STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105474	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Beach Care Center	1310 37th St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 33103 Based on record review and interview, the facility failed to honor resident's choice to sleep in and utilize a reclining chair for 1 of 7 reviewed for choices, Resident #138. The findings included: Review of Resident #138 medical records revealed the resident had multiple admissions with the latest admission on 08/07/24. He has diagnoses that included Lymphedema, Chronic Systolic Congestive Heart Failure, Venous Insufficiency, Chronic Kidney Disease, Anxiety Disorder, Depression, Dyspnea, and Severe Morbid Obesity. His MDS (Minimum Data Set) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicting cognition is intact. Review of the physician Progress Notes on 09/12/24, with a service date of 09/10/24, revealed the physician documented the resident is not being compliant with elevating his legs during the day, but he is wearing compressive ACE wraps. He documented he has given up on trying to get a recliner chair for his room which would assist in elevating his legs. He was trying to work with social services to get it done without success. He documented the resident's legs still hurt, as does his right neck. Review of a physician Progress Note dated 09/06/24 documented the resident is receiving furosemide (Lasix) 40mg BID (twice a day). The Note documented no significant improvement in his lower extremity swelling, and that the lower legs are uncomfortable, but he continues to spend a lot of the day in his wheelchair without the legs elevated. The Note documented he (the resident) is still working on getting a recliner chair paid for his room so that he can better elevate his legs. Review of the physician Progress Note dated 08/22/24 documented that he has been advised to elevate legs as much as possible. Review of Resident #138's care plan dated 08/08/24 with a revision dated 09/11/24 documented Resident #138 has an ADL [Activity of daily Living] self-care deficit related to ADL needs and participation vary, and resident has recliner in room to assist with sleeping and mobility. Another care plan was added on 09/12/24 that Resident #138 has a preference to sleep in the recliner and able to get into bed for ADL care, and able to reposition himself. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Vero Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 37th St Vero Beach, FL 32960	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 7:40 AM, Resident#138 came up to the surveyor and stated he has been requesting a recliner since the day he came in on 08/07/24. He had spoke to the Administrator yesterday and they said they would get one to him. He stated that he has CHF (Congestive Heart Failure) and needs to elevate his legs and usually sleeps in a recliner. During an interview on 09/10/24 at 2:55 PM with Director of Nursing (DON), she stated that we don't have recliners in this building, and the resident told us he was going to purchase one. During an interview on 09/10/24 at 2:58 PM with the Administrator, she stated she found out about it yesterday, but he had told them he was going to purchase a recliner from [name of store]. She stated they told him he needed a credit card, and he only has a debit card, and families will usually purchase for the resident. On 09/10/24 at 3:00 PM, the surveyor spoke with resident. He stated that he can't get a chair from [name of store] because you have to have 2 forms of credit and debit card, and he doesn't. He stated he wanted to rent one not buy one. He stated that the facility won't let him bring one in as it has to be a certain dimension. On 09/11/24, the Social Service Director came to surveyor and stated the resident sat with the Administrator and her who called [name of store] and was able to get them to order a chair for him, but they were out of them and do not know when they would be in. On 09/11/24 in the afternoon, the surveyor observed a staff member bring Resident #138 a leather reclining chair, which was torn on the back of the chair. The resident stated this is good until [name of store] can bring one. On 09/13/24, the resident saw surveyor and stated, look at my legs, they have come down immensely since I have been able to keep my legs raised. During an interview on 09/13/24 at 11:15 AM with the Social Service Director (SSD), she stated that this resident has applied for Medicaid, He had an insurance and was able to get him on Medicare so that he can stay in the facility for skilled services. The SSD stated the resident had no money and when he was asking for a chair he was asked why don't you wait to get on Medicare. The SSD stated she didn't do anything with the chairs, that would be rehab or the administrator and that she only arranges Durable Medical Equipment for discharged residents. During an interview on 09/13/24 at 11:55 AM with the Rehab Director, she was asked about Resident #138 wanting a recliner. She stated that about a week or so ago he mentioned about wanting and needing a recliner because he couldn't sleep in his bed. She stated he was responsible to get his own recliner, as we don't do that. The SSD stated the Administrator would be the one as well to assist him. He said that he reached out to [name of store] but they won't take debit cards. The SSD stated it was not a therapy issue, and they wouldn't recommend or order one. During an interview on 09/13/24 at 12:05 PM with Staff Q, Maintenance Assistant, he said I overheard someone talking about a resident needed a reclining chair but wasn't sure who it was. He stated Resident #138 had a reclining chair when he was on the rehab unit, during a different admission but he did not like it, but he had found one in the maintenance area in good shape, so he had brought it to the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Beach Care Center	1310 37th St Vero Beach, FL 32960

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/13/24 at 12:10 PM with the Administrator, she stated he came to me Monday (09/09/24) but didn't ask for a reclining chair as he said he arranged for one from [name of store]) but they don't take debit cards. On Tuesday 09/10/24), he came to the office, and we went to social service office and called the store. They said they take debit cards but don't have any chairs in stock. They are ordering some. The surveyor asked the Administrator if she ordered one for him and she stated they don't do that no, they wouldn't do that. When asked if they put the resident on a list to to be called when one came in, she said 'no, I have to keep calling them'. On 09/13/24 1:15 PM, the Social Service Director brought in a fax from [store name] that documented the [name of store] currently have rentals available. On the fax, it documented that when Resident #138 reached out to them last week they did not have any. During an interview on 09/13/24 at 4:00 PM with sales representative from [name of store], she stated that they have reclining chairs in the store to rent out. She was asked if they were out of one at that time, could they order one or go on a wait list and be notified when it came in, and she said absolutely. When asked if they had one reserved for Resident #138. She stated 'no'. When aske if the accept debit cards, she stated they do accept them.

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 38893 Based on interviews and record reviews, the facility failed to promptly act on and resolve grievances voiced by residents and the Resident Council, for 8 of the residents interviewed, including Residents #113, #85, #143, #13, #122, #27, #95, and #60. Four of 4 residents in the Resident Council meeeting voiced food concerns that included Residents #85, #113, #116 and #135. The census at the time of the survey was 146. The findings included: Record review of Resident #113's most recent Minimum Data Set (MDS) assessment documented Resident #113, with a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. An interview was conducted on 09/09/24 at 10:17 AM with Resident #113, the Resident Council President, who when asked of any grievances that had not been resolved by the facility, replied that grievances related to food were ongoing and had not been resolved. During the interview, Resident #113 granted permission to this Surveyor to review Resident Council Meeting Minutes and Food Committee Meeting minutes. Record review of Resident #85's most recent Minimum Data Set (MDS) assessment documented Resident #85 with a BIMS score of 15, indicating the resident was cognitively intact. An interview was conducted with Resident #85 on 09/09/24 at 11:04 AM, who when asked about the food being served to the residents in the facility, Resident #85 replied, so-so, I eat out a lot or eat from my fridge. The menu is repetitive. Record review of Resident #143's most recent Minimum Data Set (MDS) assessment documented Resident #143 with a BIMS score of 15, indicating the resident was cognitively intact. An interview was conducted with Resident #143 on 09/09/24 at 11:27 AM, with Resident #143, who when asked about the food served to the residents in the facility, Resident #143 described the food as the worst she has ever tasted, its institutional food, I don't know where they get their idea of food, lunch and dinner is no good. Resident #143 further stated that sometimes she looks at the food and she just can't eat it. Record review of Resident #13's most recent Minimum Data Set (MDS) assessment documented Resident #13 with a BIMS score of 15, indicating the resident was cognitively intact. An interview was conducted with Resident #13 on 09/09/24 at 11:33 AM, who when asked about the food served in the facility, Resident #13 stated that she wished the food was better than what it is now, the hamburger doesn't taste like hamburger, pasta is not cooked well, vegetables are not done enough, the vegetables are hard to eat. Some of the food is too spicy. The bacon is too greasy. The sausage is spicy. Resident #13 further stated that she feels there should be better food quality and that she had reported the concerns to the Dietary Manager 'all of the time'. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #122's most recent Minimum Data Set (MDS) assessment documented Resident #122 with a BIMS score of 14, indicating the resident was cognitively intact. An interview was conducted with Resident #122 on 09/09/24 at 2:41 PM, who when asked about the food served to the residents, Resident #122 replied, it ain't the best, especially breakfast. Every day it's either one of two pancakes and a piece of sausage, sometimes it's just a slice of toast and an egg. I can't remember the last time that I had a good breakfast. Sometimes the lunch is okay and they give me what I ask for. Dinner ain't the best. Record review of Resident #95's most recent Minimum Data Set (MDS) assessment documented Resident #95 with a BIMS score of 13, indicating the resident was cognitively intact. An interview was conducted with Resident #95 on 09/10/24 at 8:00 AM, indicating the resident was cognitively intact. When asked about the food served to the residents in the facility, Resident #95 replied, the food is lousy, I can't eat none of it. It's horrible, my daughter buys me food and sends it to me. When asked if the concern had been reported to the facility, Resident #95 replied, I think my daughter did. Record review of Resident #27's most recent Minimum Data Set (MDS) assessment documented Resident #27 with a BIMS score of 13, indicating the resident was cognitively intact. An interview was conducted with Resident #27 on 09/10/24 at 9:22 AM, who when asked about the food served to the residents, Resident #27 replied, Lousy - they can't cook. They cannot even make toast. They only toast one side of the bread. It's tasteless. When asked if she had reported the concerns to the facility, Resident #27 replied, to anyone who will listen, you can't recognize what it is. A lot of times they will serve you stuff that looks like a pile of mush. Record review of Resident #60's most recent Minimum Data Set (MDS) assessment documented Resident #60 with a BIMS score of 13, indicating the resident was cognitively intact. An interview was conducted with Resident #60 on 09/10/24 at 11:14 AM, who when asked about the food served to the residents in the facility, Resident #60 replied, the facility food is horrible, the food is not fit to feed a dog, Review of the Resident Council Meeting minutes and the Food Committee Meeting minutes, on 09/10/24 at 2:45 PM, revealed no documented complaints regarding the food served to the residents. During an interview, on 09/11/24 at 9:59 AM, with active members of the Resident Council, including Resident #113 (BIMS score of 14), Resident #85 (BIMS score of 15), and Resident #135 (BIMS score of 13), when asked about the food served to the residents, the following responses were made: a. Resident #135 stated, I got 2 fried eggs and corned beef hash, it looked like it. I didn't eat it. It didn't look right. It was runny, and some of the juices and milk are warm all of the time for all meals. b. Resident #113 further stated, on 09/04/24, they served a tuna melt that was tuna salad with cheese and not toasted. Resident #113 showed the surveyor a picture that confirmed this. When asked how long the food in the facility had been a concern, Resident #113 stated, At least 6 months, it is off and on. I talk to them all of the time. Resident #113 stated, the Activities Director takes all of the minutes. (continued on next page)

