

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 02/19/2026
NAME OF PROVIDER OR SUPPLIER Vero Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident was treated in a dignified manner for 1 of 1 sampled resident reviewed for dignity, Resident #171. The findings included: Review of the policy for Resident Rights dated 09/21 and revised 01/24 documents: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. Employees shall treat all residents with kindness, respect and dignity. These rights include the resident's right to: a. dignified existence; b. be treated with respect, kindness and dignity. Record review documents Resident #171 was admitted to the facility on [DATE] with diagnoses to include: Acute Kidney Failure, Alcoholic Cirrhosis of the Liver with Ascites, End Stage Renal Disease, Dependence on Renal Dialysis, Muscle Weakness, Muscle Wasting and Atrophy, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms and Lack of Coordination. During an interview with Resident #171 on 02/16/26 at 11:00 AM, the resident stated that he had asked to be changed after he soiled his brief and every day the CNA's (Certified Nursing Assistants) tell him that they cannot change him during breakfast, so he sits in his dirty brief until they can. On 02/17/26 at 9:00 AM while talking to Resident #171, Staff J, CNA, walked into the resident's room, and he asked to be changed. She stated to the resident in front of the surveyor that she could not change him during mealtime until after all the trays are picked up. He stated to the surveyor that he pressed his call light around 2:00 AM and a CNA came in and said what do you want now he told her that he spilled his urinal that had urine in it, on the bed and himself and needed to be changed. He could not remember the CNA's name but found out later that it was Staff P, CNA. He said she gave him a nasty attitude. He stated she changed everything except his gown, which he had rolled up because it was wet. When he pressed the call light again, he could hear her stomping down the hall, she came in and he mentioned aren't you going to change my gown, I am freezing and wet. He stated again she had an attitude. During an interview on 02/17/26 at 9:05 AM with Staff J, CNA, the surveyor asked why she would not change him. She stated that they are not allowed to change residents during mealtimes because that is an infection control issue. During an interview on 02/18/26 at 10:15 AM with Staff K, Register Nurse (RN) / Supervisor / Unit Manager, she was asked about staff changing the residents' during mealtimes. She stated that the CNA's are not allowed to go into the rooms to change residents until the meals are delivered. She also stated that she wrote a grievance on what Resident #171 had told her which was slightly different than what he had told the surveyor. During an interview on 02/18/26 at 10:43 AM with Staff L, CNA, when asked if a resident requested to be changed during mealtime, what would she do and responded, 'we were trained not to do care during meals. We have to wait until the food is delivered and taken up. I will try to do my care before the trays come out. If there is an emergency, then I might (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a completed informed consent (with date) for residents prescribed psychotropic medications for 1 of 5 sampled residents reviewed for unnecessary medication review, Resident #9. The findings included: Review of the facility's policy, titled, Medication Utilization and Prescribing - Clinical Protocol, with a revised date of 01/2024, included in part the following: Consent for medications including but not limited to psychotropic medications are included in the consent to treat. Review of the facility's policy, titled, Documentation, with a revised date of 01/2026, included in part the following: Documentation for procedure and treatments will include care-specific details, including the date and time the procedure/treatment was provided. Record review for Resident #9 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Generalized Anxiety Disorder, Cognitive Communication Deficit, Dementia, Unspecified Mood (Affective) Disorder, Bipolar Disorder, and Major Depressive Disorder. Review of the Minimum Data Set assessment dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #9 revealed in part the following: An order dated 09/24/25 for Lithium Carbonate Oral Capsule 300 MG Give 300 mg by mouth two times a day related to Bipolar Disorder. An order dated 09/24/25 for Zolofl Oral Tablet 100 MG (Sertraline HCl) Give 100 mg by mouth one time a day related to Major Depressive Disorder. An order dated 09/24/25 for Nuedexta Oral Capsule 20-10 MG (Dextromethorphan HBr-Quinidine Sulfate) Give 1 capsule by mouth one time a day related to Pseudobulbar Affect. Review of the Psychoactive Medication Informed Consent for Resident #9 revealed 5 separate consents for the following: Seroquel XR 150mg, Keppra 1,000mg, Nuedexta 20-10mg, Zolofl 100mg, and Lithium Carbonate 300mg. All consent forms documented a verbal consent from the resident representative, signed by 2 staff members and no date on any part of any of the 5 consents. During an interview conducted on 02/18/26 at 4:30 PM with Director of Nursing (DON), the DON who confirmed there were no dates on any of the informed consents (5) for Resident #9 and that the informed consents should have a date on them.