STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105466	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Beach Nursing Center	4405 Lakewood Road Lake Worth, FL 33461

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide housekeeping and maintenance services in a manner to provide a clean and sanitary environment in 20 of 62 rooms and in the common areas of the facility. The findings included:During an environmental tour of the facility conducted on 01/08/26 at 10:53 AM, with the Maintenance Director and the Maintenance Assistant, both from a sister facility, the following was observed: room [ROOM NUMBER] - the floor tiles were separating from the floor throughout the room. room [ROOM NUMBER] - the hand-washing sink in the restroom did not work, the floor tiles were not secure to the floor throughout the room, the ceiling was stained indicative of being wet at some point in time. room [ROOM NUMBER] - a portion of the wall in the bathroom where a dispenser was removed was not painted. room [ROOM NUMBER]- the hand-washing sink in the restroom did not work. room [ROOM NUMBER] - the wall behind the head of the door and window beds were damaged and in need of being painted, the bottom of the room entry door was chipped. room [ROOM NUMBER] - a portion of the wall in the bathroom where a dispenser was removed was not painted. room [ROOM NUMBER] - the wall behind the head of the head of the door bed was damaged and in need of being painted. room [ROOM NUMBER] - the rubber around the exterior of the over bed table for the door bed was missing exposing the particle board underneath. room [ROOM NUMBER] - the wall behind the head of the door bed was damaged and in need of being painted. room [ROOM NUMBER] - the wall behind the head of the window bed was in need of being painted. room [ROOM NUMBER] - the wall to the left of the door bed was damaged and in need of being painted and there were rub marks above the area that was in need of being painted. room [ROOM NUMBER] - The wall in the bathroom opposite the entrance was damaged an in need of being painted, the surface of the dresser was chipped on the bottom. room [ROOM NUMBER] - the exterior of the room door facing the corridor was chipped in several places. room [ROOM NUMBER] - the wall under the toilet paper dispenser was damaged and in need of being painted. room [ROOM NUMBER] - the inside of the restroom door was chipped, the covering on the wall was coming off of the wall at the left of the door in the bathroom, the ceiling throughout the room was stained in several places. room [ROOM NUMBER] - There was an accumulation of dust and a mold-like substance inside of the vent of the wall mounted air conditioning unit, there was an odor of mold noted in the room, the wall in the bathroom below the hand-washing sink counter and the toilet paper dispenser was damaged and in need of being painted. room [ROOM NUMBER] - a face plate that was installed behind the door was cracked creating a hole in the wall, an area of the ceiling/wall juncture was stained and separating indicative of being wet, there was an accumulation of debris inside of the wall mounted air conditioning unit. room [ROOM NUMBER] - the rubber around the edge of the over bed table of the window bed was missing exposing the particle board underneath. room [ROOM NUMBER] - the face plate over an outlet for cable was not secured to the wall leaving a hole in the wall. room [ROOM NUMBER] - the rubber around the edge of the over bed table of the door bed was missing exposing the particle board underneath, the ceiling tiles in the bathroom were stained indicative of being wet at some point, there was an accumulation of dust on the vent over the commode, there was a gouge in (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the wall at the baseboard to the resident's left side of the commode.room [ROOM NUMBER] - 1 of the 3 light bulbs was burnt out and another of the 3 light bulbs over the resident's bed and the toilet was not working properly. During an interview on 01/06/26 at 8:27 AM, Resident #59, with a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact, the resident stated she had to reach into the tank of the commode and pull the chain attached to the plunger to flush the toilet for about the last week. There was a ceiling tile that was stained, indicative of being wet at some point at the second-floor nurse's station. In the Acuities/Dining Room on the second floor, there were ceiling tiles that were stained indicative of being wet at some point and the wall at the right of the entrance was damaged and in need of being painted. The handrails throughout the second floor were separating in a manner that residents would be susceptible to skin tears. The exterior of the door to the Medical Records storage room was chipped. The door of the Shower room on the second floor was chipped. During this environmental tour of the facility, on 01/08/26 at 10:53 AM, with the Maintenance Director and the Maintenance Assistant, both from a sister facility, the Maintenance Director acknowledged the findings. The Maintenance Director confirmed that the facility had not had any maintenance staff, including a Director since the beginning of December 2025 and a Maintenance staff since the end of December 2025.