STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105441	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health & Rehabilitation Center	4800 N Nob Hill Rd Sunrise, FL 33351

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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** 41837 Based on observations, interviews and record review the facility failed to treat residents in a dignified manner during dining observations for 5 out of 44 sampled residents (Residents #176, #101, #412, #162 and #135). The findings included: Review of the facility's policy titled, Promoting/Maintaining Resident Dignity During Mealtimes with a revised date of 03/2023 included in part the following: 5. All staff will be seated, if possible, while feeding a resident. 8. Ensure the resident receives the proper tray. Review of the facility's policy titled, Promoting/Maintaining Resident Dignity with a revised date of 05/2023 included in part the following: 10. Speak respectfully to residents; avoid discussions about residents that may be overheard. 1. Record review for Resident #101 revealed the resident was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia. Review of the Minimum Data Set (MDS) for Resident #101 dated 05/24/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #101 revealed the resident was not currently on isolation. On 08/06/24 at 8:45 AM an observation was made of Resident #101 sitting in wheelchair and on the overbed table in her room was partially eaten breakfast that was served in a divided Styrofoam cover dish, with Styrofoam cups, and plastic utensils on a Styrofoam tray. On 08/06/24 at 12:33 PM an observation was made of Resident #101 in the Atrium dining room on G unit, the resident was served lunch in a Styrofoam container, with Styrofoam cup, plastic utensils on a Styrofoam tray. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #176 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Protein-Calorie Malnutrition and Dementia. Review of the Minimum Data Set (MDS) dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #176 revealed an order dated 04/30/24 for Regular diet Regular texture, Regular/Thin consistency, PAPER PLATES. Review of the Physician's Orders for Resident #176 revealed the resident was not currently on isolation. On 08/06/24 at 8:35 AM an observation was made of Resident # 176 sitting up in bed eating breakfast that was served in a divided Styrofoam cover dish, with Styrofoam cups and plastic utensils on a Styrofoam tray. On 08/06/24 at 12:30 PM an observation was made of Resident # 176 in the Atrium dining room on G unit, the resident was served lunch in a Styrofoam container, with Styrofoam cup and plastic utensils on a Styrofoam tray. 3. Record review for Resident #412 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Covid-19 and Dementia. Review of the Minimum Data Set (MDS) for Resident #412 dated 07/24/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #412 revealed the resident was not currently on isolation. On 08/06/24 at 8:40 AM an observation was made of Resident #412 sitting on edge of bed eating breakfast that was served in a divided Styrofoam cover dish, with Styrofoam cups and plastic utensils on a Styrofoam tray. On 08/06/24 12:35 PM an observation was made of Resident # 412 in the Atrium dining room on G unit, the resident was served lunch in a Styrofoam container, with Styrofoam cup and plastic utensils on a Styrofoam tray. During an interview conducted on 08/06/24 at 9:50 AM with Staff M Certified Nursing Assistant (CNA) who stated she has worked at the facility for about 3 months. When asked why Residents #412, #101, and #176, were served breakfast on Styrofoam, she said they were on isolation, and I think the kitchen forgot to stop using the Styrofoam when they came off of isolation. When asked when the residents came off of isolation, she said she did not remember. During an interview conducted on 08/06/24 at 12:30 PM with Staff N, Certified Nursing Assistant (CNA), who stated she has worked at the facility for [AGE] years. When asked why some of the residents are served lunch with disposable items like Styrofoam container and cups and plastic utensils, she said the residents used to have Covid and probably the kitchen forgot to take them off. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 08/06/24 at 12:43 PM with Staff O, Registered Nurse/Unit Manager (RN/UM), who stated she has worked at the facility for 8 years. When asked why some residents are served lunch in the dining room with disposable items like Styrofoam container and cups and plastic utensils, she said they were on Covid, and the kitchen forgot to take them off. When asked how long the residents in the dining room had been off of isolation for Covid, she said about a week. She said she will call the kitchen. 40153 4. Resident #162 was admitted on [DATE] with diagnoses of protein-calorie malnutrition, Type 2 diabetes, and muscle weakness. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 02, which indicated severe cognitive impairment. In an observation conducted on 08/05/24 at 6:25 PM, Resident #162 received her dinner tray, which was placed at the side table. At 6:55 PM (30 minutes later), Staff C, Certified Nursing Assistant, was noted standing over the Resident feeding her the dinner soup. A chair was noted near Staff C, which had enough space to pull the chair near Resident #162's bed. Staff C stopped when this Surveyor walked into the room and said, She is a feeder, in front of Resident #162. In an interview conducted on 08/07/24 at 3:40 PM, Staff H, a Certified Nursing Assistant, stated that she was educated on treating the residents with dignity while assisting with dining. She needs to make sure that she sits near the residents at eye level while feeding them. Staff H further reported putting less food in the residents' mouths at one time and assisting the residents in eating their meals. 50370 5. Resident #135 was admitted to the facility on [DATE] with diagnoses of bilateral primary osteoarthritis of knees, acute kidney failure, hypertension, dysphagia, peripheral vascular disease, atrial fibrillation, asthma, respiratory disorders unspecified protein-calorie malnutrition, pleural effusion, and elevated white blood cell count. She was readmitted as hospice care on 06/14/2024. Review of MDS (Minimum Data Set) section C on 06/21/2024 showed an updated BIMS (Brief Interview for Mental Status) score of 11 indicating good cognitive function. Previous BIMS score of 9 was obtained on 06/08/2024 indicating less cognitive function. Section GG of MDS revealed the following: 1. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear- required substantial maximal assistance; 2. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower showed -partial moderate assistance; 3. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement showed - partial moderate assistance. Record review of care plan's goals and interventions dated 06/13/2024 showed to maintain resident's dignity and comfort at the highest level; keep the environment quiet and calm, lighting low, and familiar objects near. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of care plan and interventions revealed to monitor resident for signs and symptoms of respiratory distress and report to MD(Medical Doctor) prn (as needed). In an interview with Resident # 135 on 08/05/2024 at 2:00 PM, she stated there were less Staff at night. She added only one nurse was available to take vitals signs. Resident #135 stressed that she sat on her feces and urine for eight hours, and they occured more than several times. When she pressed her call lights multiple times at night, a Staff wanted to get the call light away from her. She did not remember the name of the Staff, since Staff was a floater. Resident # 135 added that Staff are not respectful. She rememebered an incident when she pressed the call light because she was experiencing difficulty of breathing, when a floater Staff came and asked her What do you want?. This incident shocked her because of the disrespect from Staff's tone and attitude. In another interview with Resident # 135 on 08/05/0224 at 6:37 PM, she stated there was no Staff available to help her get to her wheelchair. She added Staff don't come back when I pressed the call light, and when I needed help to use my wheelchair, she was talking while pointing her finger to a Staff who came in to answer her call light. Staff T, a CNA (Certified Nursing Assistant) reminded Resident #135 that she helped her move from bed to wheelchair whenever the resident asked. Resident # 135 showed a frown on her face, mouth turned downwards and moved head side to side indicating disagreement from what she heard. Resident # 135 added that Facility Staff do not listen to her whenever she requests a different type of meal. She does not like to eat eggs morning, noon, and night, and no Staff told her or informed her why she cannot have another type of meal. She asked this surveyor, how is she able to eat a cucumber salad? In another interview with Resident # 135 on 08/08/2024 at 08:18 AM , she stated that she does not like that any Facility Staff enters her room and moves her stuff without asking her permission first. She added that she is losing her dignity and respect because Staff does not communicate with her. One Staff enters her room, gets objects like her expensive Pepto Bismol without asking permission from her first. She said that a Staff uses a rough paper to wipe her body and when she asked for a linen face cloth at night, Staff tells her residents are allowed one face cloth, one bath towel and one bed blanket. Resident #135 showed and let this surveyor feel a folded brownish paper (similar to a rough kitchen paper towel) which she said Staff uses to wipe her back, chest, and bottom. During an interview with Staff E, a Registered Dietician on 08/06/2024 at 10 :00 AM, he stated that he listened to the dietary requests of Resident #135, and tried to accommodate her preferences and likes. In an interview with the Unit Manager of E Wing on 08/08/2024 at 11:00 AM, when asked his ways of showing respect and dignity to residents, he stated that he knocks on the door, and asks permission before going inside resident's room. He added that he did not remember taking any medication out of Resident #135's room.