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure the accommodation of needs for 1 of 1 sampled resident as evidenced by the lack of bedside rails for Resident #42 as per the facility's assessment and the resident's request. The findings included: Review of the facility's policy titled, Proper Use of Side Rails, dated September 2022, documented in part, 1. Side rails are only permissible if used to treat a resident's medical symptoms or assist with mobility and transfer of residents, or at the request of the resident or resident's representative. 2. A side rail evaluation will be completed to determine the resident's need for using side rails. Review of the record for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses that included mild Left-Hand Contracture (left hand curling inwards) and Ataxia (lack of muscle control or coordination). Review of the current Minimum Data Set (MDS) assessment, dated 02/04/26, documented a Brief Interview for Mental Status (BIMS) score of 15, on a 0-15 scale indicating the resident was cognitively intact. Review of the Physician's Orders indicated Resident #42 had an order dated 01/07/26 for Side rail to bilateral bed as an enabler for bed mobility. Review of the current Side Rail Evaluation, dated 01/30/26, documented the resident would benefit from the use of both side rails to promote independence for transferring and movement in bed. This evaluation also documented that Resident #42 understood the risks and benefits of the side rail and consented to its use. Review of the Side Rail Consent form dated 06/11/25 had no signature. During an observation on 02/17/26 at 9:33 AM, Resident #42 was observed in bed with no side rails in place. On 02/18/26 at 9:10 AM, the resident was again observed in bed with no side rails. During an interview on 02/19/26 at 9:45 AM, the Director of Nursing (DON) was asked to explain the facility's Side Rail policy. She stated that Physical / Occupational Therapy would screen the resident for the appropriateness, the resident would provide consent if he or she is deemed appropriate, and an order would be placed. The DON confirmed that there was an order for side rails for the resident since 01/07/26, and Resident #42 was deemed as appropriate. She further stated that not only did the resident's son provide consent in the admission records on 11/24/25, but also, Resident #42 requested to have them during a facility-wide side rail audit in January but did not get them.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment in 5 of 14 resident rooms in the [NAME] Unit affecting residents in rooms 107, 112, 115, 116, and 117. The findings included: Review of the facility's policy titled, Homelike Environment, with a revised date of 01/2025, included in part the following: Staff shall provide person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The facility staff and management shall provide to the extent possible: a clean, safe, comfortable homelike environment catered to the residents personal preferences as able. 1. On 02/16/26 at 11:30 AM, an observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord in the bathroom wrapped around the grab bar. Both residents in the room utilize the toilet. On 02/17/26 at 8:35 AM, an observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord in the bathroom continued to be wrapped around the grab bar. On 02/17/26 at 10:0 AM, an observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord in the bathroom continued to be wrapped around the grab bar. 2 On 02/16/26 at 10:32 AM, an observation was made in room [ROOM NUMBER] of the bathroom with no paper towels. The light above the head of the bed for Resident #68 did not work unless the light switch located at the room door was activated. The pull cord from the light (located behind the resident) was only about 8 inches long and the resident was unable to reach it. On 02/17/26 at 11:45 AM, a second observation was made in room [ROOM NUMBER] of the bathroom with no paper towels. 3 On 02/16/26 at 10:10 AM, an observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord wrapped around the grab bar and no paper towels. On 02/16/26 at 3:30 PM, a second observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord wrapped around the grab bar and no paper towels. On 02/17/26 10:39 AM, a third observation was made in the bathroom of room [ROOM NUMBER] of the emergency pull cord wrapped around the grab bar and still no paper towels. 4 On 02/16/26 at 10:20 AM, in room [ROOM NUMBER], an observation was made of the bathroom with one light bulb not working. 