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to prepare, store and serve food in a sanitary manner in accordance with standards for food safety professionals. The findings included:1. During the initial kitchen tour, on 01/05/26 at 9:07 AM, accompanied by the Certified Dietary Manager (CDM), the following were noted:a. The hand washing sink was not secured to the wall.b. There was an accumulation of residue on the exterior of the mechanical dishwashing machine.c. Cleaned and sanitized trays were wet nesting on the shelf in the dishwashing area.d. Staff F, Dietary Aide, was observed handling dirty and potentially contaminated wares with gloved hands. Staff F then proceeded to handle cleaned and sanitized wares as they came out of the machine with same gloved hands. The surveyor intervened and the Dietary Aide was instructed to remove the gloves and perform hand hygiene.e. The painted surface of the interior of the door of the ice machine was chipped.f. There was an accumulation of residue and debris on the shelf under the hot holding unit.g. There was an accumulation of debris behind the plate warmer.h. The surface of the wall behind the cooking equipment was damaged and peeling.i. The wall and frame around the window between the walk in cooler and the processing area was chipped and damaged.j. There was an accumulation of rust on an air conditioning vent over the processing area.k. There was an accumulation of ice from the cooling unit in the walk-in freezer. At the conclusion of the tour, the CDM acknowledged understanding of the concerns. 2. During a follow up visit to the kitchen, on 01/06/25 at 12:02 PM, a full sized six-inch-deep hotel pan containing bags of frozen mixed vegetables was observed on top of the convection oven. When asked about the observation, Staff G stated that the vegetables were frozen and were being thawed. The CDM acknowledged that placing foods at ambient room temperature was not a safe method for thawing food.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to address equipment repair of a malfunctioning bed in a timely manner for 1 of 22 sampled residents, failed to maintain a call light within reach for 1 of 22 sampled residents, and failed to maintain residents' items in an accessible manner for 1 of 22 sampled residents, Resident #3, Resident #46, and Resident #131. The findings included: 1. Record review revealed that Resident #3 was admitted on [DATE] with diagnoses to include: Acute Osteomyelitis, Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease, Chronic Embolism and Thrombosis, of Lower Extremity, and Non-Pressure Chronic Ulcers. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 14, indicating the resident had intact cognition. Review of Physician's Order dated 09/02/25 documented, Low Airloss mattress every shift for Check function q [every] shift. During an interview with Resident #3 on 01/06/26 at approximately 10:00 AM, it was observed that the resident was laying on an air mattress. He stated that the mattress did not have enough air and it tilted. It was observed that the resident was laying towards the left side of the bed. Resident #3 stated that he had reported it to a nurse during the middle of September 2025 and the Maintenance Department had come in to check it. The resident thought it was the frame of the bed, but the Maintenance Department told him it was the mattress and since it was a rental, they would contact the company and have them come and look at it. Resident #3 stated no one ever returned to repair the bed. Observation revealed a sticker at the foot of the bed which revealed the company information that included where the bed was rented from, a phone number and dates of '08/18/2023' and 'Reinspect Due Date of 08/17/2023'. Photographic Evidence Obtained. On 01/07/26 at 10:05 AM, an interview with the Interim Maintenance Director was conducted regarding the issues with Resident #3's bed. The Bed Rental Policy Contract, The Rental Agreement, and any invoices or maintenance paperwork were requested. The paperwork later provided by the facility was the delivery invoice dated 08/18/2023. Photographic Evidence Obtained. The Director checked the bed, returned and stated the resident preferred to lay on the left side of the bed because the over the bed table was on the right side where the resident kept his computer. He further stated that because the resident laid on the left side and is a large man, it caused the bed to deflate on that side. The Director also stated that he checked the mattress and it was even. On 01/07/26 at 11:47 AM, Resident #3 was revisited to discuss what the Director of Maintenance has stated about the bed. The resident insisted that the bed was not even and that he purposely had tried to lay on the