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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** 40153 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain good nutrition (assist with feeding) for a resident who is unable to carry out activities of daily living for 1 of 8 sampled residents reviewed for nutrition (Resident #121). The findings included: Resident #121 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes, Heart Failure, and Muscle Wasting. The Significant Change Minimum Data Set (MDS) dated [DATE] revealed that Resident #121 has a Brief Interview of Mental Status (BIMS) score of 04, which is severe cognitive impairment. Section GG (eating) on the above MDS showed that Resident #121 needs set-up and clean-up assistance with her eating. The Care plan dated 07/19/24 showed Resident #121 has a self-care performance deficit related to impaired cognition. Resident #121 has impaired visual function related to blurred vision. In an observation conducted on 08/05/24 at 5:40 PM, Resident #121 was noted in her room with the dinner tray. The dinner tray was observed with two scoops of egg salad, 2 ounces of pureed bread, vegetable salad, and 4 ounces of juice. No staff was noted in the room at the time of this observation. The continued observation on 08/05/24 at 6:05 PM (25 minutes later) showed that Resident #121 did not eat anything on her tray and was noted as 100% untouched. At 6:10 PM, the tray was still untouched, which was 30 minutes later after the first observation. At 6:30 PM, the tray remained untouched, and no staff member came into the room from 5:40 PM to 6:30 PM. Staff K, a Certified Nursing Assistant, entered the room at 6:32 PM and sat near the Resident to feed her dinner. She left the room [ROOM NUMBER] minutes later with the tray. In an observation conducted on 08/06/24 at 11:50 AM, the lunch tray came into Resident #121 ' s room and was set up for the Resident. At 12:10 PM, no staff was noted in the room, and the lunch tray was 100% untouched. The observation continued at 12:15 PM, and the tray was still 100% untouched, with no staff in the room. Staff J, a Certified Nursing Assistant, came into the room at 12:17 PM and left the room with Resident #121 ' s lunch tray in her hands. A review of the Activities of Daily Living (ADL) task for eating (documented by the Certified Nursing Assistants) showed that from 07/08/24 to 08/06/24, Resident #121 needed the following assistance: 107 meals with total dependence and full staff performance, six meals with extensive assistance with staff providing weight-bearing support, four meals with limited assistance and staff providing non-weight bearing assistance, 16 meals with supervision and staff encouraging and cuing and 15 meals independently with no help from staff or oversight at any time. In an interview conducted on 08/06/24 at 3:10 PM with Staff B, Certified Nursing Assistants (CNA), who stated that Resident #121 needs assistance with all her meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 08/06/24 at 3:20 PM with Staff A, the MDS Coordinator stated the following: for section GG, eatingm, a resident is coded by reviewing therapy evaluations, interviewing staff, and looking at the CNAs documentation under tasks for eating to see what type of assistance is needed for each meal. This is done by looking at the 7-day look-back period. Staff A said that she would also observe residents during dining times. Section GG for eating is coded depending on how often the same assistance is needed for each meal. When asked about Resident #121 ' s eating task, Staff A confirmed that she requires total assistance with most meals.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, interview and record review, the facility failed to assess skin in a timely manner, to identify a pressure ulcer for 1 of 7 sampled residents reviewed for facility acquired pressure ulcers, Resident #408. The findings included: Review of the facility policy and procedure on 08/08/24 at 3:10 PM titled Pressure Injury Prevention and Management provided by the Director of Nursing (DON) revised 10/2022 documented in the Policy Statement: This facility is committed to the prevention of avoidable pressure injuries .and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries Policy Explanation and Compliance Guidelines: .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury assessment, using the Braden Scale, on all residents upon admission/re-admission, weekly x four (4) weeks, then quarterly or whenever the resident's condition changes significantly .c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Finding will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse, and documented in Point Click Care. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task .Monitoring a. The Unit Manager or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, or any pressure injuries weekly .6. Modifications of Interventions a. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: .ii New onset or recurrent pressure injury development . Review of the facility policy and procedure on 08/08/24 at 3:15 PM titled Notification of Changes provided by the DON revised 11/29/22 documented in the Policy Statement: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Compliance Guidelines: . Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status iii. Exacerbation of a chronic condition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #408 was admitted to the facility on [DATE] with diagnoses which included Unspecified Displaced Fracture of Seventh Cervical Vertebra, Paraplegia Incomplete, Spondylopathy, Muscle Wasting, Dysphagia, Neuromuscular Dysfunction of Bladder, Anemia, Depression, Adjustment Disorder, Quadriplegia Hypertension, Atherosclerotic Heart Disease, Gastroesophageal Reflux Disease, Ileus, Fusion of Spine and Edema. He had a Brief Interview Mental Status (BIM) score of 13 (cognitively intact). A telephone interview was conducted on 08/07/24 at 2:04 PM with Resident #408's family member, who is the Power of Attorney (POA). Resident #408's Niece stated that she was on her way, at the time, to visit her Uncle, who was currently in the Hospital again for the same wounds which are infected, in addition to being diagnosed with Pneumonia. Resident #408's Niece went on to say that the resident had to have another debridement for his level four (4) sacral wound; which she said that she had subsequently learned had actually been worse, than she was originally told to her by facility nursing staff members. She ended by saying that the resident has no history of any sacral wounds. On 05/30/24 the 3008 Agency for Healthcare Administration (AHCA) Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form did not document any pressure ulcers, lesions or wounds, at the time, for this resident. Record review revealed that on 05/30/24, Staff U, a Licensed Practical Nurse (LPN), documented in the following admission nursing progress note, Patient arrived at the facility on stretcher accompanied by two (2) attendants and family member. admitted to room B-26-B, alert and oriented able to make needs known to staff. Skin warm to touch, scar to the neck, open area to right shin, dried blister to left heel, swelling to bilateral feet. Patient has neck brace. Patient not able to move arms and legs, very immobile, fingers are stiff. Denies any pain. No acute distress noted. Vital signs 134/60, O2 sat 100%, T97.7 P74. Will continue to monitor; with no mention of the status of Resident #408's sacral skin region. Record review of Resident #408's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 05/30/24 indicated that the resident had a score of 13 which indicated that he was at Moderate risk. An interview was conducted on 08/08/24 at 9:47 AM with Staff X, a Certified Nursing Assistant, (CNA), in which she stated that Resident #408 was totally dependent for care. She said that she fed him, washed and cleaned his entire body and dressed him, with staff member assistance. She stated that she worked with this resident on day shift for five (5) days from Tuesday 06/04/24 until Saturday 06/08/24. Staff X said that Resident #408 did not come into the facility with any open areas on his sacral/bottom area during this time, and she added that if she had seen any redness, open areas, abrasions, rash or anything of this kind, she would have reported it to the nurse. Staff X went on to say that she repositioned this resident every 2 hours on her shift, she said that she cleaned and checked the resident's sacral area on a daily basis and entered the information in the mounted computerized CNA tablet, located in the hallway of the B-wing, which documented how the resident ate, if he was continent or incontinent, if he had a bowel movement or not, the presence of a Foley catheter and the skin condition. Staff X stated and documented, that on Tuesday June 4th at 1:16 PM, she showered, Resident #408, while still in bed and on Thursday June 6th at 1:28 PM, Resident #408 had a small bowel movement, and she cleaned and changed him. Finally, Staff X stated that from Wednesday 06/05/24 until Tuesday 06/11/24 for two (2) hours daily, that both she and Staff Y, the facility Physical Therapist, who also corroborated this to the Surveyor on 08/08/24 at 11:25 AM, would get Resident #408 out of bed utilizing the Hoyer lift into a recliner wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to record review of the CNA Task list form, Staff Z, documented, that she showered, Resident #408, while still in bed and on Friday June 7th at 10 PM it was also documented that the resident had a medium bowel movement, and she cleaned and changed him on that day. Staff W, a Licensed Practical Nurse (LPN) Wound Care Nurse, who recorded the Tuesday 06/11/24 Sacral Wound Physician treatment order, and who was primarily responsible for Resident #408's sacral wound care during his short, facility stay, was out of the facility and unavailable for telephone interview, during the survey. A subsequent side-by-side record review was conducted of the Wound Care Doctor's progress notes, completed by the Advanced Registered Nurse Practitioner (A.R.N.P.) along with the facility's current Wound Care Director on 08/08/24 at 11:24 AM in which it was noted that, The initial sacral Stage III wound measurements were: 10.0 x 10.0 x 0.1 cm and the surface area was 100.00 sq.cm. on 06/11/24; no tunneling or undermining, moderate amount of serosanguinous drainage with no odor, pain level 01/10, 60% granulation, 10% epithelization; no eschar present. The Physician's order for wound care were: Normal saline, skin prep, Hydrogel, bordered dressing daily and PRN. The sacral wound measurements vs. wound presentation were: 10.0 x 10.0 x 0.1 cm and the surface area was 100.00 cm. on: 06/18/24; no tunneling or undermining, moderate amount of serous drainage with no odor, pain level 01/10, 20% granulation, 0% epithelization; no eschar present with no change in wound progression. The Physician's order for wound care were: Normal saline, skin prep, Hydrogel, bordered dressing daily and PRN. Wound evaluation done by ReNew 6/25/24 shows sacral wound remains 'Un-stageable and measures 10 x 8 x 0.4, no significant change since last week, moderate serous exudate, 80% Slough, 20% Granular, mild odor, denies pain. The sacral wound measurements vs. wound presentation (Post-debridement) were: 10.0 x 8.0 x 3.8 cm and the surface area was 80.00 cm. on: 06/25/24; no tunneling or undermining, moderate amount of serous drainage with no odor, pain level 01/10, 20% granulation, 0% epithelization; no eschar present with no change in wound progression. The Physician's order for wound care: treatment changed to 1/4 strength Dakin's moistened gauze packing and cover with bordered dressing daily and PRN; family and attending physician made aware. For the month of May and June 2024, the Medication Administration Record (MAR) documented a physician's order for a blood thinner medication for Resident #408: Enoxaparin Sodium Solution 40 mg/0.4ml Inject 40 mg subcutaneously (SQ) every twelve (12) hours for blood clotting prevention for ten (10) Days that were initialed by licensed nursing staff as being provided to this resident, and for Aspirin Enteric Coated (EC) Tablet Delayed Release 325 MG (Aspirin) Give one (1) tablet by mouth one (1) time a day for Coronary Artery Disease (CAD) with breakfast. For the month of May and June 2024, the Treatment Administration Record (TAR) documented two (2) physician's orders, beginning prior to Tuesday 06/11/24 for the following: 1) Cleanse right and left buttocks with soap and water. Apply Lantiseptic cream after each brief change every shift for prophylaxis - start date Thursday 06/06/24, and 2) Turn and re position frequently as tolerated every shift for preventative measure - start date Wednesday 06/05/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 08/08/24 at 10:22 AM with Staff AA, RN, she stated that she was part of the nursing staff who cared, for this resident, at bedside, prior to Tuesday June 11th on the following seven (7) days: Friday 05/31/24, Tuesday June 4th, Wednesday June 5th, Friday June 7th , Saturday June 8th, Sunday June 9th and Monday June 10th , for the entire week on day shift. Staff AA stated that on: Friday 05/31/24, she noticed immediately upon entering Resident #408's room, that he was, sweaty, smelling badly with his beard looking overgrown and unkempt. As a result, Staff AA stated that she asked Resident #408 if he was ok, with her giving him a shave, a good, full entire bath and nail trimming; which he agreed. Staff AA stated that on that same day, she and another aide proceeded to provide this care for him, but Staff AA also said that she saw no open skin areas on his sacrum. Staff AA added that she had not gone back at any other time during that week to see Resident #408's sacral area. Staff AA also became emotional and tearful, during the interview, indicating that when she had learned later about the resident's wound being found on his sacral, she added that, when she saw the Resident #408's skin it was just shiny and black to her, and she added that she, felt so bad about it once she was aware of and realized what had happened. On 08/08/24 at 12:25 PM an interview was conducted with, the Advanced Registered Nurse Practitioner (A.R.N.P.) for Wound Care working with Renew Wound Care Consultants, regarding the on-set of Resident #408's facility-acquired sacral wound. The A.R.N.P. stated that she had not seen Resident #408 prior to Tuesday June 11th. She said that she did not see or assess the resident until Tuesday June 11th and she saw him again one (1) week later on Tuesday June 18th and again on Tuesday June 25th. She acknowledged that all necessary preventative skin measures/interventions, should have been put into place, for this resident, to maintain skin integrity, beginning upon admission to the facility. On 08/08/24 at 1:06 PM a telephone interview was conducted with, Resident #408's Primary