5 On 02/16/26 at 10:15 AM, in room [ROOM NUMBER], an observation was made of no paper towels in the bathroom. On 02/16/26 at 10:27 AM, an observation was made in room [ROOM NUMBER] of light above bed not working unless the light switch on the wall next to the door is activated. The emergency cord in the bathroom was wrapped around the grab bar. During an interview conducted on 02/16/26 at 10:32 AM with Resident #68 who was asked about the light behind her bed, she said she cannot put it on, it has to be turned on from the switch on the wall next to the door to her room. When asked if she gets up to turn on the light switch to put the light on, she said she cannot, she cannot get out of bed without assistance. When asked if she would like to turn on the light by herself, she said sometimes it would be nice to do it herself. When asked if she uses the bathroom, she said yes but she needs assistance, she cannot do it by herself. On 02/18/26 at 9:15 AM, a tour of the facility and laundry area was conducted with the Administrator, Director of Maintenance, Director of Housekeeping and Regional Plant Operations as well as interviews while doing the tour. They acknowledged one of the light switches in the rooms next to the door controls the lights on the wall behind the head of the bed(s) in the rooms and if it is in the off position, the pull cord from the light on the wall behind the bed would not work. They also acknowledged some of the pull cords from the (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lights on the wall behind the beds were too short and residents were unable to reach the cord. They acknowledged some of the rooms did not have any paper towels in the bathroom. They also acknowledged some of the emergency pull cords in the bathrooms were wrapped around the grab bars and they should be hanging freely.		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and interview, the facility failed to ensure that when residents are admitted to the facility that there are physician orders for the residents' immediate care for 1 of 1 sampled resident reviewed for dialysis, Resident #171. The findings included: Review of the facility Policy and Procedure for New Admissions issued 01/19 and revised 02/24 documents, in part, the following: the primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility. The objectives of our admission policies are to admit residents who can be adequately cared for by the facility, reduce the fears and anxieties of the resident and family during the admission process, and assure the appropriate medical and financial records are provided to the facility prior to or upon the resident's admission. Review of Resident #171 medical records revealed the resident was admitted on [DATE] with a diagnosis to include Acute Kidney Failure, Alcoholic Cirrhosis of the Liver with Ascites, End Stage Renal Disease (ESRD), Dependence on Renal Dialysis, Muscle Weakness, Muscle Wasting and Atrophy, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms and Lack of Coordination. The resident's Brief Interview for Mental Status (BIMS) was not conducted due to the resident being a new admission, although the discharge document (Form 3308) documented he was alert, oriented and could follow directions. Review of the 3008-transfer form from the hospital did not have a discharge date but documented the last vital signs were taken at 3:30 PM for Resident #171 and included in part the following: Dialysis M_W_F [Monday, Wednesday, and Friday] chair time 5:15 AM. Review of the Physician's Orders for Resident #171 included in part the following: Hemodialysis (HD) Res [resident] receives HD every Monday, Wednesday, Friday at [dialysis facility name and address]. Chair time is 555am [5:55 AM] transported by [Transport Name and phone number] via [W/C [wheelchair], stretcher, geri-chair, etc.] with P/U [pick-up] time of 5am [5:00 AM]. Start date: 02/18/26.-HD Right Subclavian extremity precautions - no lab draws, no B/P [blood pressure], etc. every shift for hemodialysis. Start date 02/16/26 3:00 PM.-Hemodialysis - Offer Res a packaged meal and/or snack on Monday, Wednesday, Friday before HD appointment. Start date 02/18/26.-HD Right Subclavian dialysis access port/line: Do not access this line - for Hemodialysis use only. every shift for hemodialysis Start date 02/16/26 3:00 PM.-Hemodialysis - Right Subclavian PORT, dialysis access port/line: HD center [Name of renal facility] to complete routine dressing changes. May reinforce the dressing if dislodged. May replace the dressing if unable to reinforce using sterile technique.-Hemodialysis - Right Subclavian Port dialysis access port/line. Monitor site for s/s of infection, pain, drainage, increased temp, edema, bleeding, etc. Notify physician of abnormal findings.-Hemodialysis - Right Subclavian chest port: [NAME], [NAME], Permcath dialysis access port/line. Monitor site for s/s of infection, pain, drainage, increased temp, edema, bleeding, etc. Notify physician of abnormal findings. every shift for ESRD.-Observe for signs and symptoms of excessive bruising, hematuria, hemoptysis, or bleeding. Report abnormalities to the physician.