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	105474	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Beach Care Center	1310 37th St Vero Beach, FL 32960

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Resident #85 stated, you don't see them writing anything down (referring to the Food Committee meeting, including the previous day). The Dietary Manager is there, and she will just say 'okay'. During an interview, on 09/12/24 at 9:24 AM, with the Activities Director, when asked about the concerns voiced by the Resident Council, the Activities Director replied, I write when they tell me. The group as a whole, is telling me it is good. They haven't said as a group in the meeting that the food is a problem. I will encourage them during the meeting to tell us about it. During an interview, on 09/12/24 at 9:31 AM with the Dietary Manager and the Regional Certified Dietary Manager (CDM), when asked about the concerns voiced by the Resident Council, the Dietary Manager replied, they don't bring it up at the meeting. We talk about condiments, and it is documented. Tuesday, they said that breakfast and lunch is good, but dinner is the problem. People at the committee meeting ask for stuff and we give it to them. I get called in between and I talk to them all of the time then they tell me that they didn't like the way the eggs were cooked. They told me that they took pictures and that they were going to show them to you. On 09/12/24 at 10:17 AM, the Regional CDM stated that she was aware of the concern.

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NAME OF PROVIDER OR SUPPLIER: Vero Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1310 37th St, Vero Beach, FL 32960	

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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** 38893 Based on observations, interviews and record reviews, the facility failed to provide maintenance and housekeeping services to maintain a clean, comfortable and homelike environment on 4 of 5 units and in common areas. The findings included: During an environmental tour of the facility on 09/12/24 at 4:25 PM with the Maintenance Director, the following was observed: a. In room [ROOM NUMBER], there were two picture hanging hooks protruding from the wall with sharp points on them by the head of the bed. b. In room [ROOM NUMBER], there was an accumulation of residue on the exterior of the wall mounted air conditioning unit and an accumulation of debris inside of the vents of the unit. c. In room [ROOM NUMBER], there were multiple holes in the wall from where the chair rail once was. d. In room [ROOM NUMBER], the wall by the wall mounted air conditioning unit was in disrepair. e. In room [ROOM NUMBER], the bed frame was in disrepair and showed signs of wear. f. In room [ROOM NUMBER], there was residue and debris on the fall mat to the left of the B-bed closest to the air conditioning unit, there was water underneath the fall mat, the baseboard and the wall at the head of the bed, and at the wall mounted air conditioning unit was in disrepair. g. In room [ROOM NUMBER], there was an accumulation of debris under the A bed (door-bed). h. In room [ROOM NUMBER], there was an accumulation of debris in the air conditioning vent of the wall mounted unit and an accumulation of dust on the air conditioning vent over the commode in the restroom. i. In room [ROOM NUMBER], there was an accumulation of debris in the corner of the room by the bathroom, there was an accumulation of debris inside of the vent of the wall mounted air conditioning unit and on the floor throughout the room. j. In room [ROOM NUMBER], there were several towels underneath the wall mounted air conditioning unit, the wall by the unit was damaged, there was an accumulation of residue on the wall between the dressers, the top of the dresser used by the resident in the A-bed (door-bed) was not secured to the dresser and came off with minimal effort and the surfaces of the dressers showed signs of wear, and there was an accumulation of dust on the air conditioning vent over the commode in the restroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. In room [ROOM NUMBER], the door of the closet used by the resident in the A bed was missing, the baseboard at the entrance to the restroom was not secured to the wall, there was an outlet that was not secured in the opening in the wall, and the surface of the overbed table for the resident in the B-bed was damaged to a point that the particle board underneath was exposed. l. In room [ROOM NUMBER], the privacy curtain between the beds was stained, the floor was stained and dirty, there was an accumulation of debris in the vents of the wall mounted air conditioning unit, and the bed linens on the B-bed were stained with what appeared to be bodily fluid. m. In room [ROOM NUMBER], the back of the room entry door is in need of painting and the wall behind the A bed is damaged. n. In room [ROOM NUMBER], there was an accumulation of debris under the A bed. o. In room [ROOM NUMBER], the over-bed table used by the resident in the A-bed had multiple areas of scotch tape. p. In room [ROOM NUMBER], there was an accumulation of debris in the vent of the wall mounted air conditioning unit, the blinds were damaged, there was an accumulation of debris in the blinds and the baseboard was not secured to the wall. q. In room [ROOM NUMBER], there was an accumulation of debris in the wall mounted air conditioning unit, the floor around the B-bed was dirty and the commode was dirty in the bathroom. r. In room [ROOM NUMBER], there was an accumulation of a mold-like substance on the caulk at the bottom of the commode. s. The wall over the handrail between Rooms #232 and #233 was damaged. t. In room [ROOM NUMBER], there was an accumulation of debris on the fall mat to the resident's right side of the A-bed, there was an accumulation of debris in the vent of the wall mounted air conditioning unit, and the bowl of the commode in the restroom was dirty. During the environmental tour of the facility, on 09/12/24 at 4:25 PM with the Maintenance Director, the Maintenance Director acknowledged understanding of the concerns.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, interview, and policy review, the facility failed to ensure 1 of 1 sampled resident was free from physical restraint, Resident #128. The findings included: Review of the policy, titles, Identifying Seclusion and Unauthorized Restraint, revised 06/2023, documented, in part, As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify involuntary seclusion and/or unauthorized restraint of residents. Unauthorized Physical Restraints: 1. Residents are free from the use of any physical restraints not required to treat their medical condition. 2. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: a. Is attached or adjacent to a resident's body; b. Cannot be removed easily by the resident (in the same manner as it was applied by the staff); and c. Restricts the resident's freedom of movement or normal access to his/her body. 4. sometimes the use of restraints in not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) include: . e. using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising; . 6. Risk of falling is not considered a medical symptom or self-injurious behavior that warrants the use of restraints. 10. The following examples demonstrate situations where restraints are used for staff convenience or discipline and therefore unauthorized: a. Staff are too busy to monitor the resident, and their workload includes too many residents to provide monitoring; b. The resident does not exercise good judgement, including forgetting about his/her physical limitations in standing, walking, or using the bathroom alone and will not wait for staff assistance. Review of the record revealed Resident #128 was admitted to the facility on [DATE] and admitted to Hospice services as of 05/10/24. Further review of the record, to include progress notes and eInteract [electronic interact] notes (assessments completed by the nurse after a fall or change in condition) revealed Resident #128 had sustained eleven falls at the facility since her admission. Review of the orders, assessments, and progress notes lacked any documented use of a physical restraint or seatbelt. Review of the current Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #128 had a Brief Interview for Mental Status (BIMS) score of 04, on a 0 to 15 scale, indicating she was severely cognitively impaired. This same MDS documented not applicable for ambulation and substantial to maximal assistance to wheel in a wheelchair. Review of the record revealed there was no assessment or evaluation for the use of the seatbelt. Review of the care plans revealed a care plan related to falls, but it did not address the use of a seatbelt or restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 11:54 AM, Resident #128 was noted in her room, sitting in a companion chair (a small chair with wheels). The resident's adult son was in the room assisting the resident with her lunch meal. An unhooked seatbelt was noted attached to the companion chair, and hanging loosely to each side of the chair. The adult son of Resident #128 voiced that his mother had had falls while residing in the facility. The adult son pointed to the seatbelt and stated that staff needed to use it to keep his mother safe, but the facility says no. The adult son asked the surveyor to phone his sister, who was more involved in his mother's care. During a phone interview on 09/09/24 at 2:36 PM, the adult daughter of Resident #128 stated her mother was continuously trying to get out of her seat. The daughter stated her mother had sustained seven falls since April 2024. The adult daughter stated she does not believe they have enough help in that memory care unit. When asked about the seatbelt on the companion chair, the adult daughter stated she understood there were regulations related to the use of restraints and was unsure where the chair came from. The adult daughter voiced she was frustrated and just very concerned her mother was going to fall again. During an observation on 09/10/24 at 10:50 AM, Resident #128 was sitting in her companion chair just outside of her room, backed up against the wall, facing the common area. The seatbelt restraint was noted and being used around the resident's waist. During the continued observation, nursing staff were not in the area, but a group activity was in progress, with Staff J, Activity Assistant. Resident #128 was looking around toward the activity at times or down the hallway at other times. Resident #128 was observed trying to stand up twice, but unable. The resident used her hands and arms to push herself up but was only able to lift her buttock about 4 inches from the seat, and unable to stand up. The resident made no attempt to release the seatbelt and appeared to not realize that was what was keeping her from rising from the chair. At 11:06 AM, Staff J, Activity Assistant, walked by Resident #128 while attending to the group playing cards and stated, Ms. (first name of Resident #128), where are you going? Staff J did not intervene with Resident #128 at all but continued with her group activity. At 11:08 AM, Staff K, Licensed Professional Nurse (LPN), came back into the common area and unclipped the seatbelt from Resident #128. During an interview on 09/11/24 at 12:50 PM, when asked about the companion chair and seatbelt for Resident #128, Staff P, Certified Nursing Assistant (CNA), confirmed the resident had had that companion chair with the restraint for a while, but stated she had not used it because she knows they don't use restraints at that facility. During an interview on 09/11/24 at 2:45 PM, Staff K, LPN, confirmed the memory care unit currently had 29 residents. The LPN stated they always have one nurse, and usually have three CNAs on all shifts, unless they are short and then they will work with just two CNAs. The LPN stated the three CNAs were not enough for this unit, because of the cognitive impairment, care needs, and constant redirection needed. The LPN volunteered, I've not had lunch or a break today, and it's not the first time. When asked about the companion chair for Resident #128, the LPN explained upon admission to the facility, the resident used a walker and kept having falls. Staff K explained after the last fall, when they found the resident had sustained a brain bleed, Resident #128 returned to the facility under Hospice services, and the companion chair with the seatbelt came at some point. The LPN stated the facility staff were told not to use the seatbelt, as they were a restraint free facility, but the son kept putting the seatbelt on the resident when he left the building. When asked if Resident #128 would be able to unclip the seatbelt independently, Staff K, LPN, stated she could not. (continued on next page)