Care Physician (PCP)'s regarding the on-set of the resident's facility-acquired sacral wound. Resident #408's PCP stated and documented that either he or his A.R.N.P., had been in the facility to see this resident on Friday 05/31/24, Tuesday 06/04/24 and again Friday Tuesday 06/07/24. The Doctor stated that he believed that Resident #408 developed a Deep Tissue Injury (DTI) to that area, and he had very dark skin hyperpigmentation making it almost impossible to detect changes in his skin in addition to his other co-morbidities and he stated that, it would have happened anyway. Resident #408's PCP said that he personally saw and assessed Resident #408's sacral skin area with his A.R.N.P. He added that he was not aware of Resident #408's current status or condition. Resident #408's PCP also acknowledged that all necessary preventative skin measures/interventions, should have been put into place, for this resident, to maintain skin integrity, beginning upon admission to the facility. Record review of Resident # 408's CNA ADL (Activities of Daily Living) Task Flowsheet Record dated Thursday 05/30/24 thru Tuesday 06/11/24 revealed that for at least three (3) of the facility's CNA staff working with this resident on both the day and evening shifts documented that they had actually provided the following (ADL)'s of: Bathing support, Shower in bed, and Bowel elimination for the resident. Record review of Resident #408's Baseline care plan dated Friday 05/31/24 indicated that the resident was alert and cognitively intact and required extensive assistance for bed mobility, dressing, hygiene and bathing. He was also totally dependent for transfers, locomotion and toileting. Resident #408's only skin tegrity issues, at that time, were Cellulitis and Edema to leg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #408's subsequent Care plans initiated on 05/31/24 for ADL self-care performance deficit and on 06/02/24 for potential and actual impairment to skin integrity was relative to the resident's disease process, impaired balance/mobility and fragile skin. The following interventions were listed: resident is totally dependent on two (2) staff to provide bath/shower resident is totally dependent on one (1) staff for personal hygiene and oral care follow facility protocols for treatment of injury, keep skin clean and dry, weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The goals noted for Resident #408 were to improve current level of functioning through the review date and to maintain or develop clean and intact skin by the review date. A side-by-side record review was also conducted with the DON of the facility's progress notes, at that time, of the resident's skin status. However, the documentation reviewed in the progress notes, weekly Skin Only Evaluation and in the daily Skilled Evaluations forms dated Friday 05/31/24 up until Tuesday 06/11/24) only documented the general condition or status of the resident's skin area as: warm and dry, skin color within normal limits (wnl) and Turgor is normal, no edema or pitting edema present to lower extremities, and turgor normal, warm to touch, circulation check; extremities are warm and pink, Capillary Refill: Brisk < 3 seconds, skin negative for rash or bruising, no skin lesions or rashes appreciated in exposed bilateral upper extremities or bilateral lower extremities., patient has high risk for developing .ulcers and for skin breakdown which can progress to sepsis ., but with no documentation to specifically describe the resident's sacral area, as having been assessed by facility staff. In Summary, Resident #408 had been residing in the facility, seen and cared for by several different nursing staff members, for eleven (11) days, before the resident's sacral wound was discovered at a stage III; with subsequent treatment then being initiated by facility nursing staff, with no timely notification made to the resident's representative of such. The DON recognized and acknowledged during interview on 08/08/24 at 3:47 PM, that Resident #408's sacral skin wound was not discovered, identified nor documented on by the facility's nursing staff until Tuesday 06/11/24; eleven (11) days after admission to the facility.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to monitor weights, provide appropriate nutritional interventions, and ensure that dietary interventions were followed as ordered for 2 of 8 sampled residents for nutrition (Resident #162 and Resident #98). The findings included: A review of the facility's policy titled Nutritional Management, revised on 09/2022, revealed the following: A systematic approach is used to optimize each Resident's nutritional status: a. Identifying and assessing each Resident's nutritional status and risk factors. b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary. A review of the facility's policy titled Weight Monitoring: revised on 09/01/2022 revealed the following: Based on the Resident's comprehensive assessment, the Center will ensure that all residents maintain acceptable parameters of nutritional statuses, such as usual body weight or desirable body weight range and electrolyte balance unless the Resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: Weight can be a helpful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period) may indicate a nutritional problem. 1. Resident #162 was admitted on [DATE] with diagnoses of protein-calorie malnutrition, Type 2 diabetes, and muscle weakness. The Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 02, which indicates severe cognitive impairment. In an observation conducted on 08/06/24 at 12:21 PM, Resident #162's lunch tray arrived in the room. At 12:25 PM, Staff I, a Speech-Language Pathologist, noted near the Resident helping her with the lunch meal. She stated that Resident #162 initially needed total assistance with her meals, but at this point, she needs supervision. Some days, she needs more than supervision and encouragement, depending on her mood. In an observation conducted on 08/07/24 at 8:00 AM, Resident #162 was noted in her bed, with Staff D, an Occupational Therapist, sitting near her assisting her with the breakfast meal. Staff D said that at times, Resident #162 can eat on her own, and at other times, she needs more assistance and encouragement. According to Staff D, Resident #162 eats between 75% and 100%, and some days, she eats less than that. A review of the weight log showed the following weights for Resident #162: 130 pounds on 06/14/24, 123 pounds on 07/01/24, 122.5 pounds on 07/5/24, and 122.5 pounds on 08/01/24. This showed a significant weight loss of 5.7% from 06/14/24 to 08/01/24. A new weight requested by this Surveyor on 08/06/24 revealed Resident #162 at 119.5 lbs, which showed an additional weight loss of 3 pounds in 5 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's orders showed an order for House Nutritional Supplement as needed for poor meal intake, to pour 6 ounces and encourage intake if less than 50% of meals were consumed, dated 05/19/24. A review of the Medication Administration Records for July 2024 showed Resident #162 did not receive any House Nutritional Supplements for the entire month. The Nutrition Assessment completed on 05/15/24 revealed Resident #162 was at a moderate nutritional risk, meal intake between 51% to 75%, 128.2 pounds admission weight, and no height documented on Resident #162. In this assessment, Staff E, the Registered Dietitian, needed to document the estimated calories and estimated protein