STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105451	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Rehabilitation and Nursing Center	900 Beckett Way Tarpon Springs, FL 34689

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. 20536 Based on observation, interview, and record review, the facility failed to ensure two (#52 and #8) of eleven sampled residents , who dined in the main dining room, were provided and assisted with their meal until 30 and 40 minutes after all the others were served and ate their meal. Findings included: 1. On 9/16/2024 at 11:59 a.m., the main dining room was observed for lunch service. The room was observed with over twelve tables and many chairs. Prior to the meal observation, the room was used as a group activity, and there were many residents who were in attendance of that activity. After the activity was completed, there were nine residents who remained in the room to wait and be served their lunch. There were three staff members who were either talking/interacting with the residents in the room, or were providing them hydration. It was observed at this time, Residents #52 and #8 had been seated in the main dining room since the group activity ended. On 9/16/2024 at 12:08 p.m., a meal tray cart came out from the kitchen and the three staff members immediately began to serve and set up meal trays. They served two of eleven residents in the room. At 12:15 p.m. nine residents had been served and set up with their meals and were eating on their own. However, Residents #52, and #8, who were seated at tables by themselves and had not been served or assisted with their lunch meal. At that time, interviews with Staff B and C, who were Certified Nursing Assistants (CNA), revealed they were surprised Resident #52 and #8's meal had not been brought out. They said they had provided the kitchen with names of those who were eating in the dining room, about thirty minutes prior to the meal service. Staff B confirmed Residents #52 and #8 were on that list. On 9/16/2024 at 12:30 p.m., nine of the eleven residents were still eating their meals and Residents #52 and #8 still seated at their tables and had not been provided with their meal. Staff B and C walked up to both residents #52 and #8 and ensured them their meals were coming. An interview with Staff B revealed both residents #52 and #8 were to receive the primary meal so there should not have been any reason why their meal trays had not come out from the kitchen yet. It appeared resident #52 was getting irritated as to why everyone else was eating. He was overheard making loud noises and pointing at others who were eating. (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	On 9/16/2024 at 12:35 p.m., Residents #52 and #8 had still not been provided and assisted with their meal. Both had called out twice and asked staff in the room where their meal was. Both were ready and wanting to eat. Staff B again tried to reassure both were going to receive their meal shortly. Staff C went to the kitchen door to ask why Residents #52 and #8's meals had not been made and brought out to them. Staff C was observed to not get an answer from the kitchen staff. On 9/16/2024 at 12:36 p.m., the Certified Dietary Manager (CDM) brought out a meal tray cart from the kitchen and said to staff; East, as if to say it needed to go to the East hall. During that time, Resident #52 was observed now banging on the table and yelling out non understandable words, and then said, food now, food now. On 9/16/2024 at 12:39 p.m., Resident #52 was now very upset and yelled out continually; food, where is it, where is it, [curse word] where is it. At this point, Resident #52 was being very disruptive to all others who were in the room eating. He was very upset because he did not receive his meal. Staff keep telling him they would get it for him. However, his meal had not come out from the kitchen as of yet. Resident #52 took off his glasses and started to cry out loud and staff sat down next to him to try and talk with him. He continued to cry aloud and kept yelling, where is it, where is it. On 9/16/2024 at 12:42 p.m., Staff B brought out a tray for resident #8, set it up, sat down, and began to assist her with eating. Resident #8 was not interviewable. Resident #8 sat at a table near others who were served and already eating from 12:08 p.m. through to 12:42 p.m., thirty-four minutes without being provided and assisted with her meal. On 9/16/2024 at 12:44 p.m., Staff sat with Resident #52 until his meal arrived. At that point, he had been the only resident who had not been served his meal. Staff provided him with a canned soda to drink. He accepted it but still wanted his meal and was still visibly upset. On 9/16/2024 at 12:45 p.m. four residents finished their meal and left the dining room. On 9/16/2024 at 12:48 p.m. Resident #52 was finally served his meal and he began to eat immediately on his own. Resident #52 was observed with cognitive and communication impairment, but was able to express he was now happy with getting food. Resident #52 sat at a table near others who were served and already eating from 12:08 p.m. through to 12:45 p.m., 37 minutes without being provided and assisted with his meal. On 9/16/2024 at 1:00 p.m., an interview with the CDM revealed he could not explain why Residents #52 and #8 had not received their meal tray for such a long time today. He explained he had a member of a county inspection agency in the kitchen during the time of meal service, and was not able to monitor the plating of meals. He confirmed Residents #52 and #8 should not have had to wait that long for their meals and that he would look into the situation. On 9/19/2024 at 10:00 a.m.,an interview with the Director of Nursing revealed all residents who dine in the main dining room for any meal service, should all be served roughly at the same time and should not have to wait long periods of time without a meal, as others have been served and who were already eating. She confirmed Residents #8 and #52 waiting over thirty minutes should not have happened. She also confirmed that it was not due to the lack of nursing staff in the dining room, but rather it was a problem in the kitchen on 9/16/2024. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/2024 at 2:00 p.m. the Nursing Home Administrator provided the Promoting/Maintaining Resident Dignity policy and procedure, with a implementation dated of 6/1/2024 for review. The policy stated: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The Compliance Guidelines section of the policy stated the following but not limited to: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 6. Respond to requests for assistance in a timely manner. (5) The Self Determination section of the policy stated: (b) The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. 48441