other side of the bed and it still had leaned or tilted. On 01/07/26 at 3:34 PM, an interview with a supervisor from the company who had provided the air mattress and bed frame was conducted. The facility had provided the paperwork from when the bed was delivered on 08/18/23. The sticker on the bed was dated 8-18-23 and Reinspect Due Date 8-17-23. The supervisor confirmed that the year for the reinspection was incorrect and that it was recommended to reinspect the bed annually to keep it in good working order. She also explained that their equipment was rent-to-own and the facility had already most likely paid off the bed. Paperwork showing maintenance or reinspection of the bed was requested and the supervisor stated she would research it and send it to the Administrator. On 01/08/26 at 10:33 AM, Resident #3 was observed in a new bed. The resident stated that the bed (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was better inflated and now even. Observation revealed the resident laying in the center of the bed. On 01/08/26 at 2:48 PM, the supervisor of the bed rental company called and stated that Resident #3's bed was paid off after 188 days of rental and no requests for service were ever placed. She explained that maintenance of equipment was not automatic and had to be called in. 2. Record review revealed Resident #46 was admitted on [DATE] with diagnoses to include: Encephalopathy, Chronic Obstructive Pulmonary Disease, Depression, Congestive Heart Failure, Hypertension, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. Review of the Quarterly MDS assessment dated [DATE] documented a BIMS score of 09, indicating Resident #46 had moderate cognitive impairment. The MDS also indicated the resident was visually impaired. Further record review revealed a care plan with an approach initiated on 03/29/25 that documented, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an interview with Resident #46 on 01/05/26 at 11:41 AM, the resident was noted resting in bed. The resident's call light was not within his reach and hung over the wall call light panel. During the interview the resident requested to be repositioned. The surveyor activated the call light for the resident at 11:45 AM. Staff E, Certified Nursing Assistant (CNA), responded to the call light at 11:47 AM, repositioned the resident, turned off the call light, and left it hanging on the wall call light panel. On 01/05/26 at 3:38 PM, Resident #46 was observed in bed, and the call light was noted still hanging on the wall call light panel. Photographic Evidence Obtained. On 01/05/26 at 3:41 PM, Staff D, Registered Nurse (RN), was interviewed at the Nurse's Station and stated that Resident #46 was alert enough to use the call light. Staff D and the surveyor walked to the resident's room and the call light was observed still hanging on the wall call light panel. Staff D noted it was not within the resident's reach. 3. Review of the record revealed Resident #131 was initially admitted to the facility 10/28/25 and re-entered on 11/13/25 with a primary diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side. Review of the current MDS assessment dated [DATE] documented Resident #131 had a BIMS score of 06, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. This same MDS documented that Resident #131 had an impairment on one side of his upper extremities. Review of Resident #131's care plan revised 12/03/25 documented, The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t HTN, [related to Hypertension] Hemiparesis with Left sided weakness, Speech delays. muscle weakness. Review of the grievance log for 11/11/25 documented there had been a grievance for Resident #131 due to the staff not being attentive. During an interview on 01/05/26 at 1:40 PM, with the Resident 113's representative, she, when asked how the care was, stated the care was not good here and she couldn't wait to get him out. She said the resident had a stroke which had affected the mobility and function of the left side of his body and (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left him cognitively impaired. She voiced every time she came in to visit him all his belongings such as the call light and bedside table were on his affected side (left.) She expressed it was very frustrating because she had talked to the Director Of Nursing (DON) many times and it was addressed in the moment but as soon as she left, things were back to how they were before. She stated she always had to come in and check on him after work since she works close by. An observation was made of the call bell hanging on the left side by the resident's bed. During an observation on 01/06/26 at 1:45 PM, the call light and positioning remote were seen hanging from the left side of Resident #131's bed. During an interview on 01/07/26 at 2:07 PM, the Assistant Director of Nursing (ADON) was made aware of the concerns that Resident #131's representative had and she agreed that his belonging should be placed on his dominant side and stated she