-Renal diet, Regular texture, thin consistency. Start date 02/15/16. In summary, there were no orders for dialysis until 02/16/26, (admitted [DATE]), and the resident missed the treatment of dialysis on 02/16/26 (Monday). During an interview conducted on 02/16/26 at 9:00 AM with Resident #171 when asked if he had any concerns, he stated he was upset about dialysis not being done today, and he was supposed to go today at 5:00 AM. He also added he is a new dialysis patient and just started when he was in the hospital and was told he was to continue the dialysis, but he is unsure of the process since this is all new to him. It was observed that the resident was concerned about missing his dialysis (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment. During an interview on 02/18/26 at 3:34 PM with the DON (Director of Nursing) who was asked about Resident #171 and his dialysis treatment, she stated that on 02/18/26 she was reviewing Resident #171's orders since he was a new admission to the facility on [DATE]. She stated she did not see any orders for dialysis including the dialysis center, days or chair time. She called Registered Nurse (RN) Unit Manager and instructed her to ask the resident where he normally goes to dialysis and what days. The RN Unit Manager informed the DON the resident could only tell them he is new to dialysis and not sure where he was supposed to go but believed it was supposed to be in the [city] area. The DON contacted a dialysis center in [city] and the person who answered confirmed the resident was supposed to start dialysis at their center Monday, Wednesday, and Fridays with a chair time of 5:45 AM once he was discharged from the hospital, but they were never notified of the resident being discharged from the hospital. During an interview on 02/18/26 at 3:50 PM with Staff R, Admissions/ Marketing Director, who was asked about Resident #171, stated the hospital contacted her on 02/13/26 regarding the admission to see if we would accept him. Staff R stated she read the clinicals and then got authorization from his insurance. The hospital did not inform me that he was currently receiving dialysis and would need to continue dialysis treatments. When asked if she had inquired about any special circumstances or treatment(s) the resident would need, she said she did not ask. When asked what if she had any clinical knowledge, and she said she had been a Certified Nursing Assistant. She added the Form 3008, transfer document, was given to them upon admission and would come with the resident. She was asked what she looked at to determine if he was the right fit for this facility. Staff R stated that I look at history and physical, the physical therapy and occupational therapy notes and the medication list. She further stated if we knew he was on dialysis then I would have scheduled him for transport but didn't know. During a telephone interview on 02/19/26 at 10:36 AM with Staff Q, LPN (Licensed Practical Nurse), he was asked what the admission process. He stated we go over the hospital notes/orders and review the notes that were sent with him. He was asked when a resident comes in with a dialysis port, do they obtain physician orders, and Staff Q stated, he does a brief interview with the resident and then he does a head-to-toe assessment. When asked about Resident #171, the LPN stated he had an issue with his documents, he could not find paperwork or orders about dialysis. The LPN stated he reached out to his unit manager via text message, and the Unit Manager responded the next day that she would be in the next day and would take care of getting the dialysis order and setting up transportation to the dialysis center for the resident. When asked if he documented this interaction with the Unit Manager, he said I don't remember if I made a note. When asked if he contacted the admitting physician, he said he did not reach out to the physician. During an interview conducted on 02/19/26 at 12:15 PM with Staff K, RN Unit Manager (RNUM), she was asked about Resident #171, and responded she received a text message from Staff Q on Friday night (02/13/26) but she did not see the text message until the next day (02/14/26) regarding Resident #171 who was supposed to receive dialysis but he had no orders for dialysis. She texted the nurse back once she saw the message saying she would follow up and called Admissions (Staff R) to set up the dialysis, he had dialysis chair time but no orders. Staff R stated she would be in on Sunday and would set it up. Staff K, RN/UM, came in on Sunday to work but did not see Staff R following up with her to make sure the dialysis was set up. She said she spoke to the DON (Director of Nursing) on Sunday to inform her of the situation. Monday, she notified Staff R again; on Tuesday the orders were in, and the dialysis was set up. When asked if she had made the physician aware of the situation, she said no. When asked if a resident is supposed to receive