needs for Resident #162. The nutrition progress note dated 05/17/24 documented a height of 64 inches on Resident #162 and a Body Max Index (BMI) greater than 21 and less than 23 (within normal ranges). In this note, Staff E stated that Resident #162 was coded as malnourished. In the nutrition progress note dated 07/10/24 (9 days after the identified significant weight loss), Staff E documented that Resident #162 is experiencing sudden weight loss despite reports of good meal intake. The Resident appeared to have lost a significant amount of weight, and this is her usual appearance. In this note, Staff E did not make any additional nutritional recommendations or changes despite the significant weight loss noted. The nutrition care plan revealed that Resident #162 will maintain adequate nutritional status, as evidenced by maintaining weight within 3-5% of 128.2 pounds. It further showed that the individual weight loss of 3 pounds in one week or over 5% of weight loss in one month should be monitored. In an interview conducted on 08/07/24 at 8:30 AM with Staff E, he stated that a weight loss of 5% or more in one month will trigger in the electronic system and notify him of any significant weight loss. He will run a daily weight report to identify residents with significant weight changes. Staff E will intervene when the weight loss is noted and reevaluate the resident ' s nutritional status. When asked about the House Supplements ordered for Resident #162, Staff E said it is either Boost (nutritional supplement) or Ensure (nutritional supplement). He validated that Resident #162 had a severe weight loss in one month from 06/14/24 to 08/01/24. Staff E said that because Resident #162 ate between 75% and 100% of her meals, there was no indication that she would need additional calories for her daily meals. He said a significant weight loss paired with documented poor intake for an extended period would indicate a criterion for diagnosing malnutrition. Staff E stated that he could not calculate the estimated caloric and protein needs for Resident #162 on her initial nutrition assessment because he did not have the height of Resident #162. According to Staff E, a current weight of 119.5 showed that Resident #162 ' s BMI dropped from 21.9 to 20.4, placing her at borderline underweight. 41837 2. Record review for Resident #98 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Protein-Calorie Malnutrition and Unspecified Dementia. Review of the Minimum Data Set (MDS) for Resident #98 dated 06/30/24 documented in Section C a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. Review of the weights for Resident #98 revealed the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2024 the resident weighed 196.0 pounds From 06/30/24 to 07/06/24 there was no weight documented for the resident. From 07/07/24 to 07/13/24 there was no weight documented for the resident. From 07/14/24 to 07/20/24 there was no weight documented for the resident. From 07/21/24 to 07/27/24 there was no weight documented for the resident. On 7/31/2024 the resident weighed 170.0 pounds This indicated the resident had lost 26 pounds (13.27%) in 1 month which is a significant weight loss after 4 weeks of no weights. Review of the Physician's Orders for Resident #98 revealed an order dated 06/26/24 to weigh weekly one time a day every Wednesday. Review of the Physician's Orders for Resident #98 revealed an order dated 06/27/24 NAS (No Added Salt) diet Regular texture, Regular/Thin consistency. Review of the Physician's Orders for Resident #98 revealed an order dated 08/02/24 House Nutritional Supplement one time a day for nutrition support 120 ml (milliliters) document % consumed. Review of the Nutrition/Dietary Note for Resident #98 dated 08/05/24 documented the following: Weight Review: Weight taken 7/31 of 170 pounds with a BMI (Body Mass Index) of 30.1, indicative of obesity. Weight is down 26 pounds/15% in comparison to admission weight of 196 lbs. She has a hx (history) diuretic use, weight/fluid shifts anticipated. Estimated needs remain consistent to admission assessment based on adjusted BW (Body Weight). On a NAS diet with intake of 0-50%. NP notified of weight loss and suboptimal intake. Mirtazapine and Eldertonic were ordered as well as House supplement QD (daily). Pt has a history of behavioral disturbances, she has refused to be weighed at times. Attempted to contact her Emergency contact however, unavailable. Will continue on weekly weights to further assess weight trends and adjust POC (plan of care) as needed. Review of the Care Plan for Resident #98 dated 06/27/24 with a focus on the resident is at nutritional risk r/t comorbidities, advanced age, hx edema, dentures, obesity, hx PU (pressure ulcer), and therapeutic diet with supplements as ordered. Refuses weights at times. The goal was for the resident to maintain adequate nutritional status as evidenced by maintaining weight, no s/sx of malnutrition, and consuming meals daily through review date. The interventions included: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Monitor/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide and serve diet as ordered. Provide, serve diet as ordered. Monitor intake and record q meal. RD to evaluate and make diet change recommendations PRN. The resident needs a calm, quiet setting at meal times with adequate eating time. Encourage the resident's socialization and interaction with table mates during meals. Weigh per facility protocol (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 08/07/24 at 9:15 AM with Staff E Registered Dietitian (RD) who stated he has worked at the facility since June 2023. When asked how often residents are weighed, he said on admission, then weekly for 4 weeks, if weight is stable then monthly. He said if the resident has a significant weight loss they would be on weekly weights and the duration of time would be determined by the RD. When asked what is considered a significant weight loss, he stated it would be 5% or greater in 30 days, 7.5% or greater in 90 days, and 10% or greater in 180 days. When asked if the significant weight loss and interventions are entered into the resident's care plan he said yes. During an interview conducted on 08/07/24 at 10:15 AM with Staff F Registered Dietitian (RD) who stated she has worked at the facility for over 1 year. When asked about Resident #98, she said she is following the resident. When asked if the resident had significant weight loss, she said the resident lost 26 pounds (15%) in 30 days from 6/26/24 to 7/31/24. When asked if the resident was weighed weekly following admission on 06/26/24, she said no, the resident had refused, or nursing never gave her the weights. When asked if there was any documentation of resident refusing weights, she said she put it in her notes on 08/05/24. When asked if she addressed the no weights or resident refusing weights with nursing, she said yes but could not provide name of who she spoke to. She said she just did not document the resident refusing the weights until 8/05/24. She acknowledged the significant weight loss was not addressed timely. When asked about the care plan for the resident she acknowledged she did not update the care plan until 08/05/24.