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	105474	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vero Beach Care Center	1310 37th St Vero Beach, FL 32960

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 in the morning, the Director of Nursing (DON) stated the companion chair was delivered on 05/11/24 for use by Resident #128. During a phone interview on 09/12/24 at 11:09 AM, when asked about the companion chair for Resident #128, Staff L, Hospice Registered Nurse (RN), stated the chair was ordered and provided by Hospice services upon admission to their services in May of 2024. The Hospice RN confirmed the use of the seatbelt restraint by the facility staff, stating it was in use during different visits upon her arrival to the facility. When asked if Resident #128 would be able to unclip the seatbelt independently, Staff L, RN stated she did not believe so.

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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** 33103 Based on observation, record review and interview, the facility failed to ensure accurate assessments for 2 of 42 sampled resident records reviewed, Residents #48 and #60, as evidenced for Resident #48 related to visual impairment and Resident #60 for use of antianxiety medications. The findings included: 1. Review of Resident #48 medical records revealed Resident #48 was admitted to the facility on [DATE] with diagnoses tha included Heart Failure, Hypertension, Diabetes Mellitus, and Major Depressive Disorder. Review of the resident's care plan initiated and revised on 03/10/23 documented the resident is at risk for complications and impaired visual function related to dry eyes syndrome and complications of Diabetes. The interventions included to observe for and report to the nurse any complaints of eye discomfort / pain, any noted problems with or any complaints of change in eyesight. To report and document as needed (PRN) any signs or symptoms of acute eye problems: Change in ability to perform ADLs [Activity of Daily Living], Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, complaining of halos around lights, double vision, tunnel vision, blurred or hazy vision to notify the physician. Review of the last 10 Minimum Data Set (MDS) assessments that included 3 annual MDSs and 7 Quarterly MDS all showed under section B for vision document vision as adequate. The latest MDS dated [DATE] documented the resident's Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating cognition is intact. Observation and interviews made on 09/10/24 at 9:48 AM and on 09/09/24 at 1:15 PM revealed when the surveyor asked the resident if he is blind, he stated he is blind and this was also acknowledged by his roommate. An interview was conducted on 09/11/24 at 7:30 AM with Staff R, Registered Nurse (RN) who stated she has been working for the facility for 3 years and is the nurse on the hallway where this resident resides. The surveyor asked her if this resident is blind. She stated 'yes, he is legally blind'. the surveyor asked could he see anything and she stated 'maybe shadows'. When asked what they do for him, she stated that 'during meals, he likes the lid of the food container opened and placed on his stomach, and they tell him where his food is located on his plate.' An interview was conducted on 09/11/24 with the Social Service Director (SSD) who was asked if this resident has visual impairment. She stated 'he does but he can see'. The SSD and surveyor went to Resident #48's room where she asked him to repeat 'sock, blue, bed and to remember them'. He did this with no issues. She asked him the year; he knew the year and the date and month. She asked him to read the large print on a paper, she had brought in the room with her, and he stated he 'couldn't see it'. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/11/24 with Staff E, MDS Coordinator, who was asked about Resident #128's vision impairment. She pulled up his care plan and stated he is at risk for complications and impaired visual function related to dry eyes syndrome and complication of diabetes. She then pulled up his MDS and acknowledged that it documented his vision is adequate under Section B and that it is coded wrong. Further review of the current MDS by the surveyor on 09/12/24 at 8:08 AM revealed it is now coded as severely impaired. 39167 2. Clinical record review revealed Resident #60 was admitted to the facility on [DATE] with diagnosis that included Depression. The admission MDS assessment, reference date of 08/05/24, recorded a BIMS score of 13, indicating Resident #60 was cognitively intact. It was revealed this MDS coded yes under section N for medication, subsection B for antianxiety. Review of the July and August 2024 medication administration records (MARs) lacked evidence of an antianxiety medication order. On 09/12/24 at 1:51 PM, an interview and a side-by-side review of Resident #60's clinical record was conducted with Staff F, the MDS Director, and she confirmed the finding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to develop and implement care plans for 1 of 3 sampled residents related to behaviors reviewed for catheter, Resident #91, and the facility failed to develop and implement care plans to accurately account for vision deficit for 1 of 2 sampled residents reviewed for vision, Resident #48. The findings included: 1. Record review revealed Resident #91 was admitted to the facility on [DATE]. Review of the resident's most recent full assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. Resident #91's diagnoses at the time of the assessment included: Heart Failure, Hypertension, Obstructive Uropathy, Diabetes Mellitus, Hemiplegia, History of cerebral infarction, Retention of urine, and Adult failure to thrive. Resident #91 was not interviewable. Review of Resident #91's orders included: On 01/06/24, Indwelling Urinary Catheter: Size 16 fr/10 ml for diagnoses of Chronic Urinary Retention. Review of Resident #91's care plan for the catheter, initiated on 01/07/24 and most recently revised on 09/04/24, documented, Resident has a risk for injury / infection r/t [related to] presence of urinary indwelling catheter r/t urinary retention, prostatitis, and BPH {Benign Prostatic Hyperplasia] Obstructive Uropathy. The goal of the care plan was documented as, The resident will be free of complications r/t catheter use through next review. Date Initiated: 01/07/2024 Revision on: 01/19/2024 Target Date: 11/05/24. Interventions to the care plan included: o Position catheter bag and tubing so that it promotes dignity and drainage. Date Initiated: 01/07/24, Revision on: 01/07/24. o Privacy bag / cover in place. Date Initiated: 01/07/24 Revision on: 01/07/24. On 09/09/24 at 1:14 PM, Resident #91 was observed in bed sleeping with the catheter bag on the head of the resident's bed on the resident's right side (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 11:13 AM, Resident #91 was observed in bed with the catheter bag on the head of the bed on the resident's right side of the bed, with tubing noted to have yellow fluid in it and not draining into the bag. Resident #91 was sitting on the bed with his pants undone and pulled down below his buttocks. Staff B, Licensed Practical Nurse (LPN), and Staff D, Certified Nursing Assistant (CNA) were made aware of the observation and confirmed that the catheter bag was improperly placed and not draining as evidenced by the collection bag being empty. On 09/12/24 at 8:35 AM, Resident #91 was observed in bed with catheter bag to resident's right side of bed above the bladder level. An interview was conducted on 09/12/24 at 8:36 AM with Staff B, who, when the observation was brought to her attention, Staff B replied, the patient has Dementia, and he moves his bags and self-transfers. I encourage the staff to check on him to make sure that his bag is where it is supposed to be. An interview was conducted on 09/12/24 at 11:03 AM with Staff E, MDS Coordinator, and Staff F, MDS Coordinator, who, when asked about having a care plan for behaviors related to the resident and the catheter, Staff E replied, he has had a care plan for injury risk for the Foley since 01/07/24. This morning, I put in that he manipulates, I did not know about it until today. Staff F stated, I was told when I saw him during rounds this morning and the night CNAs told me. 33103 2. Observation and interview were conducted on 09/10/24 at 9:48 AM and again on 09/09/24 at 1:15 PM of Resident #48. The surveyor asked the resident if he is blind and he stated he is blind. This was acknowledged by his roommate. Review of Resident #48 medical records revealed Resident #48 was admitted to the facility on [DATE]. He had diagnoses that included Heart Failure, Hypertension, Diabetes Mellitus, and Major Depressive Disorder. Review of the quarterly MDS dated [DATE] under Section B for vision documented his vision as adequate. The resident's BIMS score was documented as 14 of 15, indicating he is cognitively intact. Review of the resident's care plan initiated and revised on 03/10/23 documented the resident is at risk for complications and impaired visual function related to dry eyes syndrome and complications of diabetes. The interventions included to observe for and report to the nurse any complaints of eye discomfort / pain, any noted problems with or any complaints of 'change in eyesight'; To report and document as needed (PRN) any signs or symptoms of acute eye problems: Change in ability to perform ADLs [Activity of Daily Living], Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, complaining of halos around lights, double vision, tunnel vision, blurred or hazy vision to notify the physician. Further review of his care plan with a revision date of 09/11/24 (third day of survey) documented the resident stated he can only see his hand and shadows 2-inches in front of his face. The Interventions dated 09/11/24 after revision included to encourage and assist the resident with providing adequate lightning as indicated. If applicable: when providing assistance with dining, inform him of location of different foods on the plate/place setting. Use the 'numbers on a clock face' to describe the location, e.g. coffee is at 3 o'clock. If indicated, approach from the side that they can see best. Provide cues for safety as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/11/24 at 7:30 AM with Staff R, Registered Nurse (RN), who stated she has been working for the facility for 3 years and is the nurse on the hallway where this resident resides. The surveyor asked her if this resident was blind and she stated 'yes, he is legally blind'. The surveyor asked could he see anything, and she stated, 'maybe shadows'. When asked what they do for him, she stated that 'during meals he likes the lid of the food container opened and placed on his stomach. They tell him where his food is located on his plate.' An interview was conducted on 09/11/24 with the Social Service Director (SSD) who stated this resident has visual impairment, but he can see. She asked him to read the large print on a paper that she brought in the room with her, and he stated he could not see it. An interview was conducted on 09/11/24 with Staff E, MDS Coordinator, who was asked about his vision impairment. She pulled up his care plan which she stated he is at risk for complications and impaired visual function related to dry eyes syndrome and complication of diabetes. Further review of the current MDS by the surveyor on 09/12/24 at 8:08 AM, revealed it was now coded as severely impaired and his care plan had been updated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to revise care plans for 2 of 9 sampled residents reviewed for nutrition and or medication use, Residents #81 and #79, as evidenced by the care plan for Resident #81 lacked information related to being aggressive toward others, and the care plan for Resident #79 noted the resident had a fluid restriction order that had been discontinued. The findings included: 1. Review of the record revealed Resident #81 was admitted to the facility on [DATE]. Further review revealed the resident was moved to different rooms on 04/20/24 and 09/04/24 after a resident-to-resident altercation. Review of the current care plans lacked any documentation related to physical aggression or any resident-to-resident events or conflicts. During an interview on 09/12/24 at 2:01 PM, the Director of Nursing (DON) agreed Resident #81 had had two resident-to-resident events and was surprised this was not noted in any of the care plans. During an interview on 09/12/24 at 2:32 PM, the Social Services Director (SSD) was asked about the lack of any documented aggression by Resident #81 in the care plans. The SSD stated they discussed it in a morning meeting, about adding the aggressive behavior to the care plans after the second resident-to-resident altercation. The SSD stated they decided since the Minimum Data Set (MDS) staff were working on those care plans, they would add the information. 