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, interview, and record review, the facility did not ensure an assessment and physician orders were obtained for medication self-administration for one (#36) of eight residents sampled. Findings include: On 9/17/2024 at 9:41 a.m., an observation was made of Resident #36 in her room. A tracheostomy with a respiratory cap was visualized along with supplies for tracheostomy care. The resident stated she did most of her own tracheostomy care including her nebulizer treatments. Resident #36 stated her nebulizer medication was in her top left hand dresser drawer. Resident #36 gave permission to open drawer. An observation was made of two packets of Albuterol Sulfate Nebulization solution 0.63 mg/3 ml (milligram/milliliter) with one packet opened. Resident #36 stated she gave herself her own nebulizer treatment but the facility supplied her with the items and medication. A review of Resident #36's Admission Record showed she was admitted to the facility with diagnoses which included but not limited to acquired absence of larynx, tracheostomy status, anxiety disorder due to known physiological condition, and unspecified voice and resonance disorder. A review of Resident #36 current physician orders showed an order dated 9/09/2024 for albuterol sulfate nebulization solution 0.63mg/3 milliliters via trach every six hours as needed for shortness of breath. A review of Resident #36's Minimum Data Set, dated dated dated [DATE] under Section O -Special Treatments, Procedures, and Programs, showed Section E1 tracheostomy care A review of Resident 36's medical record did not show an assessment for resident self-administration or a physician's order. On 9/18/2024 at 9:50 a.m., an interview and observation was conducted with the Assistant Director of Nursing in Resident 36's room. Medication of albuterol remained in Resident #36's drawer and the resident confirmed she self-administered her nebulizer treatments herself as needed. On 9/18/2024 at 10:30 a.m., the Director of Nursing confirmed the missing assessment and orders for self-administration for Resident #36. A review of the facility's policy and procedures titled: Resident Self-Administration of Medication revised date of 3/01/2024 shows the following policy statement: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facilities interdisciplinary team. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration. b. The resident's physical capacity to swallow without difficulty, open medication bottles, administer injections. c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for. d. The resident's capability to follow directions and tell time to know when medications need to be taken. e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff. f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs. g. The resident's ability to ensure that medication is stored safely and securely.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, interview, and record review, the facility did not ensure one (#67) out of eight residents sampled had the proper paperwork for the resident's code status. Findings include: A record review of Resident #67's physician orders show an order dated [DATE] for Do Not Resuscitate (DNR). Resident #67's medical record did not have the [Do Not Resuscitate order form] signed by the physician in the electronic medical record. On [DATE] at 9:55 a.m., an interview was conducted with Staff F, Licensed Practical Nurse (LPN). Staff F was assigned to the North wing of the facility and stated there was a DNR binder in the nurses' station in which all the residents in the entire facility with a DNR order were in the binder. Staff F, LPN stated there was another binder in the East wing nurses' station. Staff F, LPN stated the North wing DNR binder rational for all the residents was to account for the residents from the other wing (east) who might be transporting either walking or self-propelling via wheelchair to their wing (north). Resident #67 room assignment was on the North wing. The DNR binder in the North wing did not have Resident #67's [Do Not Resuscitate order form] signed by the physician. Staff F, LPN, confirmed Resident #67's DNR paperwork was not in the DNR binder for the North wing. The Social Service Director (SSD) was in the nurses' station as well and stated he did weekly audits of residents' DNR paperwork but the nurses were responsible for residents transferred from hospitals with established DNR paperwork. On [DATE] at 10:07 a.m., an observation was made of the East wing's DNR binder. Resident #67's DNR paperwork was present. Resident #67 had a family member with the same last name as Resident #67 residing as a resident in the East wing. On [DATE] at 10:15 a.m., an interview was conducted with Staff F, LPN. Staff F, LPN stated when a newly admitted resident was received from a hospital, the nurses would review the resident's [transfer form] and make copies of the [DNR order form] on yellow paper and place it into the DNR binder. Staff F, LPN reviewed the last [transfer form] paperwork for Resident #67 and stated there was not a check on the form indicating code status. On [DATE] at 10:25 a.m., an interview was conducted with Staff F, LPN. Staff F stated in a potential code status situation she would go to the DNR binder to determine the resident's code status. On [DATE] at 10: 28 a.m., an interview was conducted with Staff H, LPN. Staff H stated she would go to the DNR binder first to determine a resident's code status. On [DATE] at 10:35 a.m., an interview was conducted with Staff E, Registered Nurse (RN). Staff E, RN stated she would go the DNR binder first to determine a resident's code status and stated if the paperwork was not in the binder, then the resident was a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:39 a.m., an interview was conducted with Staff P, RN. Staff P, RN stated she would go to the medical records to determine the code status for the resident. Staff P demonstrated in the electronic chart where she would look to determine the resident's code status and added the physician orders could be reviewed as well to determine a code status. On [DATE] at 10:44 a.m., an interview was conducted with Staff M, RN. Staff M stated he would look in the resident's medical record and confirm with physician orders and added the DNR binder as an additional verification. On [DATE] at 10:45 a.m., an interview was conducted with Staff L, LPN/Supervisor. Staff L stated initially she would look in the DNR binder but stated she would confirm in the resident's medical record. Staff M and Staff L stated the SSD will update the binder. ON [DATE] at 11:00 a.m., interviews were conducted with Staff O, Certified Nurse Assistant (CNA). Staff O stated she would look at the DNR binder to determine a resident's code status. Staff Q, CNA stated she would go to the resident's medical