would talk to staff to address it. On 01/08/26 at 8:16 AM, the surveyor received a phone call from Resident #131's representative who stated she had visited Resident #131 yesterday (01/07/26) and repeated that his belongings and the bedside table were on his left side. She also mentioned that the resident's door was closed as his roommate's family were visiting. When she entered the room after knocking very loudly, she observed Resident #131 leaning towards his right side. She stated she was very upset to see that as he could have fallen and no one could watch him with the door closed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assess residents accurately and in a timely manner for a change in status for 1 of 1 sampled resident, Resident #5. The findings included:Record review revealed Resident #5 was last readmitted on [DATE] with diagnoses to include: Chronic Obstructive Pulmonary Disease, Emphysema, Muscle Wasting and Atrophy, Anxiety, and Dementia. Review of the resident's most recent Minimum Data Set (MDS) assessment, a Significant Change, dated 11/10/25, revealed the Brief Interview of Mental Status (BIMS) score was 13, on a scale of 0 to 15, indicating Resident #5 had intact cognition. The MDS also indicated the resident was receiving Hospice services. Further review of the resident's record revealed a physician's order documenting the resident was admitted to Hospice on 11/03/25 and a Do Not Resuscitate (DNR) form was signed on 11/04/25 by the resident. Photographic Evidence Obtained. Record review revealed a quarterly Social Services assessment, identified as a late entry, Created 12/17/2025, and Effective 11/26/2025, that did not indicate the resident was under Hospice services, and indicated that the Resident was to remain a Full Code. Photographic Evidence Obtained. On 01/07/26 at approximately 1:00 PM, an interview was conducted with the Regional MDS Nurse Coordinator. She stated that there had been no MDS Coordinator for the last two weeks and she was filling in. During the interview, she stated that the Social Worker's assessments must be completed by the Resident's Assessment Reference Date (ARD). On 01/07/26 at 1:48 PM, the Social Services Director who had been employed by the facility for two and a half years, was interviewed. She stated that she is informed of upcoming MDS's and Significant Changes, during the daily Clinicals Meeting. She stated that Social Services assessments were completed before each ARD date. Resident #5 had an assessment with an ARD date of 11/10/25 and the Social Services assessment was created on 12/17/25 which was over a month later. The discrepancies found in the assessment were discussed with the Social Services Director who could not provide an explanation and stated that she would discuss the issue with her Assistant who had completed the assessment. On 01/07/26 at 3:46 PM, an interview was conducted with the Social Services Director's Assistant, who had been employed by the facility for approximately 10 months. When asked about the discrepancies found in Resident #5's assessment, he stated that they were all mistakes. No further explanation was provided.

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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** Based on observation, interview and record review, the facility failed to timely administer PRN (as needed) pain medication to a resident with voiced pain for 1 of 1 sampled resident, reviewed for pain management, Resident #139.The findings included:Review of the facility's policy titled, Policy and Procedure: Clinical- Medication Administration. Purpose: To administer medications as per provider's orders and in accordance with regulatory guidelines and practice standards. Administration Time: Medication are to be administered within 1 hour of the scheduled administration time, unless the resident is on a liberalized med administration program.Review of the record revealed Resident #139 was initially admitted to the facility 11/18/25 and re-entered 12/09/25 with a primary diagnosis of Displaced Fracture of Olecranon Process without Intraarticular Extension of the Left Ulna (Fracture of Left Elbow). Other diagnoses included multiple fractures of her neck and back area. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #139 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact.Review of Resident #139's care plan revised 12/16/25 documented Focus: [Resident #139] is at risk for pain related to status post fall at home with left elbow fracture, T6/10/12 & L 1/2 compression fractures. Goal: [Resident #139] will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions / Tasks: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; Monitor / document for probable cause of each pain episode. Remove / limit causes where possible; Monitor / record / report to Nurse resident complaints of pain or requests for pain treatment; Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx [signs and symptoms] or c/o [complaint of] pain or discomfort.Review of