2. Review of the record revealed Resident #79 was admitted to the facility on [DATE] and with a diagnosis of End Stage Renal Disease with dependence upon dialysis, which often requires a fluid restriction by a resident. Review of the current physician orders lacked any fluid restriction. The fluid restriction order was discontinued on 06/10/24. Review of the current care plan initiated on 04/19/24, with documented revisions on 05/14/24 and 09/03/24, documented, Focus: The resident is at risk for alteration nutrition / hydration r/t [related to] increased nutrient needs, diuretic usage [weight changes anticipated], fluid restriction on order, altered texture diet on order, significant weight change, wound. On 09/13/24 at 3:37 PM, the Director of Nursing (DON) was informed the care plan for Resident #79 documented the resident had a fluid restriction order, but there was no current order for the fluid restriction. The DON had no explanation, and no further information was provided as of the survey exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on interview, the facility failed to provide services of peri care and failed to get a resident out of bed as requested for 1 of 1 sampled resident, Resident #44, reviewed for Activities of Daily Living (ADLs). The findings included: Clinical record review revealed Resident #44 was admitted to the facility on [DATE] with diagnosis that included: medically complex conditions. The admission Minimum Data Set (MDS) assessment, reference date 09/03/24, recorded a Brief Interview for Mental Status score of 14, indicating Resident #44 was cognitively intact. This MDS evidenced Resident #44 exhibited moods that included: Feeling down, depressed, or hopeless. Poor appetite or overeating. Feeling bad for herself - or that she is a failure or have let herself or her family down. This MDS also documented Resident #44 required substantial / maximal assistance with toileting hygiene, shower / bath self, and lower body dressing, and required partial / moderate assistance with upper body dressing. Additional review of the MDS revealed Resident #44 was occasionally incontinent of urinary, and frequently incontinent of bowel. Review of baseline care plan initiated 09/03/24 documented Resident #44 has Activity of Daily Living (ADL) self-care deficit related to cellulitis. Intervention included: Encourage and assist with ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal hygiene, etc. On 09/10/24 at 10:57 AM, an interview was conducted with Resident #44 who stated, some of the Certified Nursing Assistants (CNA's) do not do their job right. When asked to explain what she meant, the resident said, yesterday [09/09/24], she had a bowel movement, she needed to be changed, the attending CNA put her to bed and changed her. Subsequently, around 5-10 mins later, around 1:00 PM, after lunch, she wet her adult depends and asked the same CNA to change her. The CNA stated oh! you only peed that's all and the CNA left the room without providing assistance in changing her. Resident #44 didn't get changed until the next shift came in (3:00 PM). On 09/12/24 at 1:17 PM, an interview was held with Staff H, Patient Care Technician (PCA). She revealed she was working with Staff I, CNA, at the SSU on 09/09/24 during the day shift, Resident #44 wanted to use the bathroom, the PCA couldn't do her by herself, the PCA (Staff H) and Staff I (CNA) put Resident #44 back to the bed, then changed her and left her on the bed to watch TV. She stated subsequently, Resident #44 wanted to get change again and get back to the wheelchair, but Staff I didn't feel like doing all that work, Staff I told the resident oh! No, uh-uh and told the resident she couldn't put her back in the wheelchair, because it was hard putting her in the wheelchair. When asked of the PCA if they changed Resident #44's adult depends, the PCA did not answer and did not confirm if they'd changed the resident or not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 at 2:10 PM, a subsequent interview was held with Resident #44, to find out how she was doing. She voiced again, on 09/09/24 after lunch she needed to get change, she asked the attending CNA for help, the CNA said, oh! you only peed, that's all, she left the room without changing her and left her in wet adult depends. On 09/12/24 at 2:12 PM, an interview was conducted with the social service Director who was made aware of the resident's concern related to the lack of care and services which occurred on 09/09/24 after lunch.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, interview, and Hospice Agreement review, the facility failed to ensure coordination of care and services for 2 of 2 sampled residents, as evidenced by the lack of orders for Hospice services and oxygen use for Resident #25; and failure to coordinate the provision of an offloading boot, lack of Certificate of Terminal Illness (CTI) paperwork, and lack of current Hospice notes for Resident #87. The findings included: Review of the Hospice Agreement effective 01/15/24 documented, 6a. Patient Admission Process: 1. ii. 3. Hospice shall notify Home, as appropriate, of patients being admitted to service, the day of the referral. Hospice shall provide copies of the Initial Hospice admission paperwork. 8. Coordination, Supervision and Evaluation of the Care/Service: . b. Home Responsibilities . iv. Home shall assist the Hospice in the coordination of patient care from admission up through and including discharge from service. 1) Review of the record revealed Resident #25 was admitted to the facility on [DATE]. A physician/practitioner progress note dated 08/29/24 at 9:54 AM documented the daughter of Resident #25 had agreed upon a Hospice consult. A nursing progress note dated 09/01/24 at 1:59 PM documented Resident #25 had been admitted to hospice care with new orders received and in place. This note also documented the resident remained on oxygen at 2 liters for comfort. Review of the current orders lacked any order for the provision of Hospice services or the administration of oxygen. Review of the document section of the electronic medical record lacked any documentation of the Hospice admission, including the lack of a CTI, or any hospice progress notes. An observation on 09/09/24 at 1:12 PM revealed Resident #25 in bed, receiving oxygen via a nasal cannula at 3 liters per minute. During an interview on 09/11/24 at 3:14 PM, when asked about the oxygen use for Resident #25, Staff K, Licensed Practical Nurse (LPN) stated she was unaware of any previous oxygen use, or any order for oxygen, but when she arrived on Monday (09/09/24), Resident #25 was wearing the oxygen. The LPN explained she spoke with the nurse practitioner who asked her to check the Resident's oxygen level. Staff K stated she then ordered the oxygen on a PRN (as needed) basis. When asked to locate and provide the oxygen order, the LPN was unable to do so and stated, Maybe hospice ordered it. During a side-by-side review of the record and interview on 09/11/24 at 3:57 PM, Staff A, Unit Manager, confirmed Resident #25 was on hospice services. When asked to locate and provide orders for both hospice and the oxygen, the Unit Manager was not able to find any such orders. 2) Review of the record revealed Resident #87 was admitted to the facility on [DATE] with admission to hospice services as of 07/09/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a terminal illness and had two pressure ulcers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the orders lacked any documented admission to hospice services until an order dated 09/09/24, even though the resident was admitted to hospice on 07/09/24. The record lacked the Certification of Terminal Illness papers from hospice and lacked any documented hospice notes for visits since the admission on 07/09/24. Observations on 09/09/24 at 11:47 AM, and on 09/11/24 at 9:13 AM and 12:23 PM, all revealed Resident #87 curled up in bed, leaning toward her right side. On the 09/11/24 observation at 12:23 PM, the resident's right foot was noted directly on the mattress. Staff had placed a thin pillow under the calf, but it did not offload the foot. During an interview on 09/11/24 at 10:36 AM, the Wound Care Nurse stated he had done the wound care the previous day and that it would be due again on Friday. During an observation at this time, in order to see the dressing to the resident's right foot, the Wound Care Nurse had to gently pull the resident's right leg out from under her, revealing that the foot was not offloaded. The nurse explained that all the wounds were in the foot and lower leg area. No type of offloading boot was noted. When asked about the use of a boot, the WCN stated, I've been here just two weeks. I think I saw a boot at some point, but not sure. Staff P, Certified Nursing Assistant (CNA) was nearby and stated she was told Hospice sent the boot to the laundry on Sunday 09/08/24, but further stated she had never seen a boot on this resident. The Wound Care Nurse stated he could speak with the nurse and ask Hospice to order one if needed. The Wound Care Nurse agreed the right leg was not off loaded and that the resident did favor her right side. Review of the physician's wound care evaluation dated 09/12/24 revealed Resident #87 had three pressure ulcers, all to the right lower leg and foot. Further review of this note documented the use of a pressure relieving boot, but that it was currently in the laundry. On 09/13/24 at 2:26 PM, Resident #87 was again on her right side, with her right foot bent up and directly on the pillow, not offloaded. There was no pressure relieving boot noted. When asked about the boot that had possibly been in the laundry all week as per a previous interview and documentation, Staff K, LPN, was unable to find any order for the boot and unsure why the resident did not have one. On 09/13/24 at 2:28 PM, when asked if he had followed up with hospice related to the use of a pressure relieving boot, as discussed on 09/11/24, the Wound Care Nurse stated he spoke with the wound care physician on 09/12/24 and with Staff K previously that week in order to get one. When told there still was no pressure relieving boot noted for Resident #87, he had no answer. During a supplemental interview on 09/13/24 at 2:41 PM, the Wound Care Nurse stated he had called Hospice, and they would be out Monday to assess for the need. During an interview on 09/13/24 at 2:53 PM, when told there were no hospice notes since the July admission for Resident #87, the DON agreed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, record review, and policy review, the facility failed to follow their fall prevention policy for initiating new interventions, updating care plans, and ensuring supervision to prevent falls for 1 of 4 sampled residents reviewed for accidents (Resident #128). The findings included: Review of the policy Falls - Managing, Preventing, and Documentation revised 01/2024 documented, Standard: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Guideline: The resident's plan of care will be developed and followed accordingly to prevent or minimize the risk of falls or fall related injuries. Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring Subsequent Falls and Fall Risk . 2. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. Documentation: . 2. The resident's care plan should be updated timely with the new interventions determined by the interdisciplinary team. Review of the record revealed Resident #128 was admitted to the facility on [DATE]. Review of the baseline care plan dated 11/04/23 documented Resident #128 had a history of falls with major injury and that the resident was at risk for falls. All fall risk assessments from admission forward revealed the resident was at risk for falls. The following falls with supplemental interdisciplinary notes and care plan reviews were noted in the record: 1) On 11/05/23 at 2:45 PM, a progress note revealed Resident #128 was found on the bathroom floor of another resident's room, sitting straight up on her behind. The resident reported she fell while trying to get up off the toilet. Staff did not find any injury although the resident complained of head and knee pain. Upon arrival of the resident's daughter, she feels for a bump on her head. The note lacked if a bump was noted. The resident was sent to the hospital for an evaluation. Resident #128 had a bruise on the palm of her right hand and her right knee was swollen. a) On 11/06/23 the interdisciplinary team (IDT) reviewed the fall, and a therapy screen was completed for review of abilities with self-ambulation, they initiated a psych follow up, and a medication review was requested. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) A post fall evaluation dated 11/06/23 documented interventions initiated included bed in lowest position, remove clutter from room, a therapy referral, and a medication review. This note documented, Education was provided to the following people: Other therapy screen. The teaching methods used for the education provided was: Demonstration. The outcome of the education provided was Unsuccessful. c) A care plan for falls initiated as of 11/06/23. 2) On 03/30/24 at 9:18 PM, a progress note revealed Resident #128 was heard falling to the floor and found lying on her back in another resident's room, after following behind a staff member without that staff member knowing. The resident was placed on every 15-minute checks for altered mental status. a) On 04/01/24 the IDT documented the resident would be placed in activities appropriate for her. This intervention was already part of the initial care plan. b) Review of the care plan lacked the initiation of any new interventions. 3) On 04/19/24 at 3:55 PM, a progress note revealed Resident #128 tripped over a floor mat in another resident's room and was sent to the hospital for an evaluation. The resident had sustained a laceration to her left eye and mouth. a) The record lacked any IDT review. b) A new care plan intervention to monitor the resident going into other resident's rooms was added. 4) On 05/01/24 at 4:38 PM, a progress note revealed Resident #128 was standing by a door that someone opened and the resident fall backwards. The resident sustained a laceration to her mouth. The resident was sent to the hospital. Report from the ER upon return to the facility indicated the resident had sustained a subacute subdural hematoma from a previous fall. a) A post fall evaluation dated 05/01/24 documented, The following interventions and approaches have been implemented for the resident: Bed in lowest position. The fall risk evaluation was reviewed with the following people: Resident. Education was provided to the following people: Caregiver. The teaching methods used for the education provided was: Verbal Discussion. the outcome of the education provided was: Needs Practice Reinforcement. (Note the intervention of the bed in lowest position was initiated after the first fall on 11/06/23. Fall risk evaluation reviewed with Resident #128, who had a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment, is not appropriate). b) The record lacked any IDT review. c) A new care plan for a medication regimen review by the consultant pharmacist was added. 5) An eInteract form for a fall was documented on 05/05/24 at 4:57 AM revealed Resident #128 was found lying on the floor in her bedroom with no apparent injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) A post fall evaluation documented verbal education was provided to the resident with practice reinforcement needed. b) An IDT post fall note documented the resident was impulsive and unaware of safety needs. The note also documented the resident could be encouraged, but not educated because of her low BIMS. The team would like to place mats at bedside and increase rounding. c) The care plan lacked any new documented interventions. d) Resident #128 returned to the facility on [DATE] and was admitted to Hospice services. 6) A progress note documented on 05/16/24 at 12:50 PM, Resident #128 heard her name, tried to turn around when her shoes got stuck while trying to turn. The resident attempted to grab the hallway rail but was unsuccessful. a) An IDT note dated 05/17/24 documented the team will ensure proper footwear and check environment for sticky floors. b) The initial fall care plan already indicated proper footwear. No additional intervention was documented on the care plan. 7) A progress note dated 05/20/24 at 5:50 AM documented Resident #128 was observed on the floor sitting on buttocks, with no apparent injuries noted. a) A post fall evaluation dated 05/20/24 at 6:15 AM documented the fall risk evaluation was reviewed with the family, education was provided to the family, and the outcome was unsuccessful. A second post fall evaluation dated 05/20/24 at 6:50 AM documented the fall risk evaluation was reviewed with the resident and education was provided to the resident via a phone call, and the outcome of the education was unsuccessful. (Note a second fall was not clearly documented in a progress note). b) An IDT note dated 05/20/24 at 9:35 AM documented they will toilet the resident more frequently, so she doesn't try to get up by herself. An IDT note dated 05/20/24 at 9:41 AM documented IDT review for second fall of 05/20/24 resulted in the provision of Dycem (a sticky surface placed in a chair to keep a resident from slipping) would be placed in her wheelchair. c) The care plan was updated to include more frequent toileting and the use of Dycem. 8) A progress note dated 05/24/24 at 6:07 PM documented Resident #128 had an unwitnessed fall and hit the back of her head. A progress note dated 05/24/24 at 9:54 PM documented the resident returned from the hospital with one staple noted to the back of her head. The resident was placed on 1:1 supervision for the night upon return from the hospital. The 1:1 supervision did not continue. a) An IDT note dated 05/28/24 at 9:08 AM to review the fall of 05/24/24 documented to offer more frequent toileting and rounding. Keep resident in common areas when out of bed. b) No new interventions were added to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9) The record lacked a progress note, but an eInteract note dated 07/08/24 at 4:42 PM simply documented a fall with no specifics as to what occurred. This note documented Recommendations: yea but lacked any new orders or intervention. a) A post fall evaluation dated 07/08/24 at 4:47 PM documented post fall interventions included call light re-orientation via verbal education to the resident with an outcome of verbalizing understanding. b) No new interventions were added to the care plan. 10) A progress note dated 08/13/24 at 11:00 PM documented staff heard yelling and found Resident #128 lying on her side on the floor in the dining room, crying. No injuries were noted. The resident was placed on every 30-minute safety checks, frequent toileting, and close monitoring. a) An IDT note dated 08/14/24 at 8:52 AM documented neurological checks and 30-minute checks for 72 hours for safety. b) No new interventions added to the care plan. During an interview on 09/09/24 at 11:54 AM, the adult son of Resident #128 voiced his concern related to his mother's falls. During a phone interview on 09/09/24 at 2:36 PM, the adult daughter of Resident #128 explained her mother had had 7 falls since April of 2024 and she keeps trying to get out of her seat. With one of the falls, her mother lost a tooth and crown. The daughter feels the facility does not have enough staff, especially for the memory care unit. The daughter voiced frustration and stated she just doesn't want her mother to fall again. During an interview on 09/11/24 in the morning, when told of concerns with the multiple falls, lack of new interventions, education of a therapy screen to a resident with a very low BIMS, and documented education as unsuccessful, the DON had no response. On 09/11/24 at 1:49 PM, Resident #128 was placed on 1:1 supervision related to poor safety awareness. During an interview on 09/11/24 at 2:45 PM, Staff K, Licensed Practical Nurse (LPN), confirmed the memory care unit currently had 29 residents. The LPN stated they always have one nurse, and usually have three CNAs on all shifts, unless they are short and then they will work with just two CNAs. The LPN stated the three CNAs were not enough for this unit, because of the cognitive impairment, care needs, and constant redirection needed. The LPN volunteered, I've not had lunch or a break today, and it's not the first time. When asked what happened today during the medication pass with another surveyor, the LPN stated Resident #128 stood up and was walking to the exit. The LPN explained she was trying to pass medications, and the other aides were assisting other residents. The LPN stated she had to redirect Resident #128, and the resident was quite resistant. The LPN explained they do have an aide who is very helpful with the resident as she speaks Spanish, but she was helping another resident. The LPN stated Resident #128 gets up all the time. Stated she has been on 1:1 in the past, especially after a fall, but only for a short time.