records. Staff R, CNA stated she would go to the medical records under her [brand name for a file system that gives a brief overview of the resident] to view code status of a resident. Staff J, LPN/Supervisor stated she would go to the resident's medical record first. On [DATE] at 11:21 a.m., an interview was conducted with the SSD and the Director of Nursing (DON). The SSD stated code status audits were initially done monthly for their Quality Assessment and Performance meetings but with the transition to a new ownership, he discovered missing residents' code status; therefore, switched to weekly audits. The DON was aware of the different responses sampled staff answered when questioned on where they would go to determine a resident's code status during an actual code situation. A review of the facility's policy titled, Advance Directives revised [DATE] shows in their policy statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. A review of the facility's policy titled, Emergency Procedure -Cardiopulmonary Resuscitation (CPR) revised , d+[DATE] shows: 1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: a. Instruct a staff member to activate the emergency response system (code) and call 911. b. Verify or instruct a staff member to verify the DNR or code status of the individual. c. Initiate the basic life support sequence of events.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observation, interview, and record review, the facility failed to ensure a base line care plan was developed for the use of continuous oxygen therapy for two (#206 and #360) of twenty sampled residents who received oxygen therapy. Findings included: 1. On 9/16/2024 at 10:00 a.m., an observation and interview was conducted with Resident #206. She was lying in bed, under the covers and with the head of her bed at approximately 45 degrees. An oxygen concentrator was on the left side of the bed. The concentrator was on and the flow rate read 4.5 (lpm) liters a minute. The resident said she needed oxygen all the time and did not know what the flow rate should be. She confirmed it felt a little rushed in through her nose. When she found out the oxygen flow rate on the concentrator was at 4.5 lpm, she said that was too high. She revealed she had just been readmitted from the hospital and had been utilizing the oxygen since her readmission. Resident #206 revealed she had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and that was the reason for her oxygen therapy, and nebulizer treatments. Resident #206 then remembered that when she was receiving oxygen therapy from the machine, it should be at 2 liters a minute. She did not know why the flow rate was so high and at 4.5 liters per minute. Resident #206 confirmed she had some slight discomfort in her nostrils and with some dryness. On 9/16/2024 at 1:20 p.m., Resident #206 was again observed in her room and lying upright in bed. She was still observed receiving oxygen therapy via the oxygen concentrator. The flow rate gauge on the concentrator read 4.2 - 4.5 lpm. On 9/17/2024 at 8:00 a.m., Resident #206 was observed in her room and seated upright in bed at 90 degrees. The resident was receiving oxygen therapy via the oxygen concentrator. The gauge on the concentrator revealed 4.2 - 4.5 lpm. Resident #206 again revealed she was not sure why the flow rate was so high, but she did need oxygen all the time due to her COPD. On 9/17/2024 at 12:10 p.m. Resident #206 was observed in her room and seated upright in bed. She was observed receiving oxygen therapy via the oxygen concentrator. The gauge on the concentrator revealed a flow rate of 4.2 - 4.5 lpm. On 9/18/2024 at 9:35 a.m., an interview with the Staff E, Registered Nurse, and who was assigned to the resident the past three days (9/18, 9/17, 9/16/2024), confirmed resident #206 had been a recent readmission from the hospital and also confirmed the resident needed continuous oxygen via the oxygen concentrator. Staff E was not sure why the resident was not ordered for oxygen use upon her admission and not until just this morning and was not sure why the resident was utilizing 4.5 lpm yesterday (9/17/2024), and the day before (9/16/2024). Staff E also confirmed Resident #206 had not been able, nor had the ability to adjust the oxygen flow rate on the oxygen concentrator. She confirmed there was no order for continuous oxygen use. Review of the medical record showed the Physician's Order Sheet dated 9/2024 did not indicate an order (routine or as need), related to oxygen use. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission/Readmission Nursing evaluation dated 9/11/2024, Section K, Alerts revealed devices to include oxygen use at 2 liters a minute. Section M, Information notes revealed; Resident was alert and oriented, able to make needs known. A review of the physician's order sheet dated 9/18/2024 showed a new order for oxygen use. The order read may have O2 at 2 lpm continuous. A review of the hospital discharge record and hospital discharge medication list dated 9/9/2024 did not show the use of oxygen or oxygen therapy. A review of the current care plans with a next review date 12/11/2024 did not reveal any type of oxygen therapy to include the use of continuous oxygen, with problem area, goals and interventions. On 9/19/2024 at 9:00 a.m., an interview with the Care Plan Coordinator revealed she was not that familiar with the resident and wanted to look her up on the electronic medical record system. The Care Plan Coordinator revealed she was not aware the resident was admitted and receiving continuous oxygen therapy since her admission. She said she would have developed a care plan for oxygen use had she identified an order for it. The Care Plan Coordinator confirmed the resident was not formally ordered continuous oxygen use until just yesterday (9/18/2024), which was seven days after she was admitted . The Care Plan Coordinator revealed she typically would develop a care plan problem area after it was identified within the next business day. She further confirmed that if the resident used and had been using continuous Oxygen therapy since her admission, it should have been first ordered and then brought to her attention so she could develop the problem area with goals and interventions. On 9/19/2024 at 12:10 p.m., an interview with the Director of Nursing revealed she was made aware Resident #206 was receiving oxygen therapy since her readmission to the nursing facility on 9/11/2024 and there was no physician's order in place. She revealed as part of process of admission/readmission, it was the responsibility of the admitting nurse to assess and obtain orders from the physician. She further confirmed she was not sure who admitted Resident #206, but confirmed the nurse should have obtained an order for use of oxygen. The Director of Nursing said Resident #206 should not have had a flow rate of 4.2 - 4.5 lpm during the days she had it running between 9/11/2024 and 9/18/2024. The Director of Nursing confirmed though Resident #206 was not appropriately ordered for the oxygen use, there should have been a base line care plan with a problem area and interventions with related to oxygen therapy. 