Resident #139's active orders revealed a PRN (as needed) order for Oxycodone-Acetaminophen Oral Tablet 10-325 MG, Give 1 tablet by mouth every 4 hours as needed for pain.Review of the Resident #139's January's MAR/TAR (Medication Administration Record / Treatment Administration Record) for Oxycodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth every 4 hours as needed for pain documents as follows:On 01/01/26 at 9:10 AM for a pain level of 9; 1:34PM for a pain level of 8; 6:10 PM for a pain level of 8.On 01/02/26 at 3:00 AM for a pain level of 7; 10:03 AM for a pain level of 6; 2:44 PM for a pain level of 6; 8:54 pm for a pain level of 8.On 01/03/26 at 3:47AM for pain level of 7; 10:12 AM for a pain level of 7; 3:44PM for a pain level of 7; 8:05 PM for pain level of 6.On 01/04/26 at 5:10AM for a pain level of 7; 10:49 AM for a pain level 5; 3:43 PM for a pain level 5.On 01/05/26 at 2:40 AM for a pain level of 7; 9:11AM for a pain level of 7; 2:28 P for a pain level of 7; 6:30 PM for a pain level of 7; 10:35 PM for a pain level of 6.On 01/06/26 at 4:10 AM for pain level of 6; 8:19 AM for a pain level of 6; 1:22 PM for a pain level 7; 5:57 PM for a pain level of 6.On 01/07/26 at 12:30 AM for a pain level of 8; 7:40 AM for a pain level of 6; 12:46 PM for a pain level of 7.During an interview on 01/05/26 at 11:52 AM, Resident #139 was observed wearing a left arm sling and her arm was wrapped with an elastic bandage. When asked how her care was Resident #139 stated she had been in and out of the facility and hospital since November due to falling into a drained pool where she broke her left arm. She stated, I don't know if they are busy and forget or get sidetracked, but I have to wait a really long to get my pain medication especially during the night. Resident #139 stated she would feel throbbing pain on her arm sometimes. She stated, When I ask for my pain medication they say they don't have the keys yet or that it's too early especially during shift change. It has gotten to the point where I've had to start tracking times on my own. I will write down the time they gave it to me and add ten minutes to give them time to document it, and I've noticed long lapses of time. Resident #139 stated the times she misses her as needed dose ranges from a couple of hours up to 12 hours at a time. Resident #139 showed the surveyor her recorded times along with a picture of an x-ray to show the severity of her broken arm. She stated, I really am in pain, I don't want to get anyone in trouble, but I (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	am in pain. During an interview on 01/07/26 at 2:07 PM, a side-by-side chart review was conducted with the ADON (Assistant Director of Nursing) where January's MAR/TAR was reviewed for PRN administration of Oxycodone-Acetaminophen. The ADON identified the lapses of administration with the surveyor and agreed it should have been administered timely if Resident #139 was voicing pain. During a follow up interview on 01/7/26 at 2:40 PM, Resident #139 stated it was mostly night shift who didn't provide her with her pain medication timely and stated the past night she overheard her night shift nurse complaining that all her residents were on pain medication. Resident #139 stated it wasn't her issue if all the residents were on pain medications, but it also made her feel better that she wasn't the only one asking for it. During an interview on 01/08/26 at 11:15 AM, Resident #139 stated although she was going home tomorrow, she was happy her night was good and finally got her pain medication on time. She stated she didn't want other residents going through what she went through and thanked the surveyor for the help.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record review, the facility failed to accurately document the narcotic medication dispended, administered or disposed of for 3 of 4 sampled residents reviewed for Narcotic Medication Storage, Residents #25, #33 and #58. The findings included: Review of the facility's policy titled, Clinical-Narcotic Count/Disposal, dated 12/08/25, included the following: Procedure: 5. When a schedule II medication is administered, the licensed nurse will complete an entry on the count sheet indicating the date and time of administration, amount administered, amount remaining and signature. 6. If a dose of schedule II narcotics is removed from the container but refused by the resident or not given for any reason, it will be destroyed in the presence of 2nd licensed nurses. This disposal will be documented on the count sheet. 1. Medication storage review was conducted on 01/08/26 at 12:05 PM, of the North Cart on the second floor with another nurse surveyor present. Two residents were selected for review of narcotics. Staff B, Registered Nurse (RN), was asked to show the Oxycodone 5-325mg tablet that was prescribed for Resident #25. She removed the medication from the locked narcotic box and there were 13 pills in the packet. The controlled medication utilization record for Resident # 25 revealed that there were 13 Oxycodone 5-325mg tablets remaining. During a side-by-side comparison of the narcotic sheet and the electronic medication administration record (MAR), there were no electronic entries for the medication signed out on 01/08/26 at 02:30 AM and 01/04/26 at 12:29 PM. Staff B, RN and Director Of Nursing (DON) were present and agreed that there were no entries made on the electronic record for these two removals. 