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25404

Based on observation, interview, and record review, the facility failed to ensure sufficient staffing as evidence by falls and a consistent stale urine odor on 1 of 5 units ([NAME]); lack of ADL care for 1 of 5 sampled residents (Resident #44); lack of Hospice coordination for 2 of 2 sampled residents (Resident #25 and #87); and voiced complaints by residents, families, staff, and resident council.

The findings included:

1) Resident #128, who was admitted to the facility on [DATE], sustained eleven falls while residing on the [NAME] unit. Review of these falls lacked evidence the facility followed their fall prevention policy. (Refer to F689 for details). Review of the fall log from 07/01/24 through the survey date of 09/13/24 revealed the facility had 38 falls, 10 of which were on the [NAME] unit.

Upon entering the [NAME] unit on all five days of the survey (09/09/24 - 09/13/24) a constant urine odor was noted throughout. Although a specific resident was not identified during the survey, the odors remained.

2) Observation and interview revealed staff failed to provide personal care on two occasions during the survey, when requested by Resident #44. Staff also failed to assist the resident out of bed upon her request. (Refer to F677 for details).

3) Residents #25 and #87 were both on Hospice services, and the facility failed to coordinate care, ensure orders, and ensure hospice documentation was available. (Refer to F684 for details).

4) The following voiced complaints were voiced by residents and family members during the survey process:

a) During an interview on 09/09/24 at 11:02 AM, Resident #90 who had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating she was cognitively intact, stated it took the night shift two hours the previous evening to answer her call bell. The resident stated she was feeling short of breath, and when staff finally came in, they did assist her with repositioning/raising the head of the bed, and completed a set of vital signs. During this interview, her roommate, who also had a BIMS of 14, agreed with her roommate's concerns.

b) During an interview on 09/09/24 at 11:27 AM, Resident #143, who had a BIMS of 15 indicating she was cognitively intact, stated the facility needs more aides as she has had to wait an hour for help.

c) During an interview on 09/10/24 at 7:59 AM, Resident #95, who had a BIMS of 13 indicating she was cognitively intact, stated the staff on the 11 PM to 7 AM shift is not answering the call lights timely. The resident also stated the staff are double diapering for their convenience, and when she complained that she didn't like that, staff told her it doesn't matter because no one will come check at night.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) During an interview on 09/10/24 at 11:14 AM, Resident #60, who had a BIMS of 13 indicating she was cognitively intact, stated the facility did not have enough staff as they are always complaining they are too busy. The resident stated that wasn't her problem and if they are too busy, they shouldn't accept any more residents or they should hire more people. e) During an interview on 09/10/24 at 11:46 AM, Resident #147, who had a BIMS of 6, indicating moderate cognitive impairment, stated that they did not have enough staff and that he has to wait an hour for staff to answer his call light. During this interview, his roommate Resident #145, who had a BIMS of 15, confirmed Resident #147 put on his call light and it goes unnoticed for two hours. f) During an interview on 09/09/24 at 10:06 AM, Resident #104, who had a BIMS of 15, stated when he calls to get assistance with personal care during the night shift, he often waits an hour to an hour and a half to get cleaned up, especially if he'd had a bowel movement. Resident #104 stated staff are often heard fighting about their job duties with respect to getting a resident up for therapy. The resident complained that often the CNAs (Certified Nursing Assistants) won't get him up in the morning, so his therapist has to take 15 minutes out of their time to do the CNA's work. g) During an interview on 09/09/24 at 11:34 AM, Resident #150, who had a BIMS of 14, stated the facility is understaffed as it takes 45 minutes to an hour for her call light to be answered, the resident stated at night it is worse and she has to ask staff a couple of times to get anything done. h) During an interview on 09/10/24 at 9:25 AM, Resident #27, who had a BIMS of 13, stated she waits a minimum of one hour for assistance. During this interview, her roommate stated, I was here all night one night with crap in my pants. i) During an interview on 09/10/24 at 11:53 AM, Resident #145, who had a BIMS of 15, stated the facility is understaffed, especially at night. The resident stated he can't get any water during the night shift, has waited over an hour for staff to answer the call light, and the CNAs get overwhelmed. j) During a phone interview on 09/09/24 at 2:36 PM, the daughter of Resident #128 voiced her concern with a lack of staff, as her mother had had seven falls since April 2024. k) During an interview on 09/09/24, Resident #132, who had a BIMS of 15, stated he relies on staff for personal care, and he had missed physician appointments because staff won't attend to him in a timely manner. 5) During an interview on 09/11/24 at 2:45 PM, Staff K, Licensed Practical Nurse (LPN) stated the current staffing for the [NAME] unit was not enough, considering the cognitive impairment and needs for safety in the memory care unit. (Refer to F689 for details). When asked about leaving Resident #112 alone during a nebulizer treatment on 09/11/24 at 12:25 PM, Staff K explained that she had to leave Resident #112 alone because she saw another resident who should not have been walking independently, doing so, and she had to go attend to her. During an observation on 09/11/24 at 2:45 PM, Resident #112 was alone, with the nebulizer running, and the nebulizer mask had been pulled down to his chin, instead of over his nose. 6) Review of Resident Council minutes revealed concerns with delayed response to call lights in June 2024, August 2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the Resident Council meeting held on 09/11/24 at 9:59 AM, Resident #85, who had a BIMS of 15, stated one night when he was sick and ended up in the hospital, it took 52 minutes for staff to answer his call light. This resident stated he has seen and taken photos of staff sleeping.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation and interview, the facility failed to ensure timely posting of nurse staffing information on 4 of 5 day during the survey (Monday 09/09/24 through Thursday 09/12/24). The finding included: On 09/09/24 at 8:40 AM, upon entrance to the facility the nurse staffing information, that included the number of Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants, along with the actual hours worked by each category, was not posted in the lobby area. At 9:09 AM a walk-through of the facility was conducted, to include a second observation of the lobby area and all units in the main building, and no nurse staffing information was found. Upon arrival to the facility on [DATE] at 8:30 AM, the nurse staffing information for 09/09/24 was noted in the lobby on the receptionist desk (Photographic Evidence Obtained). When asked who was responsible for the posting, the staff sitting at the receptionist desk stated, I'm really not sure, but (name of Administrator) has something to do with it. On 09/11/24 at 8:48 AM, the nurse staffing information for 09/10/24 was noted on the receptionist's desk in the lobby (Photographic Evidence Obtained). On 09/12/24 at 7:49 AM, the nurse staffing information for 09/11/24 was noted on the receptionist's desk in the lobby. During an interview on 09/13/24 at 4:54 PM, when asked who was responsible for posting the nurse staffing information at the beginning of each shift, the Administrator stated it was the responsibility of the night supervisor and receptionist.

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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 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** 25404 Based on observation and interview, the facility failed to secure medication storage on 2 of 5 units, as evidenced by leaving the medication and treatment carts unlocked and unattended on the [NAME] Unit, the designated memory care unit, and a random observation of non-secured ointments on the [NAME] Unit. The findings included: 1) An observation on 09/09/24 at 11:43 AM revealed the medication cart was positioned against the wall in the common area of the [NAME] unit, unlocked with at least three bubble pack medication cards with pills in at least one pack, noted on top of the cart. Staff K, Licensed Practical Nurse (LPN) was noted at the desk on the other side of the common area, working on the computer. The LPN retrieved the bubble pack medication from the medication cart, but left the medication cart unlocked (Photographic Evidence Obtained). During the continued observation on 09/09/24 at 12:01 PM, both the medication cart and the treatment cart remained unlocked in the common area. Although three staff were in and out of the common area, all three were busy delivering lunch trays to the memory care residents. At 12:20 PM the carts remained unlocked and Staff K had her back to the cart assisting a resident with lunch. The two carts remained unlocked through the lunch meal. Staff continued to move throughout the unit, in and out of the common area. During the continued observation on 09/09/24 at 12:56 PM, Staff K, LPN, was back at the nurse's station looking at her cell phone. Three cognitively impaired residents were self propelling in or about the common area. Another resident was noted independently ambulating down the hall and a staff member assisted her back to the common area. During the continued observation on 09/09/24 at 1:29 PM, both carts remained unlocked. Residents and staff continued to move in and out of the common area. At 1:35 PM, when asked why she had left her medication cart unlocked for the past two hours, Staff K, LPN, looked surprised and stated she hadn't realized it was unlocked. When told the treatment cart was also unlocked, the LPN was unaware. Both of these carts had medications and treatment creams and ointments for use in the unit (Photographic Evidence Obtained). 2) During a random observation on 09/10/24 at 12:21 PM, the medication cart was noted between rooms [ROOM NUMBERS], unattended. Two tubes of Zinc Oxide were noted in a bin on the side of the medication cart (Photographic Evidence Obtained). 3) During an observation on 09/11/24 at 9:28 AM the treatment cart was noted in the common area unlocked and unattended. When asked if she had used the cart that morning, Staff K, LPN stated she had not used the treatment cart that day nor noticed it was unlocked. Nine cognitively impaired residents were noted in the common area at that time.