50732 2. Review of the Admission Record for Resident #360 showed the resident was admitted to the facility with diagnoses which included acute respiratory failure with hypercapnia, acute respiratory distress, pneumonia, altered mental status. Review of Resident #360's Minimum Data Set Assessment (MDS) dated [DATE] showed Section C-Cognitive Patterns showed the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated severe cognitive impairment. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 3:45 p.m., Resident #360 was observed in her room sitting by the bed sleeping in her wheelchair. The resident was observed wearing a soft cervical collar and a bandage on her forehead. Resident #360 was receiving oxygen via a nasal cannula and an oxygen tank was observed on the back of her wheelchair. On 09/19/2024 at 8:35 a.m., Resident #360 was observed in bed sleeping. The resident was receiving oxygen via oxygen concentrator at bedside via nasal cannula at 2 liters per minute. 09/19/2024 10:20 a.m., Resident #360 was observed in bed sleeping. The resident was receiving oxygen via oxygen concentrator at bedside via nasal cannula at 2 liters per minute. 09/19/24 1:08 p.m., Resident #360 was observed in her room sitting up in bed eating lunch. The resident said she was hungry and was quickly eating lunch. She said she was feeling good, just a little sleepy today. The resident was receiving oxygen via oxygen concentrator at bedside via nasal cannula at 2 liters per minute. Review of Resident #360's current physician orders showed the resident had an order for continuous oxygen via nasal cannula at 2 liters per minute. Review of Resident #360's Care Plan dated 09/05/2024 revealed the resident did not have a baseline care plan for continuous oxygen use. On 9/19/2024 the Nursing Home Administrator provided the Baseline Care Plan policy and procedure with a revision date of 3/1/2023, for review. The Policy stated: The facility will develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The Policy Explanation and Compliance Guideline revealed; 1.The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician's orders. iii. Dietary orders. iv. Therapy services. v. Social services. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vi. PASRR recommendation, if applicable. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician's orders, and discussion with the resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii .Any special needs such as for IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format. 3. A supervising nurse shall within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. 5. A supervising nurse or MDS nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided by completion of the comprehensive care plan. 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record.

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, interview, and record review, the facility did not ensure services provided/arranged by an individual had the skills, experience, knowledge and licensure to perform tasks for one (#57) out of eight residents observed. Findings include: On 9/17/2024 at 8:15 a.m., an observation was made of an individual feeding Resident #57 in his high back wheelchair. An observation was made of the resident assisted by this individual to drink from a small plastic commercial bottle of apple juice without a straw. On 9/17/2024 at 10:14 a.m., an observation and interview were conducted in Resident#57's room with the individual sitting next to him. The individual sitting next to Resident #57 denied she was the resident's Certified Nursing Assistant (CNA) but a companion hired by the family. Resident #57's hired companion stated she would feed the resident in which the staff would provide the meal tray. The hired companion stated she would do incontinence care for the resident as well and stated the staff would bring her the supplies such as briefs and linen. The hired companion stated before she ended her shift, she would provide the resident with incontinence care by returning the resident to his bed. The hired companion stated the staff did not assist nor provide a lift to return the resident back to bed but she would lift the resident herself stating, he's light. The hired companion stated once the resident had been returned to his bed, she would provide incontinence care and reiterated the staff would bring briefs and linen. The hired companion denied CNA, feeding assistant or medical assistant licensure or status. On 9/17/2024 at 10:55 a.m., an observation and interview was conducted of Resident #57. Resident #57 was in bed covered in a blanket. The hired companion denied the staff returned the resident back to bed. The hired companion stated she got the resident back to bed. When asked if the hired companion lifted the resident back to his bed, she stated this time she was able to get the resident to stand stating, sometimes he can stand and take some steps with assistance. The hired companion stated the resident had a small bowel movement today but not enough to report to the staff. The hired companion stated she had at times talked to staff to inform them of events relevant during her stay with the resident. The hired companion stated she came every Tuesday, Friday and Sundays and had been doing this regularly for the past month. The hired companion stated she usually fed the resident breakfast once it was provided to her but would feed the resident lunch on Sundays because she started later every Sunday. On 9/17/2024 at 1:45 p.m., an interview was conducted with the hospice nurse assigned to Resident #57. The hospice nurse stated the resident was declining, and the family member had requested hospice to visit earlier than planned due to his decline. The hospice nurse stated an aide from hospice would come every Wednesday and Saturday to provide ADL care. On 9/17/2024 at 2:02 p.m., a request was made for the facility to provide an employee file for [hired companion.] (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2024 at 2:40 p.m., an interview was conducted with the Nursing Home Administrator (NHA), Director of Nursing (DON), the Assistant Director of Nursing (ADON), Regional Nursing Consultant, and Staff L, Licensed Practical Nurse (LPN)/ Supervisor for the east wing. The DON stated they were unable to locate an employee file for [hired companion] and the family had been contacted to verify the hiring of this companion. These individuals were not aware of the care provided by the hired companion related to feeding, transferring and providing incontinence