hand sanitizer, Staff V opened the Probiotic capsule and emptied the contents into a medication cup. She then locked the medication cart and again without washing her hands entered Resident #31's room and administered the crushed medications mixed with apple sauce to the resident. 4. Record review for Resident #78 revealed an initial admission date 12/30/23 with a re-admission dated 08/15/25 with diagnoses that included: Essential (Primary) Hypertension (HTN); Hyperlipidemia; and Type 2 Diabetes Mellitus. Review of the Quarterly MDS dated [DATE] revealed Resident #78 had a BIMS of 14 indicating intact cognition. On 05/04/26 at 9:28 AM, a medication administration observation was conducted with Staff V, LPN. She was observed preparing 11 medications for Resident #78 without performing hand hygiene. She then locked the medication cart and entered the resident's room. She was then observed closing the door and pulling the curtains for privacy. Staff V then noticed Resident #78's roommate wanted to get out of bed, she donned on gloves and assisted the roommate to the bathroom. She then removed her gloves and without washing her hands grabbed and discarded the empty medication cup from Resident #78. Staff V exited the room, returned to the medication cart to document in the computer. Staff V was asked about performing hand hygiene and acknowledged not washing her hands during the medication administration observation.		