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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. 38893 Based on observations, interviews and record reviews, the facility failed to provide food prepared, stored and served in a sanitary manner and in accordance with professional standards for food safety. The findings included: 1). During the initial kitchen tour, on 09/09/24 at 8:43 AM, accompanied by the Dietary Manager, the following were noted: a. The hand washing sink and the baseboard by the food assembly area were not secured to the wall. b. Cleaned and sanitized utensils (knives, forks and spoons) were not inverted while being stored and were stored directly underneath the hand washing sink. c. The floor paint was noted to be peeling throughout the kitchen. d. There was an accumulation of debris and residue on blade and mechanism of the counter mounted can opener. e. The shelving underneath the hot holding unit was damaged and rusted. f. There was an accumulation of dust on the air conditioning vents in the ceiling throughout the kitchen. g. The oven mitts were noted to be torn and uncleanable. h. In the walk in cooler, there were packages of raw beef stored directly over a 6-inch deep full sized hotel pan of prepared tuna salad. i. The interior of the door of the walk in cooler was damaged. j. Cleaned and sanitized hotel pans were stacked and wet on a shelf in the ware washing area. k. There was an accumulation of debris on the slicer and the sharpening stones of the slicer that was stored in the dry storage area. l. There was an accumulation of rust and dust on the air intake vent by the walk in cooler. m. The hand sink in the food service area by the ice machine was not maintained in working order. n. The floor throughout the food service area was damaged. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the conclusion of the initial kitchen tour, the Dietary Manager acknowledged understanding of the findings. 2). During the follow up kitchen tour, on 09/11/24 at 11:01 AM, Accompanied by the Dietary Manager and the Regional Certified Dietary Manager (CDM), Staff G, Dietary Aide, was observed using a paper towel to dry the trays prior to meals being placed on them and then being placed in the carts used to transport the meals to the units. At the time of the observation, the Dietary Manager, the Regional CDM and Staff G acknowledged understanding of the concern.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review, interview, and policy review, the facility failed to ensure complete and current medical records for 3 of 42 sampled residents (Resident #5, #26 and #81). The findings included: Review of the policy Documentation revised 01/2024 documented, Procedure: . 2. The following information is to be documented in the resident medical record: . c) Treatments or services performed; 1) During an observation on 09/09/24 at 10:41 AM, Resident #5 was noted with thick elongated toenails. The resident reported he had not been seen by a podiatrist. Review of the record revealed Resident #5 was admitted to the facility on [DATE]. Review of the electronic medical record lacked any documented podiatry services. During an interview on 09/12/24 at 4:44 PM, when asked about podiatry services for Resident #5, the Social Services Director (SSD) stated the resident had been seen by the podiatrist. When asked to locate and provide evidence of the services, the SSD was unable to locate any documented podiatry service notes. The SSD called the Medical Records person who stated she had not been provided any podiatry notes to scan and there were no notes pending scan. During this same interview, the SSD volunteered that she hasn't seen any psychologist notes either. When asked if she had done anything about not having any notes, the SSD stated she spoke with the clinicians when they were in the building. When asked about the documented notes, the SSD stated she had the ability to get into their electronic records as needed. When asked again if she had spoken with anyone in the facility about the lack of consultant progress notes in the medical records, the SSD stated, not really. 2) Review of the record revealed Resident #26 was admitted to the facility on [DATE]. Review of an order dated 02/23/24 revealed the resident was to have a follow-up appointment with an orthopedic physician. The record lacked any evidence of a follow-up appointment with ortho or any reason the appointment was not made. The Director of Nursing (DON) was asked to locate and provide any documentation related to the ordered follow-up appointment and none was provided during the survey. 3) Review of the record revealed Resident #81 was admitted to the facility on [DATE]. Review of the orders revealed the resident was being monitored for behaviors and had had two resident-to-resident altercations since admission, one on 04/20/24 and the second on 09/04/24. the record lacked any psychological notes since 2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 4:11 PM, Staff A, Unit Manager, stated she had seen psychotherapy at the facility visiting the resident here the day after incident on 09/04/24. The Unit Manager stated the psychologist sends their notes to Medical Records, who then uploads it into the medical record. During an interview on 09/12/24 at 4:17 PM when asked how she gets the psychology notes, Staff O, Medical Records, stated, It is supposed to be via email. When asked if she had any pending notes, she said no. When asked if the psychology staff routinely send in their notes to the facility to be scanned, she stated no.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on review of the client's Arbitration agreement and interview, the facility failed to ensure the arbitration agreement is explained to the resident or representative in a manner they understand, and had a signature from the resident if they agreed to the arbitration agreement, for 2 of 3 residents reviewed for Arbitration (Resident #149 and Resident #143). The findings included: During the initial entrance conference on 09/09/24 at 9:17 AM, the surveyor requested a list of residents who currently reside in the facility and entered into a binding arbitration agreement. On 09/11/24 Surveyor was given a list of residents that have a Y or a N next to their name. Surveyor chose three residents that were recently admitted to the facility with a high BIMS (Brief Interview for Mental Status) to interview. A review of Resident #149 medical records revealed this resident is on the Rehab unit (SSU) and admitted to the facility on [DATE]. Her 5-day Medicare MDS (Minimum Data Set) documents her BIMS (Brief Interview for Mental Status) as a 15/15, which means her cognition is intact. During an interview with Resident #149 on 09/12/24 at 12:15 PM, the surveyor asked this resident if she signed an arbitration agreement (Surveyor had this resident's documents in hand). The resident stated, oh someone just came in and had me sign something in reference to that. Surveyor showed her the piece of paper and asked if that was the paper and was that her signature. She stated yes that's it. Surveyor asked if the person who came in explained to her what she signed, the arbitration agreement. She stated no. She was asked if she knew what she signed and she stated no. When asked if they had her sign on the computer pad, she stated no. When asked if they left a copy of the arbitration agreement for her, she stated no. A review of Resident #143 medical records revealed this resident is on the Rehab Unit (SSU) and was admitted on [DATE]. Her MDS documents she has a BIMS of 15/15, which means her cognition is intact. During an interview on 09/12/24 at 12:35 PM with Resident #143, the Surveyor asked this resident if she signed an arbitration agreement. She stated, someone just came in and had me sign something in reference to that. The Surveyor showed the document to her. She stated yes that's it. When asked if they explained the arbitration agreement, she stated no. Did you know what you signed, she stated no. When asked if they had her sign on the computer pad, she stated no. She was asked if they left her a copy of the arbitration agreement, she stated no. She also stated they had her sign the paper but told her not to date it. During an interview on 09/12/24 at 12:40 PM with the Marketing Director, she stated that the previous Admissions Director was promoted and no longer in facility. The new Admissions Director started last week on Monday. Surveyor asked who went to talk to the residents and she stated I think it was the backup, the Receiptionist on SSU (the Rehab Unit), she was the backup support to the Admissions Director. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 1:05 PM with the Receptionist on SSU, Staff S, she stated she did backup for admissions. She stated she did not go in anyone's room today to have them sign arbitration agreements. If patient can speak for themselves, I go and talk and talk with them, tell them who I am, go through admission packet and tell them what arbitration agreement. If arbitration is not e-signed (electronically signed) that means they don't want arbitration. I go through the process on the computer tablet. The next section says do you want to go forward without an e-signature and click confirmed. If you don't see an e-signature, then they didn't want arbitration, and we then e-sign our name. On 09/12/24 at 1:30 PM, the Marketing Director and Administrator came in the conference room. The Marketing Director acknowledged that it was not Staff S, it was Staff T, Admissions Director, who went into the rooms today. I have not trained her yet. The Administrator then stated Staff T misunderstood me, when I told her to print out the packets and get the signature pages for me. She stated that she had an arbitration packet. The Marketing Director stated that the list she had given to me (the Surveyor) was a printed list on who signed the acknowledgement not who signed the arbitration. Surveyor then asked for them to print a list of who signed and wanted the arbitration agreement. She came back with a list of residents and had a 0 or 1 next to their name. She stated the 1 is who agreed to do the arbitration agreement and 0 they did not agree to it. Surveyor reviewed the list, and the residents she originally looked at had a 1 next to their name but the actual arbitration agreement did not have a e-signature on the documents but had a printed name. None of the arbitration agreements that had a 1 next to their name had an e-signature. During an interview on 09/13/24 at 12:22 PM with Staff T, Admissions Director, she stated the Administrator asked me to print the arbitration agreements for the three names you had requested. She said that the paper showed that they had signed the acknowledgement page, but they didn't have their signatures. The Administrator asked for me to go to the two residents' rooms to get them signed. I am new just been here since 08/20/24, I haven't been trained on them yet, but starting to learn. They both signed. I did give Resident #149 a copy to read when I was in the room but did not give either resident a copy of the arbitration agreement. She acknowledged that she did not bring in her tablet to have them electronically sign.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, record review, and policy review, the facility failed to follow infection control standards to ensure appropriate treatment for a rash outbreak on 1 of 5 units ([NAME] Unit) affecting sampled Residents #25, #30, #32, #33, #40, #42, #56, #73, #87, #93, #99, #109, #123, and #133; failed to report a rash outbreak to the Florida Department of Health (DOH); and failed to follow Enhanced Barrier Precautions (EBP) for 1 of 3 sampled residents with an indwelling urinary device for Resident #112. The findings included: 1. On 09/12/24 at 3:20 PM, a call from the Florida DOH revealed they had received a report of numerous residents on the [NAME] unit that had had a rash that was not identified, not reported to the DOH, and or that the facility was hiding as dermatitis (inflammation of the skin). On 09/13/24, the Director of Nursing (DON) was asked to provide a list of residents that have had any type of rash since 07/01/24 to the present time. The DON provided a list of ten residents, all who resided on the [NAME] unit. Review of these residents revealed the following: a) Resident #25 was administered 12 mg of Ivermectin, an anti-parasite medication, on 07/30/24 for dermatitis. The resident was never administered a second dose. b) Resident #40 (roommate of Resident #25) was administered 12 mg of Ivermectin on 07/30/24 for prophylaxis. Resident #40 did not receive a second dose. c) Resident #30 was ordered 12 mg of Ivermectin on 07/30/24 for dermatitis, with the order being discontinued on 07/31/24 and not provided. d) Resident #87 (roommate of Resident #30) was administered Nystatin powder starting on 08/01/24, daily for 30 days, for a rash. e) Resident #32 was ordered 12 mg of Ivermectin on 07/30/24 for dermatitis, with the order being discontinued on 07/31/24 and not provided. f) Resident #123 (roommate of Resident #32) had a rash in March and April 2024. The resident was not treated for any rash in July. g) Resident #33 was administered Ivermectin 12 mg on 07/30/24 for dermatitis. The resident received a second 12 mg dose of Ivermectin on 08/06/24 for dermatitis. h) Resident #56 (roommate of Resident #33) was administered 12 mg of Ivermectin on 07/30/24 as prophylaxis. The resident was not administered a second dose. i) Resident #42 was administered 12 mg of Ivermectin on 07/30/24 for dermatitis. The resident received a second dose on 08/06/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j) Resident #109 (roommate of Resident #42) was administered Ketoconazole Cream 2% for seborrheic dermatitis, daily for 90 days, starting on 07/31/24. Ketoconazole Shampoo was initiated on 08/03/24, to be applied twice weekly for seborrheic dermatitis, for 90 days. Resident #109 was not treated prophylactically with the Ivermectin. k) Resident #73 was treated with 12 mg of Ivermectin on 07/22/24 for scabies. The resident did not receive a second dose. l) Resident #133 (roommate of Resident #73) was not treated prophylactically. m) Resident #93 was administered 9 mg of Ivermectin on 07/31/24 for dermatitis. The resident received a second dose on 08/07/24. n) Resident #99 (roommate of Resident #93) was ordered 9 mg of Ivermectin on 07/30/24 for dermatitis, with the order being discontinued on 07/31/24 and not provided. Resident #99 was never treated prophylactically. The above revealed seven residents on the [NAME] unit were administered Ivermectin for either dermatitis or scabies. As per the DOH representatives, who were onsite with the surveyor on 9/13/24, if there are three or more residents with any type of rash, it is considered an outbreak. Any outbreak must be reported to the Florida DOH for tracking and to provide education and assistance to the facility. The facility failed to report the July and August 2024 rash outbreak on the [NAME] unit. As per the DOH representatives, recommendations regarding a possible scabies outbreak, which is treated with Ivermectin, is to treat all residents and staff on the unit in order to irradicate the parasite. During a phone interview on 09/13/24 at 10:54 AM, when asked if she was aware of skin issues on the [NAME] unit in July/August 2024, the Physician Assistant (PA) who ordered the Ivermectin stated she say all types of skin issues and confirmed she ordered the Ivermectin for dermatitis as per the physician's recommendations. When asked the guidance used for dosing the Ivermectin, the PA stated she followed Epocretes and dosed per the resident's weight. The PA stated she ordered one dose followed by a second dose in one week. When asked if she was aware that some of the residents did not receive the second dose, she stated she was not. When asked if all of the roommates were treated prophylactically, the PA stated, probably not. When asked to describe the rashes observed and treated with the Ivermectin, the PA stated she did not recall all the rashes, but most were a red papule or dot, some with scratching and open areas, with most on the resident's truck, arms, and legs. When asked if she reported the rash outbreak to anyone, the PA stated she provided a list to the DON. During an interview on 09/13/24 at 11:00 AM, when asked if they had a rash outbreak in July/August of 2024, the DON stated they had several cases of dermatitis but denied any scabies outbreak. When asked if she reported the rash outbreak to the Florida DOH, the DON stated she was not aware she needed to do so. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the policy, titled, Enhanced Barrier Precautions, revised 05/28/24 documented, in part: Procedure: 1. Enhanced Barrier Precautions (EBP) are used for residents with any of the following: . b. wounds and/or indwelling medical devices even if the resident is not known to be colonized with MDRO (Multidrug-resistant organisms). 9. Appropriate PPE for EBP would include: a. Gown b. Gloves. 10. Employees should wear appropriate PPE when performing the following duties for residents requiring EBP: . f. Providing pericare such as changing briefs . h. Device care. Review of the record revealed Resident #112 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #112 had a Brief Interview for Mental Status (BIMS) score of 4, on a 0 to 10 scale, indicating severe cognitive impairment. This same MDS documented the resident had an indwelling urinary catheter with substantial to maximum assistance with toileting. Review of the care plan initiated on 04/10/24 documented the resident required EBP during high contact resident care activities. During an observation of personal and indwelling urinary catheter care on 09/11/24, beginning at 11:10 AM, Staff P, Certified Nursing Assistant (CNA), donned gloves, obtained supplies and provided personal and indwelling catheter care for Resident #112. The CNA failed to don a gown at any time during the care. Upon trying to turn the resident, the CNA realized she needed assistance, removed her gloves and left to get assistance. Upon return, Staff P provided hand hygiene, donned another pair of gloves and started providing care again. A second CNA entered the room with gloves and gown donned. Staff P stated, I forgot a gown. They didn't tell me to. When asked if she understood why gowns were being uses, Staff P stated, No they haven't told my anything about it. 38893