care. Staff J, LPN/Supervisor for the north wing stated she knew of the companion but denied any observation of the hired companion transferring or providing incontinence care. Staff J stated she might see the hired companion feed the resident but nothing else. On 9/17/2024 at 2:55 p.m., an interview was conducted with Staff G, CNA and Staff I, CNA. Both stated they knew of the hired companion. Staff G, CNA stated prior to this current hired companion there was a man that would come be with Resident #57. Both stated the male hired companion would feed the resident as well. Staff G, CNA stated she transferred Resident #57 out of bed to his high-back wheelchair with two- person assist but could not state how the resident was returned to bed. A review of Resident #57's Admission Record showed an original admitted [DATE] with a readmitted [DATE]. Diagnoses include but were not limited to Parkinson's disease without dyskinesia, generalized anxiety disorder, unspecified dementia without behavioral, psychotic mood and anxiety disturbance, neurocognitive disorder with Lewy bodies, psychotic disorder with hallucinations due to known physiological condition, other seizures, dysphagia oropharyngeal phase, repeated falls, and cognitive communication deficit. A review of Resident #57's physician orders show an order dated 3/26/2024 for regular diet pureed texture, nectar consistency, fortified foods to all meals, NO STRAWS, scoop plate weighted utensils. An order for frozen nutritious treat two times a day for nutrition -document amount for lunch and dinner dated 01/09/2024. Hospice services for diagnosis of Parkinson's disease dated 9/06/2024. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #57's current care plan showed a Focus area of potential nutritional risk related to diagnosis history of Parkinson's disease with a goal to consume food and fluids to his comfort level through review. Interventions include but not limited to monitor and report to physician as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusal to eat, appears concerned during meals and monitor intake, record meal percentage. Resident #57 shows a Focus area of at risk for possible falls with injuries related to deficits in his cognition, dementia, impairment of vision and needs assistance with ambulation, locomotion, mobility, transfers, toileting, and incontinent care needs. The goal will be to minimize risk of falls and fall related injuries. Resident #57 has a Focus area of recent reduction in prior levels of mobility and at risk for possible further changes declines in present levels of mobility due to the amount of assistance that is presently required with mobility and transfer needs related to diagnosis of Parkinson's disease, diabetes, dementia, repeated falls, seizures, peripheral vascular disease, chronic kidney disease. He requires assistance with his ambulation, locomotion, mobility, transfers, toileting, and incontinent care needs. Current interventions include but are not limited to sit to stand substantial /Maximal assistance; chair bed to chair transfer: substantial /Maximal assistance. Resident #57 has a Focus area of swallowing problem related to dysphagia with a goal to have minimal risk of injury related to aspiration. Interventions include but are not limited to all staff to be informed of resident special dietary and safety needs alternate small bites and sips use a teaspoon for eating do not use straws check mouth after meal for pocketed food and debris report to nurse provide oral care to remove debris instruct the resident to eat in an upright position, to eat slowly and to chew each bite thoroughly, monitor for shortness of breath, choking, labored respirations, lung congestion ,monitor, document and report as needed any signs and symptoms of dysphasia. A review of Resident #57's Minimum Data Set Section C -Cognitive Patterns dated 8/26/2024 showed a Brief Interview for Mental Status score of nine which indicated moderate cognitive impairment. Section GG-Functional Abilities and Goals GG0130 Self-Care showed substantial/maximal assistance for eating. GG0170 Mobility showed dependent, two or more persons assist with chair/bed-to -chair transfer. On 9/19/2024 at 10:15 a.m., an interview was conducted with Staff J, LPN/Supervisor. Staff J stated she was not familiar with the hired companion for Resident #57 and under no circumstances was the resident to be assisted with feeding, transferring, and toileting by the hired companion. On 9/19/2024 at 1:01 p.m., an interview was conducted with Staff I, CNA. She stated she noticed the hired companion in Resident 57's room a month ago and inquired who she was. The hired companion stated she was hired by the family. Staff I stated she had observed the hired companion feeding the resident once with apple juice. She stated Resident #57 was on a regular pureed diet with thickened liquids. She stated she believed the hired companion had thickened the liquid. Staff I stated Resident 57's room would be closed by the companion during her visits. Staff I stated the hired companion never asked her for supplies such as briefs or linen. She stated Resident #57 would be transferred by a two-person assist because he could be unsteady on his feet. Staff I stated the hired companion never would communicate if the resident had a bowel movement. Staff I stated prior to the hired companion, there was a male companion who would escort the resident to the bathroom and communicate if the resident had a bowel movement. Staff I stated the male resident would bring Resident #57 outside for walks in his wheelchair and assist the resident during meals. Staff I stated she had assumed a staff member was getting the resident back to bed for the past month. Staff I assumed the hired companion was a private CNA. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/2024 at 1:02 p.m., an interview was conducted with Staff G, CNA. Staff G stated she did not know the name of the hired companion but noticed her a month ago. Staff G stated prior to this hired companion there was a male companion who assisted the resident to the bathroom for a bowel movement; and would let the staff know. Staff G stated the male companion was good about taking the resident outside for fresh air and sun but never witnessed him in providing direct care to the resident. Staff G stated the new hired companion would shut the door and never witnessed her taking the resident out of his room. Staff G stated the hired companion did not ask her for supplies. Staff G stated Resident #57 was on a pureed thickened fluid diet and a two-person transfer because he could be unsteady on his feet. Staff G stated she thought both hired companions were CNAs. On 9/19/2024 at 1:15 p.m., an interview was conducted with Staff F, LPN. Staff F stated the hired companion never communicated with her. Staff F stated she thought the