2. On the same medication storage review conducted on 01/08/26 at 12:05 PM, of the North Cart on the second floor, Staff B, RN was asked to show the Oxycodone 10mg tablet that was prescribed for Resident #33. She removed the medication from the locked narcotic box and there were 4 pills remaining in the packet. The controlled medication utilization record for Resident #33 revealed that there were 4 Oxycodone 10 mg tablets remaining. During a side-by-side comparison of the narcotic sheet and the electronic MAR, the orders on the pill pack stated that the medication can be administered every 8 hours as needed but the MAR stated that the medication can be administered three times per day, AD LIB. The time stamp for the MAR was requested to compare with the entries made on the narcotic sheet. A review of the administration timestamp in the MAR was conducted with a side-by-side review with the Unit Manager (UM) on the first floor. The dose that was administered on 01/07/26 at 9:36 PM (2136 hours) was given 6 hours after the dose administered on 01/07/26 at 15:27 PM instead of after 8 hours. 3. A second medication storage review was conducted on 01/08/26 at 12:41 PM, of the South Cart on the first floor, with another nurse surveyor present. One resident was selected for review of narcotics. Staff C, Registered Nurse (RN) was asked to show the Tramadol HCL 50 mg tablet that was prescribed for Resident #58. She removed the medication from the locked narcotic box and there were 19 pills in the packet. The controlled medication utilization record for Resident # 58 revealed that there were 19 Tramadol HCL 50 mg tablets remaining. During a side-by-side review of the narcotic sheet, line 5 of the document was incomplete. It did not have a date or time entered. There was documentation in the column amount given as one. There were 2 initials in the initial if error column. The DON who was present during the review and agreed that the entry on line five did not include a date or time. The DON was unable to confirm if the signatures on the bottom of the sheet for Narcotic Waste/Spillage were correlated to the initials on line five with the missing date and time. Both surveyors listened while Staff D, RN, was called via speaker phone from the DON's office on 01/08/26 at 1:19 PM regarding the narcotic documentation for Resident #58. Staff D stated that when he noticed that the pill was open, he did not want to put tape on the back, so it was wasted with another nurse working that day. Staff D did not remember who co-signed the waste. The DON called Staff L, RN, on 01/08/26 at 1:45PM. Both surveyors listened via speaker phone. Staff L, RN stated, the pill was loose, whenever that happens, we waste it. When asked if she remembered when this took place, she said no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105466	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Beach Nursing Center	4405 Lakewood Road Lake Worth, FL 33461

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to appropriately label and store drugs in accordance with currently accepted professional principles for 1 of 3 sampled residents for medication administration observation, Resident #16. The findings included: Review of the policy, titled, 5.0 Medication Storage, documented, Policy: Medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with FL Department of Health guidelines. Procedure. C. Medications will be stored in the original, labeled containers received from pharmacy.Review of the record revealed Resident #16 was initially admitted to the facility 03/22/21 and had a re-entry date of 10/19/22 with the primary diagnosis of Parkinsonism. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment.Review of Resident #16's care plan dated 12/08/25 documented, Resident #16 is on anticonvulsant medication due to DM [Diabetes Mellitus] Neuropathic Pain. Administer anticonvulsant medications as ordered by physician.Review of the current orders documented, Gabapentin Oral Capsule Give 100 mg orally three times a day - 1 capsule by mouth three times daily for diabetes mellitus neuropathy pain, dated 05/17/25.A medication administration observation was conducted for Resident #16 on 01/07/26 at 9:34 AM with Staff A, RN (Registered Nurse), where Staff A was observed dispensing the resident's morning medications. Upon the medications being dispensed, Staff A stated she was dispensing Gabapentin 100 mg and proceeded to pop one capsule into the medication cup. Staff A then handed the surveyor the medication card, the medication card read as followed, Gabapentin Cap 