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to maintain a functioning call system for 1 of 26 sampled residents, Resident #27; and failed to maintain a call light in a manner to be accessible to the resident for 1 of 26 sampled residents, Resident #95. The findings included: 1. Record review revealed Resident #27 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitive was intact. During an interview with Resident #27, on 09/10/24 at 9:20 AM, and the surveyor requested Resident #27 to initiate the call system by pressing a button at the end of the call light cord. Resident #27 pressed the button and there was no light over the door to indicate that the resident had initiated the call light and no signal at the nurse' station to indicate that Resident #27 had initiated the call light. At the time of the observation, Staff B, Licensed Practical Nurse (LPN), was notified of the concern and confirmed there was no indication on the unit and at the nurse's station that the call light had been initiated by Resident #27. 2. Record review revealed Resident #95 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Quarterly MDS, dated [DATE], revealed Resident #95 had a BIMS score of 13, indicating cognition was intact. During an interview with Resident #95 on 09/10/24 at 10:42 AM, and the surveyor requested Resident #95 to initiate the call light. It was then noted that the cord for the call light was tightly wrapped around the bedrail to the resident's left side of the bed and the button that Resident #95 would need to push to initiate the call light was at the end of the cord underneath the resident's bed. Resident #95 stated the call light was where the resident was unable to reach it. At the time of the interview and observation, the Environmental Services Director was notified of the concern. At this time, the Environmental Services Director struggled to untangle the cord from the resident's bedrail.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Surveyor: [NAME], [NAME] Based on observations, interviews and record reviews, the facility failed to provide a safe, sanitary and comfortable environment for residents, staff and the public, in the common areas on 4 of 5 units ([NAME], Canterbury, [NAME], and [NAME]). The findings included: 1. There was an accumulation of dust and mold-like substance in the air condition vents and ducts on the [NAME] Unit, the Canterbury Unit, the [NAME] Unit and the [NAME] Unit, as well as the common areas and dining areas of the units. 2. In the Shower room on Canterbury unit, there was a large puddle of water on the floor at the commode, the toilet was running, the wall under the shower on the left side of the room was damaged, there was an accumulation of dust on the inside of the air conditioning vent and duct. 3. In the soiled utility room on the Canterbury unit, the wall was damaged inside of entrance to the room, and there was a sink filled with standing dirty water. 4. The wall in the employee bathroom of the [NAME] Unit was damaged, the base board at the commode was damaged, the wall at the hand washing sink was damaged and unfinished. 5. There was an accumulation of debris in the vents of the wall mounted air conditioning units in the patio area of the [NAME] Unit. 6. In the restroom at the nurse's station between [NAME] and Canterbury, the hand washing sink was not secured to the wall and there was a hole in the wall behind the pedestal supporting the sink. 7. In the restroom at the nurse's stations between [NAME] and [NAME], the handle for cold water at the hand washing sink was broken off and oxidizing, and the wall behind the sink pedestal was damaged. 8. There were several holes in the wall around the nurse's station in the [NAME] Unit. 9. In the pantry between the [NAME] and Canterbury Units, a water cooler was stored on a piece of raw plywood, there was an accumulation of debris behind a secured box for shredding documents, and there was an accumulation of dust on the air conditioning vent. 10. In the pantry between the [NAME] and [NAME] Units, there was an accumulation of debris behind a secured box for shredding documents. 11. During an environmental tour of the facility, on 09/12/24 at 4:25 PM, with the Maintenance Director, the Maintenance Director acknowledged understanding of the concerns.