facility knew about this hired companion because the family had a male companion prior to the current companion. Staff F could not state when the hired companion started because she was on medical leave. Staff F stated Resident #57 had an order for honey thickened liquids but could not state why the resident was observed drinking apple juice with the hired companion. Staff F stated the kitchen would provide commercial thickened liquid such as apple juice or the staff would thicken the liquid. On 9/19/2024 at 1:30 p.m., an observation was conducted with Staff F, LPN in Resident #57's room. Resident #57 had a small refrigerator with twenty-one bottles of small twist top bottles of commercial made apple juice, two bottles of orange juice, one water bottle, apple sauce and pudding [photographic evidence obtained]. The Regional [NAME] President immediately removed the bottles of juice and stated the family would be informed and educated on the resident's order for honey thickened liquid. The Regional [NAME] President stated the staff was responsible for thickening the resident's liquids. One bottle of apple juice was opened and half full. The Regional [NAME] President stated the bottle of liquid had a thickened appearance. On 9/19/2024 at 2:01 p.m., a telephone conversation was conducted with [hired companion]. The hired companion confirmed the days she would visit Resident #57 as every Tuesday, Friday and Sundays. The hired companion stated she has had multiple conversations with staff members and gave an example of one of her last conversations. The hired companion stated the resident's family member had asked her to ask the nurses the last three documented weights. The hired companion stated the staff in the nurses' station told her the resident's weight was 125 pounds on three separate dates. The hired companion stated she put thickened mix in the resident's apple juice. The hired companion stated the family member provided the packets of thickener which could be located in the resident's dresser drawer. The hired companion stated she assumed the staff wanted her to provide incontinence care because they would provide the briefs and linen every time she showed up at the facility for her two to three-hour duty. A review of the facility's guest sign in sheet showed the hired companion signed in on 9/17, 9/15, 9/13, 9/10, 9/06, 9/04, 8/30, 8/23, and 8/21. On 9/12/2024 family member signed in the facility's guest sign in sheet. On 9/12/2024 a weight was entered for Resident #57 of 112 pounds. A review of the facilities policy titled: Private Duty Aides, revised March 2021, shows a policy statement: The use of private duty aide are permitted when approved by the resident's attending physician and the facility's director of nursing services. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Residents desiring the use of private duty aides must first obtain written approval of the attending physician and the director of nursing services. 2. The director of nursing services consults with the administrator when private duty aides are requested 3. Private duty aides follow the facilities established nursing care policies and procedures and instructions issued by the nurse supervisor charge nurse. Private aides do not administer direct care to the resident unless authorized in writing by the attending physician. 4. 5. Private duty aides report to the nurse supervisor charge nurse when coming on and off duty. 6. Private duty aides are directed to report changes in a residence condition to the nurse supervisor charge nurse immediately

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48441 Based on observation, interview, and record review, the facility failed to ensure enteral feedings were provided according to physician orders for one (#67) of two residents observed. Findings include: On 9/16/2024 at 11:10 a.m., an observation was made of Resident #67's enteral feeding pump of the total volume infused at 22,525 milliliters (ml). Photographic evidence obtained. On 9/17/2024 at 9:30 a.m., an observation was made of Resident #67 out of her room with the enteral feeding hanging, bottle half empty and pumped turned off. Staff H, Licensed Practical Nurse (LPN) assigned to Resident #67 stated resident was out to dialysis. Staff H stated the resident was scheduled early for dialysis and left the facility between 5:00 a.m. to 6:00 a.m. On 9/17/2024 at 11:37 a.m., an observation was made of Resident #67 returning from dialysis and wheeled into her room by a staff member. On 9/17/2024 at 12:35 p.m., an observation was made in Resident #67's room. The enteral tube feedings had not been connected to the resident for enteral nourishment. Photographic evidence obtained. On 9/17/2024 at 2:37 p.m., an observation was made of Resident #67's enteral feedings connected to the resident and infusing at 55 ml/hour and a total volume infused at 22 milliliters. On 9/17/2024 at 12:57 p.m., an interview was conducted with Registered Dietician (RD). The RD stated she was familiar with Resident #67 and the challenges she has had nutritionally. The RD stated at one point Resident #67 was eating, despite having a feeding tube and doing well. The RD stated since her last hospitalization , she had been fully dependent on tube feedings. The RD stated Resident #67 was originally on Glucerna but switched to Nepro on 8/17/2024. The RD stated she would follow the labs from dialysis and stated she had a good coordination and communication with the dietician from the dialysis center. The RD stated potassium had been an ongoing issue but she normally ran on the low side but recalled an incident when it was elevated which was unusual for her. The RD stated today she was made aware of a low sodium from a previous lab chemistry drawn on 9/14/2024. The RD stated she would change the enteral feedings back to Glucerna and reduce the amount of free water the resident was receiving. The RD was made aware of the findings from initial observation of Resident 67's total volume infused at 22, 252 ml and stated she would be changing the order for the tube feedings so it would not be so confusing for the staff. A record review of Resident #67's Admission Record showed an original admitted [DATE] with a readmitted [DATE]. Diagnoses includes but were not limited to end stage renal disease, type two diabetes mellitus with ketoacidosis without coma, dysphagia oropharyngeal phase and gastrostomy. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #67's current physician orders showed a new order dated 9/17/2024 for enteral feed order: every shift for nutrition Glucerna 1.5 Cal at 80 ml/hour x 18 hours or until total volume 1440 ml infused in 24 hours. May turn off for care/services. Down at 8:00 a.m. Up at 2 p.m. Verify infusing every shift, clear pump when total volume has infused. A new physician order dated 9/17/2024 to flush gastrostomy tube with 60 ml of water every shift for hydration. On 9/18/2024 at 11:45 a.m., an interview was conducted with the Director of Nursing (DON). The DON provided a binder of the education for the nursing staff regarding competencies for providing resident care. Gastrostomy care was listed as a nursing competency where the nurse was checked off by demonstration. The DON was made aware of the initial observation for Resident 67's enteral feeding pump at 22, 252 total volumes infused. The DON stated education was needed. A review of the facility's policy and procedures titled, Appropriate Use of Feeding Tubes, revised 11/01/2022 shows the following policy statement: It is a policy of this facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status. Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary. . 5. c. Assessment of the resident's nutritional status, which may include usual food and fluid intake, pertinent laboratory values, appetite and usual weight and weight changes. Consideration of factors affecting appetite and intake, such as psychosocial factors or medications. 6. A resident who was fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal pharyngeal ulcers.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 48441 Based on observation, interview, and record review, the facility did not ensure the timeliness of reporting critical lab values for one (#67) out of eight residents sampled. Findings include: On 9/16/2024 at 11:10 a.m., an observation was made of Resident #67 in her room. Resident #67 was in bed, eyes closed with heavy breathing. Resident #67 did not wake up while interviewing her roommate. An unknown nursing staff member stated Resident #67 sleeps like that all the time. A review of Resident #67's medial record showed a critically low lab value dated 9/14/2024 for serum sodium of 127 millimoles per liter (mmol/L). A previous sodium level was from a lab drawn on 9/12/2024 with a sodium result of 132 mmol/L (normal 133-143 mmol/L). Photographic evidence obtained. On 9/17/2024 at 9:05 a.m., an interview was conducted with the Assistant Director of Nursing (ADON) regarding the low critical serum sodium level dated 9/14/2024. The ADON stated she would call the dialysis center to have them collect a specimen for a repeat lab for the resident's chemistry but stated the results might take a while. The ADON stated she would call the resident's physician to inform the physician of the results. On 9/17/2024 at 9:50 a.m., the ADON stated the physician was made aware of Resident #67's low serum sodium. The ADON stated she received orders from the physician for a STAT (Immediately) lab chemistry and a nephrology consult once the resident returned from dialysis today. On 09/19/24 at 10:13 a.m., an interview was conducted with Staff J, Licensed Practical Nurse (LPN /UM). Staff J stated she would take care of the labs ordered by physicians. Staff J stated the physicians were good about notifying her when labs were ordered. During the day, Staff J stated she would acknowledge orders from physicians but in the evening shift the nurse responsible for the resident would acknowledge the orders. Staff J stated the electronic chart would notify the nurse to confirm orders. Staff J stated the lab was connected to the facility's electronic medical record. The evening nurses would print the lab requisitions from the electronic chart to provide to the lab personnel to draw labs in the morning. Staff J stated results were available in the electronic medical records for all to see. Staff J stated the lab would call us for critical lab values and send us a fax. On 09/19/24 at 3:09 p.m., a telephone interview was conducted with Resident #67's physician. The resident's physician stated she received a call regarding the resident's low serum sodium two days ago but denied she received a call prior to the ADON's call. The physician stated she was aware of a low serum potassium of which the resident received an order for a potassium supplement. A review of the facility's policy and procedures titled Diagnostic Services revised 5/1/2024 shows an intent statement: it is the policy of the facility to provide diagnostic services in accordance with state and federal regulations. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for the quality and timeliness of the services. 2. The facility will provide or obtain laboratory services only when ordered by the attending physician. 3. The facility will promptly notify the residents attending physician of laboratory results to assure that appropriate action may be taken if indicated for the resident's care.

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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. 20536 Based on observation, interview, and record review, the facility failed to provide two (#206 and #54) of forty-four sampled residents with food items per their preference during one of three breakfast meal services observed. Findings included: 1. On 9/16/2024 at 10:00 a.m., Resident #206 was observed lying in bed, under the covers and with the head of the bed at approximately 45 degrees. She had an over the bed table placed in front of her with many personal items on it. During the visit, Resident #206 complained she was not receiving the correct diet and the food came to her cold, as well as she received things she did not like. On 9/17/2024 at 8:00 a.m., Resident #206 was observed in her room and seated upright in bed at 90 degrees. She was observed with her over the bed table placed in front of her with her breakfast tray on it, along with various other personal items. Her breakfast consisted of scrambled eggs, sausage, mashed potatoes, coffee, milk and water. The resident's meal ticket read she was to receive a Mechanical Soft CCHO [Controlled Carbohydrate] diet. Observation revealed she did receive the correct diet and texture. However, it was unknown why she received mashed potatoes. Photographic evidence obtained. The resident said she did not know why she received mashed potatoes and that she would eat them. She said she did not order them and she would in fact not eat mashed potatoes for breakfast, ever. She also revealed staff did not come in and go over her daily meal menu plan. She said she was sure she would receive tacos today and she did not like tacos. She revealed staff would have already gone over the menu choice today, but had not done so as of yet. On 9/17/2024 at 12:10 p.m., Resident #206 revealed she had not received her lunch tray. She confirmed that no staff members had come into her room today to ask her what she wanted for lunch, and she did not want what was on the menu as the primary meal. She said she did not eat tacos whether they were soft or hard. She said the spices did not agree with her. Resident #206 said she was not given the chance to change her order this morning and staff were not consistent with