100 mg; 3 Caps (300MG) by mouth twice daily for neuropathy. There was no resident name noted on the medication card and it appeared to have been ripped off. Photographic Evidence Obtained.A reconciliation count was made where Staff A was asked to count the total amount of pills she had in her medication cup; Staff A stated her total number of pills was 9 and the surveyors count was 11 per the medication card's doses. Staff A was asked to review the Gabapentin medication card, upon her review Staff A stated oh it should be 3 capsules and popped 2 extra pills into her medication cup. When asked how she knew the medication card belonged to Resident #16 if there was no Resident name on it, she looked at the medication card and then went through additional medication cards she had for Resident #16 where a second medication package was also found to read Gabapentin Cap 100 mg; 3 Caps (300MG) by mouth twice daily for neuropathy. This medication pack was also missing the Resident name on it. Upon further review, Staff A looked at her orders for Resident #16 which stated, Gabapentin Oral Capsule give 100 mg orally three times a day - 1 capsule by mouth. Staff A realized these medication cards did not belong to Resident #16 and stated she was going to take the medication cards to back order. When asked why she was using medication cards with no resident label, Staff A was not able to answer. She agreed the importance of reading the medication cards prior to dispensing medication and stated she would send it back to pharmacy.On 01/07/26 at 10:15 AM, during a side-by-side review of the medication administration findings, the Director of Nursing (DON) agreed with the findings and stated the medication cards would be sent back to pharmacy to be labeled appropriately.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the approved recipe for the desserts that were served for lunch on 01/06/26 and 01/07/26. The findings included: 1. Review of the approved menu documented the residents were to be served a Cinnamon [NAME] Sugar Blondie for dessert for lunch on 01/06/26. During an observation of the lunch meal, on 01/06/26 beginning at 11:37 AM, it was noted that many of the residents, including Residents #3, #120, #122, and #163, were served what appeared to be a serving of chocolate pudding. The residents' tray tickets that accompanied the meal documented that they were to be served 'Vanilla Pudding Parfait'. The approved recipe for 'Fortified Pudding Parfait' documented: Garnish with whipped topping; and may use any flavor of pudding. During an interview, on 01/06/26 at approximately 12:30 PM, with the Certified Dietary Manager (CDM) when asked about the dessert, the CDM stated the pudding was for residents with orders for fortified foods. During the interview, the CDM acknowledged that the pudding that was served was not the correct 'Vanilla Pudding Parfait' as it was not vanilla and did not have any garnish. 2. Review of the approved menu for the lunch meal on 01/07/25 documented that the residents were to be served 'Marble Cake with [NAME] Frosting'. The approved recipe for the 'Marble Cake with [NAME] Frosting included the following instructions: 1. Combine chocolate cake mix and water. 2. Combine white cake mix and water. 3. Pour both cake batters into greased and floured half sheet pans. Gently mix batters together to make large swirls in the batter. 4. Bake in the oven at 350 degrees. 5. Spread frosting evenly on cooled cake. During the follow up kitchen tour, on 01/07/26 at 11:16 AM, it was noted that the kitchen staff had prepared what appeared to be a yellow cake with a dollop of white frosting and a swirl of chocolate syrup on top. When the CDM was asked about the marble cake, the CDM voiced the details of the recipe for the marble cake and acknowledged that the cake that was prepared and being served was not a marble cake. The CDM acknowledged that the yellow cake that was being served and the marble cake that was supposed to be served had entirely different flavors. 3. Record review revealed Resident #3 was admitted on [DATE] with diagnoses that included: Acute (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Osteomyelitis, Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease, Chronic Embolism and Thrombosis, of Lower Extremity, and Non-Pressure Chronic Ulcers. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 14, on a scale of 0 to 15, indicating intact cognition. Review of the physician orders documented Resident #3 had a Diet Order dated 08/21/25 for CCD (Controlled Carbohydrate Diet) NAS (No Added Salt) diet, Regular texture, Regular/Thin Liquids consistency. During an interview with Resident #3 on 01/06/26 at approximately 10:00 AM, the resident stated the Dietary Staff were not following what was on the meal tickets. On 01/06/26 at 12:08 PM, during a meal observation in Resident #3's room, it was observed that the resident's tray ticket specified Vanilla Pudding Parfait. The resident had Chocolate Pudding. Photographic Evidence Obtained.