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice for 1 of 1 resident reviewed for pain (Resident #358). The findings included: A review of the facility's policy titled Pain Management, revised on 09/01/2022, revealed the following: facility staff will observe for nonverbal indications that may indicate the presence of pain. These indicators include but are not limited to, the impact of pain on quality of life (sleeping, appetite, and mood), currently prescribed pain medications, dosage and frequency, and the resident's goals for pain management and satisfaction with the current level of pain control. Resident #358 was admitted on [DATE] with diagnoses of Muscle Wasting, Type 2 Diabetes, and Muscle Weakness. The 5-day Minimum Data Set, dated dated dated [DATE] revealed that Resident #358 had a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. A review of the Physician's orders showed the following: Oxycodone (pain medication) oral tablet, 10 milligrams to give one tablet by mouth every 12 hours for chronic pain, which was discontinued on 08/5/24. Oxycodone (pain medication) oral tablet, 10 milligrams to give one tablet by mouth every 8 hours for chronic pain dated 08/5/24. In an interview conducted on 08/05/24 at 11:00 AM, Resident #358 stated that he spoke to the facility's Social Worker two days ago regarding the issue with his pain medication not being given on time. He said that his pain medications are given later, and at times, it is 2-3 hours past the scheduled medication time. Resident #358 reported that he asked for his pain medication this morning at 7:30 AM, which was only given to him around 10:00 AM this morning. In an interview conducted on 08/07/24 at 11:00 AM, Resident #358 stated that he could not sleep well last night because he was in pain, and Staff are still not giving him his pain medication on time. In an interview with Staff G, a Registered Nurse (RN), on 08/07/24 at 11:10 AM, the RN stated that Resident #358 is getting his pain medication every 8 hours. He received his pain medication this morning at 6:00 AM, and his next one is due at 2:00 PM today. A review of the Care Plan for Pain showed that Resident #358 has the potential for acute/chronic pain and that he is on routine pain medication. Anticipate the resident's need for pain relief, respond immediately to any complaint of pain, and administer pain medication as per orders. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medication administration audit report showed the following: On 08/02/24, Oxycodone was scheduled for 8:00 AM and was given at 9:20 AM, an hour and a half later. On 08/03/24, Oxycodone was scheduled for 8:00 AM and was actually presented at 10:49 AM, which was almost 3 hours later; on 08/05/24, Oxycodone was scheduled for 8:00 AM and was actually given at 10:47 AM, which was nearly 3 hours later, and on 08/05/24, Oxycodone was scheduled for 10:00 PM and was actually given at 11:50 PM which was almost 2 hours later. In an interview conducted on 08/07/24 at 3:30 PM with the Director of Nursing, she stated that pain medication is usually given either an hour before or an hour after the scheduled medication time.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to provide food that accommodates resident preferences and appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 2 of 8 residents sampled for nutrition (Resident #88 and Resident #172). The findings included: A review of the facility ' s policy titled Nutritional Management, revised on 09/2022, revealed the following: Interviewing the Resident and Resident representative to determine if their personal goals and preferences are being met. ii. Directly observing the Resident. iii. Interviewing the direct care staff to gain information about the Resident, the interventions currently in place, their responsibilities for reporting on these interventions, and possible suggestions for changes if necessary. 1. A record review revealed that Resident #88 was admitted to the facility on [DATE] with diagnoses of Underweight, Muscle Wasting, and Depression. A review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 11, which was normal to low cognitive impairment. In an observation conducted on 08/05/24 at 4:45 PM, Resident #88 received her dinner tray in her room. The dinner tray consisted of navy bean soup, egg salad with two slices of bread, cucumber tomato salad, apple crisp, and apple juice. In this observation, Resident #88 was heard saying, I don't want to eat this; every day, it is an egg salad. When asked by this Surveyor, Resident #88 said, I don't like the food on this dinner tray, and refused to answer any more questions. In an observation conducted on 08/06/24 at 12:35 PM, Staff were setting up Resident #88's lunch tray in her room. Resident #88 meal tray consisted of: roast turkey, stuffing and green beans. Resident #88 did not want to eat the choices on her lunch plate and asked for a tuna sandwich and fruit instead. Continued observations showed that Resident #88 ate the tuna sandwich and the grapes which she requested instead of the regular food items that were served for the lunch meal. The initial nutrition assessment dated [DATE] revealed that Resident #88 was at nutritional risk related to poor appetite and intake of meals. Patient reports poor appetite with an average meal intake of 25% to 50% of meals. In an interview conducted on 08/07/24 at 11:00 AM with Staff F, Registered Dietitian, she stated that she assessed Resident #88 when she was admitted on [DATE], and Resident #88 only reported that she did not like eggs. Staff F attempted to call Resident #88's husband to obtain food likes and preferences but was not able to speak to Resident #88's husband. When asked regarding the menu choices that were provided to Resident #88, Staff F said the Resident was not picking her menu choices but was provided with options for the day that were provided on the menu. Staff F reported that Resident #88 was confused when she tried to obtain food choices and preferences in the past. Staff did not tell her anything about Resident #88's disliking the food choices she was receiving. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings were to explained to her in an interview with the nursing home administrator on 08/08/24 at 2:30 PM. 50370 2. Resident #172 was readmitted to the facility on [DATE] with diagnoses of Muscle Weakness, Type 2 Diabetes Mellitus, Anemia, Chronic Kidney Disease, Intermittent Claudication bilateral legs, Renal Disease, Kidney Transplant Failure, and unspecified Protein-Calorie Malnutrition. His initial admission was on 01/27/2024 with diagnoses of Muscle wasting, Acute Respiratory Distress Syndrome, Pleural Effusion, Atherosclerotic Heart Disease, and Dependence on Renal Dialysis. Record review of MDS (Minimum Data Set) Section C revealed a BIMS (Brief Interview for Mental Status) score of 12 indicating good cognitive function. Resident #172 speaks Spanish. He does not read English but has minimal understanding of spoken English. Review of Facility's Policy titled Communicating with Persons with LEP (Limited English Proficiency) copyrighted in 2022, states that facility is to take reasonable steps to ensure that persons with LEP have meaningful access and an equal opportunity to participate in facility's services. Policy explanation and Compliance Guidelines # 1 states that facility staff will identify the language and communication needs of the LEP person during the pre-screening and admission process; #4 states that notification of the availability of language assistance services will also be provided through one or more of the following : outreach documents, telephone voice mail menu, and/ or the facility's website. Nutrition and Dietary Progress Notes record review