coming in the room every day to take meal service orders. On 9/17/2024 at 12:59 p.m., Resident #206 was served her lunch by Staff D, Certified Nursing Assistant (CNA). The meal consisted of a soft flour tortilla with ground meat and shredded cheese. A disposable cup was observed with a thick tomato chunky red salsa. Resident #206 revealed she would not be able to eat the tortilla as the texture would not agree with her. Staff D asked the resident if she wanted anything else and the resident could not decide. So, she had the aide take the soft taco back to the kitchen to chop up the meat and not bring a tortilla with it. However, Staff D brought back the same identical food items, only appeared to be reheated. Resident #206 stated again to the aide; I don't want tacos, I can't eat that, and I can't eat and swallow the tortilla. Review of the meal ticket revealed: Diet order: Mechanical Soft CCHO, 2000 ml fluid restriction, to receive ginger ale. Staff D confirmed she did not visit with the resident that morning to ask what she wanted for lunch. Staff D said whoever the resident was assigned to today, would have been the staff to ask her what she wanted for lunch. Staff D confirmed later in the day that Resident #206 did not eat the taco meat and tortilla, and revealed she did not want anything else. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105451	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Rehabilitation and Nursing Center	900 Beckett Way Tarpon Springs, FL 34689

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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	Review of the current Physician's Order Sheet for the month of 9/2024 revealed an order for a CCD (Consistent Carbohydrate) diet, Mechanical soft ground meats texture, Regular/thin consistency liquid and ground/chopped veggies, 2000 ml fluid restriction with a start date of 9/19/2024. Review of the current care plans with a next review date 12/11/2024 revealed the following problem areas, but not limited to: a. Has nutrition problem or potential nutrition r/t increased nutrient demand r/t skin impairment AEB (as evidenced by) need for healing of Pressure Ulcer. Nutritional risk r/t obesity, HF, diuretic therapy, on fluid restriction. Difficulties chewing and swallowing, with interventions in place to include: Administer medications as ordered. Observe and document for side effects and effectiveness, consult Speech Therapy as need, Fluid restriction, Observe signs and symptoms of dysphagia, pocketing and chocking, Provide supplements as ordered, Provide and serve diet as ordered, RD to evaluate and make diet change recommendations as need, Weigh per facility protocol. 2. On 9/17/2024 at 8:20 a.m. the 200 lounge/dining area was observed with Resident #54 seated at a table, while seated in her wheelchair and had her breakfast tray placed in front of her. She was finishing her meal and was able to eat without assistance. Resident #54 was interviewed and she revealed she was ok with the meal other than her untouched mashed potatoes. She was asked about her mashed potatoes and revealed she would not eat those for breakfast and did not order them. She was not sure why she received them and confirmed again she would not eat them, especially for breakfast. As Resident #54 was being interviewed, Staff D was observed to walk in the room to check on the resident. She sat down next to her and asked how she was doing. Resident said she was fine and thought she was done. Staff D was asked why Resident #206 had received mashed potatoes. She explained that when a resident was on a special diet CCHO, she was told that residents could not have hash browns so that seemed to be the replacement. Staff D said that residents who received mashed potatoes for breakfast, generally would not eat them. Review of the current Physician's Order Sheet dated for the month 9/2024 revealed orders for [nutritional shake] 2 times a day as a Supplement and a diet order for a Regular diet, pureed textured, regular thin consistency. On 9/17/2024 during the breakfast observation, from 8:10 am., through to 8:45 a.m., four additional random residents were observed who were all served mashed potatoes with their meal. Interviews with those four residents revealed they were interviewable and able to speak with relation to their daily care and services, and all who wished to remain as anonymous interviews. The four random and confidential resident interviews all revealed they had never had mashed potatoes for breakfast and would not eat them. They were not sure why they were served seasoned mashed potatoes for breakfast. It was observed when all four residents were finished with their meal, none ate the mashed potatoes. On 9/17/2024 at 11:00 a.m., an interview with the facility's Registered Dietitian revealed she reviewed the planned menu for each cycle and confirmed that today's (9/17/2024) primary breakfast meal was Cheesy Scrambled eggs, Cereal of choice, Hash browns, Milk, Coffee. She was asked if she knew mashed potatoes were served and if so, why did the kitchen served them to residents for breakfast. The Registered Dietitian revealed she was not aware of residents being served mashed potatoes but revealed there was hashbrowns. She revealed residents who were on a Mechanical Soft diet, would not be able to have the crunchy hashbrowns, and perhaps there was an alternate, but it should not have been mashed potatoes. She revealed she would follow up with the Dietary Manager. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/2024 at 8:45 a.m., the Registered Dietitian revealed she could not find out if the kitchen staff served mashed potatoes or not during the previous day's breakfast meal. She revealed it could have been hashbrowns that were processed to be more of a mechanical soft consistency. She was shown a photograph of what Residents #54 and #206 were served and she noted they did appear to look like mashed potatoes. On 9/18/2024 at 11:20 a.m., an interview with the Dietary Manager revealed he was not present on the line for breakfast meal service the day before on 9/17/2024, but overheard from the Registered Dietitian that possibly mashed potatoes were made and served. He could not be for certain if that happened or not as he had interviewed the previous day's cook and he could not get an answer if that happened or not. That cook was not present during this time on 9/18/2024 for interview. A review of the planned weekly menu revealed on 9/17/2024, breakfast consisted of Cheesy scrambled eggs, Cereal of choice, Hash browns and milk. There was no note of mashed potatoes to be served or offered. On 9/19/2024 the Nursing Home Administrator revealed the facility did not have a specific resident food preferences policy and procedure, but confirmed residents who did not want mashed potatoes for breakfast, should not have received them.