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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** Based on observations, interviews, and record review, the facility failed to provide food that avoids allergens for 1 of 6 sampled residents, Residents #103, and the facility failed to provide food according to residents' preferences for 1 of 6 sampled residents, Residents #3. The findings included: 1. Record review revealed Resident #103 was readmitted on [DATE] with diagnoses to include: Cerebral Infarction, Cerebral Atherosclerosis, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Seizures, Depression, Hypertension, and Hypothyroidism. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 02, on a scale of 0 to 15, indicating Resident #103 had severe cognitive impairment. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 06/12/23 indicated under allergies, Gluten. Photographic Evidence Obtained. As per the Diet History and Food Preference document dated 10/17/25, under Food Allergies/Intolerances, it documented, GLUTEN no bread. Photographic Evidence Obtained. On 01/05/26 at 11:57 AM, during a dining room observation, it was noted that Resident #103's tray ticket had in large, bold Allergies: flour. The lunch tray was observed with Chicken Pot Pie. An attempt was made to interview the resident regarding the allergy, but the resident was unable to respond appropriately due to her poor cognition. Photographic Evidence Obtained. On 01/06/26 at 12:12 PM, Resident #103's lunch tray was observed with Egg Noodles and Ground Swedish Meatballs. She had consumed all the meatballs. Photographic Evidence Obtained. On 01/06/25 at 12:48 PM, the Certified Dietary Manager (CDM) provided the ingredients for the Meatballs and Noodles. Both contained flour. Photographic Evidence Obtained. The CDM stated that he did not have any Gluten Free items. The Pot Pie Filling recipe was also provided, and it contained flour. Photographic Evidence Obtained. On 01/06/26 at approximately 1:00 PM, an interview was conducted with the Registered Dietitian (RD) regarding Resident #103's allergy to gluten. The RD stated the resident's representative had provided dietary preferences since the resident was unable to and the resident did not get bread on meal trays. On 01/06/26 at 1:06 PM, a phone call was placed to Resident #103's representative who stated that he had never asked for the resident to be on a Gluten Free Diet. On 01/07/26 at 11:53 AM, Resident #103's lunch tray was observed with an Open-Faced Sandwich on Bread and Marble Cake for dessert. The Tray Ticket no longer indicated the resident was allergic to flour. Photographic Evidence Obtained. On 01/08/26 at 11:42 AM, an Advanced Practice Registered Nurse (APRN) progress note with an effective date of 01/07/26 was observed with, Patient stated has been taken Gluten without reaction. Allergy resolved per patient. Photographic Evidence Obtained. On 01/08/26 at 11:45 AM, a RD note, effective 01/06/26, documented, RD did discuss with Nursing attaining an allergy test, as feasible to ensure [resident] has No true allergy for her overall health and avoiding any negative reactions to food provided to her. will monitor and review per policy. Photographic Evidence Obtained. On 01/08/2026 at 04:20 PM the RD was interviewed over the phone. The RD stated that she had not removed the allergy from the meal tickets and that Nursing had removed it. The RD stated that she had spoken with the Director of Nursing (DON) about the allergy. The RD called back a few minutes later and stated that she had again spoken with the DON who stated that Resident #103's APRN had been contacted and had advised to remove the allergy. On 01/08/26 at 5:12 PM, an interview was conducted with the Director of Nursing (DON) who was made aware of the progress note written by the APRN stating that the resident reported not having an allergy to gluten. When reminded that Resident #103's last BIMS score was 02, the DON made no comment. 2. Record review revealed Resident #3 was admitted on [DATE] with diagnoses to include: Acute Osteomyelitis, Diabetes, Hypertension, Hyperlipidemia, Chronic Kidney Disease, Chronic Embolism and Thrombosis, of Lower Extremity, and Non-Pressure Chronic Ulcers. Review of the quarterly MDS assessment dated [DATE], documented a BIMS score of 14, on (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a scale of 0 to 15, indicating Resident #3 had intact cognition. Review of Resident #3's physician diet order dated 08/21/25, CCD (Controlled Carbohydrate Diet) NAS (No Added Salt) diet, Regular texture, Regular/Thin Liquids consistency. During an interview with Resident #3 on 01/06/26 at approximately 10:00 AM, the resident stated that the Dietary Staff were not following what was on the meal tickets. On 01/06/26 at 12:08 PM, during a meal observation in Resident #3's room, it was observed that the resident's lunch tray ticket specified Vanilla Pudding Parfait and Lemon Butter Baked Fish Fillet. The resident had Swedish Meat Balls and Chocolate Pudding. The resident stated that he did not care for the meatballs and declined asking for another food item. Photographic evidence was obtained.