dated 07/30/2024, and 06/30/2024, showed Staff F, a Registered Dietitian reviewed the menu with Resident # 172. In an observation on 08/05 2026 at 5:30 PM, a meal tray was seen on top of a table with a meal ticket written in English. The meal ticket showed the following: Resident #172's name , ticket #404, date= 08/05/2024, meal period -week 3 Mon Lunch, P 11. Additional notes included large servings, fluid restriction 1000 ml, 1 (one) juice (116 ml); Expo items showed 1 Rice, 1 Fruit Salad (1/2 cup), 1 Cranberry Juice (4 fluid oz {ounces}); Hot showed 1 stuffed green pepper, 1 California blend (SHC)(4 oz); Diet: regular texture, RG7, renal, fluids-thin; DR -eats in room. During another observation on 08/06/2024 at 4:45 PM, Resident #172 was not in his room, but a meal tray was observed on top of a table. The meal ticket was written in English. The meal ticket revealed the following: Resident#172's name, ticket #332 , date-08/06/2024, meal period -week 3 Tuesday lunch , P11; notes-large servings, fluid restrictions 1000ml, and one juice (116 ml); expo items- 1 French style green beans (1/2 cup), 1 sherbet (1/2 cup), 1 cranberry juice (4 fluid oz); hot-1 roast turkey (3 oz), 1 cornbread stuffing (4 oz), 1 dinner (1 each with margarine); diet - regular texture RG7, renal, fluids-thin. Above the meal table was a calendar of activities written in English. (continued on next page)

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	105441	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health & Rehabilitation Center	4800 N Nob Hill Rd Sunrise, FL 33351

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation of Resident # 172 on 08/06/2024 at 4:00 PM, he stated that he did not like the food offered to him at lunch time today and at other mealtimes, because they were not his food preferences. He was offered American style dishes, but he likes Hispanic dishes. When asked if any Staff spoke with him regarding his food preferences , choices, likes and dislikes, he stated No When asked if someone explained the menu to him, he added that the facility Staff must have told him, but he does not understand English. When asked about a menu for the week, he pointed to the activity calendar posted on the wall. In an interview with the Staff F, a Registered Dietitian on 08/06/ 2024 at 4:19 PM, she stated that when a resident is admitted or readmitted , she will go over diets, likes and dislikes and any food preferences based on the MD's (Medical Doctor's) orders as well. Staff F stated that the food preferences and likes are sometimes documented in the nutrition assessment if there are any that are reported by the residents. It may also be documented under the dietary profile. The choices and preferences are then updated in the nutrition management system for the main kitchen. When asked if she went over preferences and menus with Resident #172, she said she did not think so. When asked about the nutrition assessment, she said that it is limited to the sections and did not have a section for food preferences. She added that she speaks Spanish and can communicate effectively with Resident #172. When asked if she talked to this resident regarding his preferences for Hispanic foods, she stated No, I do not think so. She added Resident #172 is on dialysis which makes selection of food very limited, and she has not heard Resident #172 complained about his food. In another interview with Staff S on 08/08/2024 at 12:20 PM, she stated Resident #172 ate 10 % of his lunch. She added that she asked if he wanted a sandwich instead, to which Resident #172 refused. She added that she will tell the Nurse. During an interview with the DON on 08/08/2024 at 3:30 PM the above information was shared.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on interview, observation, and record review the facility failed to effectively communicate, and educate Staff regarding fluid restriction, failed to ensure supervision, communication, and education of a resident about the allowable amount of liquids for fluid restriction, and failed to document the amount of provided liquid per shift based on the guidelines of a medically prescribed order for fluid restriction for 1 of 1 sampled resident (Resident # 172). The Findings included: Resident #172 was readmitted to the facility on [DATE] with the diagnoses of Type 2 Diabetes Mellitus, End Stage Renal Disease, Kidney Transplant Failure, Unspecified Protein-Calorie Malnutrition and Acute Pulmonary Edema. His initial admission was on 01/27/2024 with diagnoses of Muscle wasting, Acute Respiratory Distress Syndrome, Pleural Effusion, Atherosclerotic Heart Disease, and Dependence on Renal Dialysis. Record review of MDS (Minimum Data Set) Section C revealed a BIMS (Brief Interview of Mental Status) score of 12 indicating good cognitive function. Resident #172 speaks Spanish. He does not read English but has minimal understanding of spoken English. Review of orders dated 05/26/2204 showed fluid restriction of 1000 ml (milliliters) for 24 hours for Resident #172. It elaborated that Nursing Staff must provide 360 ml for 24 hours to be divided as follows: 150 ml for the 7 AM to 3 PM shift; 150 ml for the 3 PM to 11 PM shift; and 60 ml for the 11 PM to 7 AM shift. In addition, dietary fluid allowance is 640 ml for 24 hours. Record review of facility's Fluid Restriction Policy, reviewed on 04/2023, showed facility ensures that fluid restrictions will be followed in accordance with physician's orders. This policy's compliance guidelines # 4 states that water will not be provided at the bedside unless calculated into the daily total fluid restriction; #5 states that risks and benefits of the fluid restriction will be explained to the resident and or representative. A review of a paper titled Diet Type Report provided by Staff Q , Director of Activities, showed that Resident #172 has the following data: Diet Type is Renal, Diet Texture is Regular, Fluid Consistency is Regular/Thin, with blank spaces under Diet Supplements and Additional Directions columns. There were no comments or notes regarding fluid restrictions. Further record review of Physician's Quarterly Progress Notes dated 08/07/2024 section J revealed Resident #172 is on moderate nutritional risk related to comorbidities, advanced age, dependence to hemodialysis, history of fluid overload, status post (after) thoracentesis (a surgical procedure of draining extra fluids from the pulmonary system), therapeutic diet and 1 (one)Liter fluid restriction per hemodialysis. Additional comments on section K showed to continue 1 (one) Liter Fluid Restriction per hemodialysis. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional record review of Dietary Notes dated 07/30/2024, 06/30/2024, 05/31/2024, and 03/29/2024 revealed Resident #172 was to remain on a fluid restriction of 1000 ml per day. Further Dietary Notes record review dated 03/04/2024 showed notes by Staff F suggesting Resident #172 to have fluid restriction of 1000 ml daily- 640ml by dietary, and 360 ml from nursing, distributed as follows: 7 AM to 3 PM shift to give 150 ml, 3 PM to 11 PM shift to give 150 ml, and 11 PM to 7 AM to give 60 ml. Review of Facility's Policy titled Communicating with Persons with Limited English Proficiency stated that facility staff will identify the language and communication needs of the LEP (Limited English Proficiency)person during the pre-screening and admission process. Further record review of fluid restriction on the MAR (Medication Administration Record) and TAR (Treatment Administration Record) during the whole month of July 2024 (totaling 31 days) , and the beginning dates of August 2024 (8 days), revealed X symbols under all dated columns, with no Nurses initials or recorded amount of fluid provided to Resident # 172 per shift. Additional record review of a paper titled Nursing Point Click Care Emar dated 3/22, stated that the symbol X on e-mar means that the day selected was prior to the start date of the order start date, this can be due to a new order, and it was not started until a certain effective date. PCC (Point Click Care) automatically populates with an X for all dates that have passed from the start of a new order. In an observation conducted on 08/05/24 at 5:49 PM, Resident #172 was not in the room. The dinner tray was noted on the side table with the following:2 pieces of stuffed green peppers, fruit salad, 4 ounces of juice, mashed potatoes, and blended veggies. The meal ticket revealed the following: Regular texture renal diet, large servings, fluid restrictions 1000ml, and one serving of 4 ounces juice. Closer observation revealed 12 ounces of water in a Styrofoam cup, 4 ounces of bottled water and 4 ounces can of coke (which showed a total of 20 ounces of liquids, equals 600ml of fluids). In another observation conducted on 08/06/24 at 10:00 AM, 4 ounces can of coke and 4 ounces of juice noted at the bed side (which showed a total of 8 ounces, equals 240ml of fluids). During an interview conducted on 08/06/24 at 12:30 PM with Resident #172, he stated that he was not educated on fluid restrictions and did not know how much liquids he is allowed daily. Additional interview and observation on 08/06/2024 at 3:50 PM, showed Resident# 172 was filling up a cup with red colored liquid from a jug at the front entrance of the facility. This surveyor observed him throwing the empty container after drinking the total amount (4 ounces or 120 ml of fluids). In an interview with Resident # 172 on 08/06/2024 at 4:00 PM, he stated no Staff had informed him of any fluid restrictions. When asked if somebody communicated to him the allowable amount of fluids to drink during each shift, he seemed confused and said, I only drink from this cup while pointing at a plastic container (8 ounces or 240 ml) during mealtimes. He added that the facility Staff must have told him, but he does not understand English. When asked about a menu for the week, he pointed at the activity calendar on the wall. An hour later, this surveyor observed Resident #172 had an opened can of coke (4 ounces or 120 ml of fluids) on his table. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff F, an RD (Registered Dietitian) on 08/06/ 2024 at 4:19 PM, she stated that when a resident is admitted or readmitted , she will go over diets, likes and dislikes and any food preferences based on the MD's(Medical Doctor's) orders as well. Staff F added that the food preferences and likes are sometimes documented in the nutrition assessment if there are any that are reported by the residents. It may also be documented under the dietary profile. The choices and preferences are then updated in the nutrition management system for the main kitchen. When asked if she went over preferences and menus with the Resident, she said she did not think so. When asked about the nutrition assessment she said that it is limited to the sections and did not have a section for food preferences. She added that she speaks Spanish and can effectively communicate with Resident #172. When asked if she spoke to the Resident regarding fluid restrictions or educated the Resident on fluid restrictions, she said No. During an observation and an interview with Staff S, a CNA (Certified Nursing Assistant), who clarified to this surveyor that she speaks Spanish on 08/08/2024 at 08:28 AM, she stated that Resident #172 does not have any fluid restrictions. She asked Resident # 172 if he wishes to fill up his empty cup on the meal tray with more water. Resident #172 refused, and Staff S left the room. During an interview with the DON (Director of Nursing) on 08/08/2024 at 10:20 AM, when this surveyor pointed out that Fluid restriction column was marked with several X's on July 2024 (31 days), and August 2024 (8 days), she stated that all the X's on Resident #172's MAR and TAR mean that the order has not yet started. In an interview with Staff R, a CNA, on 08/08/2024 at 11:50 AM she stated that Resident #172 can get extra water to drink from his bathroom. When asked if Staff R tells the Nurse the amount of fluids Resident # 172 consumes , she replied No She was not aware that Resident # 172 is on fluid restrictions. She picked up and read Resident #172's meal card , stepped out of the room and talked to the Nurse outside. During another interview with Staff S, a CNA, on 08/08/2024 at 11:53 AM , she stated Resident #172 takes water from the bathroom sink to fill up his empty cup. During this interview, Resident # 172 was observed with 2 cups(8 ounces each) of water about 3/4 full next to his lunch tray on the table. When asked if Resident # 172 is allowed to drink all the liquids inside the meal tray and the 2 cups next to the meal tray, Staff S stated, It is fine. In an interview with Staff P, an Activities Assistant on 08/08/2024 at 11:00 AM, she stated that she does not know Resident #172 is on Fluid Restriction. When asked if she provides fluids to Resident #172 during activities, she stated she gives him coffee. She added that she ensures the correct diets and preferences are provided to the residents based on a dietary paper. When asked to show this surveyor the dietary paper where she checks Resident #172's prescribed diet and preferences, she stated she will copy it. An hour later, she came back with Staff Q, and both stated that they give a maximum amount of 4 ounces of fluids everytime Resident #172 asks for refreshments or drinks. When asked if they can show this surveyor where they documented the amount of liquids given to Resident #172, they stated they did not document anything. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Staff Q, Director of Activities on 08/08/2024 at 12:00 PM, she stated that she does not know Resident # 172 is on fluid restriction, since she provides morning coffee pass to all residents who attended activities, or when she performs room visits, and no Nurse told her about fluid restriction order for Resident #172. She verifies diet information from a paper titled Dietary Notes, where she checks Facility residents' prescribed diet, preferences, and other dietary comments. Resident # 172 does not have fluid restriction notes under the additional directions column of the Dietary Notes according to her. In another interview with the new Clinical Educator on 08/08/2024 at 11:15 AM, when asked about the fluid restriction order on the MAR and TAR, he explained that the X symbols signified the task has not started. He added that fluid restriction was not a Physician order, so Nurses do not need to put their initial on the dated columns. When asked how would Staff communicate the acknowledgement of fluid restriction and the total amount of fluids provided to Resident # 172 for each shift according to the prescribed fluid restriction guidelines, he stressed that fluid restriction for Resident #172 was not a Physician order, so Nurses do not need to document the exact amount of fluids per shift or put their initials. In an interview with the DON on 08/08/2024 at 3:30 PM, the above information was shared.