dialysis, and it is not set up or they have no orders would they notify the physician, she said they would notify the physician. When asked if she did this, she said she (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code antipsychotic medication use for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #82; failed to accurately code mobility status for 1 of 4 sampled residents reviewed for Activities of Daily Living, Resident #42; and failed to code the presence of a colostomy for 1 of 3 sampled residents reviewed, Resident #153. The findings Included:1. Clinical record review revealed Resident #82 was admitted to the facility on [DATE], with a readmission on [DATE], with diagnoses including Non-Alzheimer's Dementia, Anxiety Disorder, and Depression. Review of the Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/04/25 revealed the following: Under Section N (Medications), item N0410A (Antipsychotic Medications), the resident was coded as No. Review of the December 2025 Medication Administration Record (MAR) indicated the resident received Seroquel (quetiapine) 25 mg by mouth twice daily for brief psychosis/mood stabilization from 12/01/25 through 12/05/25. Section N0410A should have been coded as Yes. On 02/19/26 at 9:20 AM, a side-by-side review and interview was conducted with Staff E, the MDS Coordinator. Staff E confirmed the medication was administered during the look-back period and agreed the assessment was coded inaccurately. 2. Review of the medical record documented Resident #42 was admitted to the facility on [DATE] with medical diagnoses that included Mild Left-Hand Contracture (left hand curling inwards) and Ataxia (lack of muscle control or coordination). Review of the current MDS assessment, dated 02/04/26, documented Resident #42 had no impairment to the upper extremities and a diagnosis of Left-Hand Contracture. Review of the Physician's order dated 01/12/26, instructed that Resident #42 wear a left-hand Blue Carrot orthosis (carrot shaped hand splint) in the mornings and after activities of daily living as the resident tolerated. During a side-by-side record review and interview on 02/19/26 at 10:00 AM, Staff E, MDS Coordinator, was asked about the documentation of the resident's range of motion. Staff E confirmed that the MDS assessment documented no impairment to the resident's upper extremity and the resident's left hand is contracted. 3. Review of the record revealed Resident #153 was admitted to the facility on [DATE]. Further review of the record revealed the resident had a colostomy (a surgical procedure that creates an opening in the abdominal wall to divert waste into a replaceable bag) as of 10/30/24. During an observation on 02/17/26 at 3:08 PM, when asked if he had a colostomy, Resident #153 stated he did and showed it to the surveyor. Review of the Quarterly MDS assessment dated [DATE] documented the resident did not have a colostomy. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/26 at 2:33 PM, when asked if she knew Resident #153 had a colostomy, Staff E, MDS Coordinator, stated she did. When asked about the MDS coding of no colostomy, Staff E stated, I know he has a colostomy, and agreed with the findings.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and interview, the facility failed to ensure appropriate care and services for 6 of 44 sampled residents as evidenced by the failure to ensure hospice nursing services for Resident #29; failure to ensure timely medication administration for Residents #110, #155, and #169; and failure to follow physician ordered blood pressure parameters for Residents #1 and #41. Findings include: Review of the Hospice Agreement dated January 5, 2024, between the hospice agency and the facility indicated: Hospice agrees to provide services to eligible residents according to a hospice plan. Regulations require that each hospice patient has a hospice plan, and that all services provided be consistent with such plan. Hospice shall provide the appropriate scope and frequency of services individualized to patient needs. Home shall prepare and maintain medical records for each hospice patient receiving services pursuant to the agreement. Medical records shall consist of progress notes describing all services and events. Hospice, in conjunction with the patient, family, and facility, schedules visits as indicated in the hospice plan. This includes visits from all team members. The scope and frequency of services will reflect the needs of the patient. 1. Clinical record review revealed Resident #29 was admitted to the facility on [DATE] and 10/12/22. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 00, indicating significant cognitive impairment. Review of the physician order dated 08/19/25 indicated admission to hospice services related to Cerebral Atherosclerosis. Review of the care plan revised 01/20/26 documented the resident was receiving Palliative and/or Hospice Services. Review revealed the Hospice Recertification Period was from 11/17/25 through 02/14/26. Review of the Orders indicated Skilled Nursing: 1 visit per week for 13 weeks (effective 11/17/25); Home Health Aide (HHA): 1 visit per week for 1 week (effective 12/28/25); and then 2 visits per week for 6 weeks. Review of the documentation lacked evidence of required HHA visits for multiple weeks, as follows: 01/11/26–01/17/26: Only 1 documented visit (01/12/26); no evidence of second required visit. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/18/26&ndash;01/24/26: Only 1 documented visit (01/22/26); second required visit not evidenced. 01/25/26&ndash;01/31/26: No documented HHA visits. 02/08/26&ndash;02/14/26: No documented HHA visits. Due to lack of documentation, there was no evidence ordered services were provided. Review of the documentation lacked evidence of weekly skilled nurse visits for the following weeks: 11/23/25&ndash;11/29/25 12/07/25&ndash;12/13/25 12/14/25&ndash;12/20/25 12/21/25&ndash;12/27/25 01/11/26&ndash;01/17/26 01/25/26&ndash;01/31/26 02/01/26&ndash;02/07/26 02/08/26&ndash;02/14/26 There was no documented evidence to support that ordered skilled nursing visits were completed. On 02/19/26 at 9:32 AM, an interview and side-by-side record review was conducted with the Director of Nursing (DON). When asked to provide documentation of the hospice nurse and HHA visits in accordance with the recertification period (11/17/25&ndash;02/14/26), the DON acknowledged a lack of documented visits in the facility record. When asked how often the hospice nurse and aides were scheduled to visit Resident #29, the DON did not provide a response. When asked how hospice visits were tracked, the DON stated that hospice typically emails visit notes to the facility. The DON contacted the hospice agency and requested documentation for the specified certification period. Documentation was not provided to account for the required visits. On 02/19/26 at 12:01 PM, the hospice nurse was interviewed and was informed of the lack of documented skilled nurse and HHA visits based on the ordered frequency. The hospice nurse stated she would search for the documentation. The requested documents were not provided. 2. Review of the policy for Medication Administration issued 10/20 and revised 01/24 documents that medication are ordered and administered safely and as prescribed; 6. documents under procedures that medications are administered within one hour before or after their prescribed time unless otherwise specified. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Review of Resident #110 medical records revealed Resident #110 was admitted to the facility on [DATE] with diagnoses to include Nondisplaced Bimalleolar Fracture of Right Lower Leg, Chronic Obstructive Pulmonary Disease (COPD), Type II Diabetes, and Migraines. Review of Resident #110 MAR (Medication Administration Record) for February 2026 revealed the following medications on the dates and times below were administered past the 1-hour requirement: On 02/10/26, the 3:00 PM medication Metoprolol Tartrate Oral Tab 50 MG Give 1 tablet by mouth every day and evening for Hypertension, was not given until 9:07 PM. On 02/11/26, the 3:00 PM medication Metoprolol Tartrate Oral Tablet 50 MG Give 1 tablet by mouth every day and evening for Hypertension, was not given until 7:52 PM. On 02/11/26, the 5:00 PM medication Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder 1 inhalation orally two times a day for COPD, was not given until 7:45 PM. On 02/12/26, the 3:00 PM medication Metoprolol Tartrate Oral Tablet 50 MG Give 1 tablet by mouth every day and evening for Hypertension, was not given until 9:14 PM. On 02/13/26, the 9:00 AM medications were not given until the following times. *Cyanocobalamin tab 1000mcg Give 1 tablet by mouth one time a day for Anemia, was not given until 11:19 AM. *Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder 1 inhalation orally two times a day for COPD, not given until 11:22 AM. *Aspirin EC tab delayed response 81 mg Give 1 tablet by mouth one time a day for Coronary Artery Disease, was not given until 11:19 AM. *Furosemide Oral Tab 20 MG Give 3 tablets by mouth one time a day for Edema, was not given until 11:19 AM. *Metoprolol Tartrate 50 MG Give 1 tablet by mouth two times a day for Hypertension, was not given until 11:19 AM. *Prednisone Oral tab Give 20 MG by mouth one time a day for swelling for 5 days until finished, was not given until 11:20 AM. *Lactulose Oral Solution 20 GM/30ML. Give by mouth one time a day for constipation, was given until 11:22 AM. On 02/17/26, the 9:00 PM medications were given at 10:53 PM for the following medications: Topiramate Oral Tablet 100 MG Give 1 tablet by mouth at bedtime for seizure activity/mood disorder. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rosuvastatin Calcium Tablet 10 MG 1 tablet by mouth at bedtime for hyperlipidemia Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth every morning and at bedtime for neuropathy. Amitriptyline HCL Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression Metformin HCL oral tablet 500 MG Give 500 mg by mouth every 12 hours for DM2. During an interview on 02/16/26 at 2:36 PM with Resident #110, she stated her medications are always late. 2b. Review of Resident #155 medical records revealed Resident #155 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Atrial Fibrillation, Hyperlipidemia, Depression and Heart Failure. Review of the MDS assessment dated [DATE] documented a BIMS (Brief Interview Mental Status) score of 14, indicating intact cognition. Review of Resident #155's MAR for February 2026 revealed that the following medications on the dates and times below were administered past the 1-hour requirement: On 02/03/26, the 9:15 PM medication Trazadone HCL Tablet 50 MG 1 tablet by mouth three times a day for MDD (Major Mood Disorder) was not given until 11:04 PM. On 02/06/26, the following medications that were scheduled for 5:00 PM, and were not given until 9:02 PM: Fluticasone-Salmeterol 50-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath was not given until 9:02 PM Amiodarone HCL oral tablet 200 MG Give 1 tablet by mouth two times a day for arrhythmia. Tizanidine HCL oral tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasm. Eliquis oral tablet 5 mg Give 1 tablet by mouth two times a day for Atrial-Fib. Rosuvastatin Calcium Oral Tab 5 MG Give 1 tab by mouth at bedtime for Hyperlipidemia. Buspirone HCL Oral tab 5 MG Give 1 tablet by mouth two times a day for Anxiety. On 02/07/26, the following medications scheduled for 9:00 AM, were given at the following times: Desvenlafaxine ER oral tab extended release 24-hour 50 MG 1 tab by mouth (PO) one time a day for MDD, not given until 11:06 AM. Centrum Women oral tab Multi vitamins with minerals. Give 1 tab PO one time a day for supplement, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not given until 11:02 AM. Culturelle oral capsule Give 1 tab by mouth one time a day for probiotic, not given until 11:01 AM. GlocoLax Powder Give 17 gram by mouth one time a day for constipation mix with 8 oz of liquids, not given until 11:06 AM. Eliquis oral tablet 5 mg Give 1 tablet by mouth two times a day for Atrial Fibrillation, not given until 11:07 AM. Furosemide Tab 20 MG Give 1 tab by mouth one time a day for Edema, not given until 11:06 AM. Cholecalciferol tablet 1000 unit Give 2 tablets by mouth one time a day supplement, not given until 11:01 AM. Biotin Oral tab 2.5 MG Give 1 tab by mouth one time a day supplement, not given until 11:01 AM. Metformin HCL Oral tab 500 MG Give 1 tablet by mouth one time a day for Diabetes Mellitus, not given until 11:06 AM. Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath, not given until 10:57 AM. Guaifenesin ER tab extended release 12-hour 600 MG Give 1 tab by mouth every 12 hours for cough, not given until 11:06 AM. Pepcid oral tablet 20 MG Give 1 tab by mouth one time a day for heartburn, not given until 11:09 AM. Pantoprazole 30 MG caps delayed release Give 1 capsule by mouth every shift for GERD, not given until 11:09 AM. Tizanidine HCL oral tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasm, not given until 11:09 AM Roflumilast Oral tablet 500 MCG Give 1 tablet by mouth 1 time a day for COPD, not given until 11:09 AM Metoprolol Succinate ER oral tablet extended release 24 hours 25 MG. Give 1 tablet by mouth one time a day for Hypertension, not given until 11:16 AM. Amiodarone HCL oral tablet 200 MG Give 1 tablet by mouth two times a day for arrhythmia, not given until 11:00 AM. Morphine Sulfate ER 60 MG Give 1 tablet by mouth every 12 hours for pain, not given until 11:00 AM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/26, the following medications scheduled for 5:00 PM, were given at the following times: Amiodarone HCL oral tablet 200 MG Give 1 tablet by mouth two times a day for arrythmia, not given until 7:29 PM. Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath, not given until 7:25 PM. Tizanidine HCL oral tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasm, not given until 7:25 PM. Eliquis oral tablet 5 mg Give 1 tablet by mouth two times a day for Atrial Fibrillation, not given until 7:25 PM. Buspirone HCL Oral tab 5 MG Give 1 tablet by mouth two times a day for Anxiety, not given until 7:25 PM. On 02/13/26, the following medications scheduled for 9:00 AM, were given at the following times: Centrum Women oral tab Multi vitamins with minerals. Give 1 tab PO one time a day for supplement, not given until 12:28 PM. Morphine Sulfate ER 60 MG Give 1 tablet by mouth every 12 hours for pain, not given until 12:33 PM. Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath, not given until 12:33 PM. Tizanidine HCL oral tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasm, not given until 12:35 PM. Metoprolol Succinate ER oral tablet extended release 24 hours 25 MG. Give 1 tablet by mouth one time a day for Hypertension, not given until 12:37 PM. Trazadone HCL Tab 50 MG 1 tab by mouth three times a day for MDD, not given until 12:35 PM, not given until 12:35 PM. On 02/15/26, the following medications scheduled for 9:00 AM, were given at the following times: Trazadone HCL Tab 50 MG 1 tab by mouth three times a day for MDD (Major Depressive Disorder), not given until 10:33 AM. Morphine Sulfate ER 60 MG Give 1 tablet by mouth every 12 hours for pain, not given until 10:32 AM Metformin HCL Oral tab 500 MG Give 1 tablet by mouth one time a day for Diabetes Mellitus, not given until 10:32 AM (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath, not given until 10:33 AM Metoprolol Succinate ER oral tablet extended release 24 hours 25 MG. Give 1 tablet by mouth one time a day for Hypertension, not given until 10:41 AM. On 02/17/26, the following medications scheduled for 5:00 PM, were given at the following times: Trazadone HCL Tab 50 MG 1 tab by mouth three times a day for MDD, not given until 7:08 PM. Amiodarone HCL oral tablet 200 MG Give 1 tablet by mouth two times a day for arrhythmia, not given until 7:12 PM. Fluticasone-Salmeterol 500-50 MCG/ACT Aerosol Powder 1 inhalation inhale orally two times a day for short of breath, not given until 7:12 PM. Tizanidine HCL oral tablet 4 MG Give 1 tablet by mouth three times a day for muscle spasm, not given until 7:08 PM. Eliquis oral tablet 5 mg Give 1 tablet by mouth two times a day for Atrial Fibrillation, not given until 7:12 PM. During an interview on 02/16/26 at 1:06 PM with Resident #155, the resident stated she has been getting her meds late, she is supposed to be getting her 8:00 AM medication that includes Blood Pressure (B/P) medication and doesn't receive it until 11:45 AM; and when the nurse comes in to check her blood pressure (BP), it was high. She stated to the nurse that's because I haven't received my BP medication yet. 2c. Review of Resident #169 medical records revealed Resident #169 was admitted to the facility on [DATE] with diagnoses to include Displaced Posterior Arch Fracture of First Cervical Vertebra, Displaced Intertrochanteric Fracture oof Left Femur, Major Depressive Disorder, Hypothyroidism, Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, and Lack of Coordination. Review of the February 2026 MAR documented, that on 02/13/26, her 9:00 AM medications were not given until the following times: Flomax Capsule 0.4MG Give 1 capsule by mouth one time a day for urinary retention for 14 days, was not given until 11:15 AM. Trazadone HCL Oral Tablet 150 MG Give 150 MG by mouth three times a day for Depression, was not given until 11:15 AM. Midodrine HCL Tablet 5 MG Give 1 tablet by mouth three times a day for hypotension for 10 days, was not given until 11:15 AM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enoxaparin Sodium Solution 30 MG/0.3ML Inject 30 MG Subcutaneously two times a day, was not given until 11:31 AM. On 02/15/26, the resident's midnight medication Methocarbamol Oral Tablet 500 MG Give 1 tab by mouth every 6 hours for spasms for 10 days, was not given until 2:08 AM; and Tylenol Oral Tablet 325 MG Give 2 tablets by mouth every 6 hours for pain for 10 days, was not given until 2:08 AM. On 02/17/26, her 9:00 PM Medications were not given until 11:01 PM. Trazadone HCL oral Tab 150 MG Give 1 tab three times a day for Depression Midodrine HCL Tab 5 MG Give 1 tab by mouth three times a day for Hypotension. Holed for SBP [systolic BP] greater than 130. During an interview on 02/16/26 at 10:00 AM with Resident #169, she stated her nighttime meds were not brought to her until 2:00 AM and were supposed to be at 10:00 PM. On 02/16/26 at 1:30 PM, the resident was asked if she refused her meds last night, as that was documented in the progress notes, and the resident stated no. During an interview on 02/18/26 at 10:00 AM with Staff I, Licensed Practical Nurse (LPN), she was asked what the parameters are for giving medications. She stated it is 1 hour before and 1 hour after the med is supposed to be given. She acknowledged that she was late on several occasions. During an interview on 02/18/26 at 10:25 AM with Staff H, LPN / Wound Care Nurse, she stated she can give the meds 1 hour before and 1 hour after when they are due. 3. Review of the record revealed Resident #1 was admitted to the facility on [DATE] with diagnosis to include hypotension (low blood pressure). Review of the current physician orders documented as of 12/22/25, the resident was to receive midodrine (a medication to increase blood pressure) 10 mg (milligrams) three times daily for hypotension at 9:00 AM, 1:00 PM, and 5:00 PM. This order further directed the nursing staff to hold the medication if the resident's systolic blood pressure (the upper number) was greater than 120. There was an additional order for nursing staff to obtain the resident's vital signs every six hours - at midnight, 6:00 AM, 12:00 PM, and 6:00 PM. These blood pressures were documented on the Medication Administration Record (MAR). The electronic record also contained sporadic additional blood pressure readings in the vital sign section of the record. Review of the current February 2026 MAR revealed the following: a) On 02/11/26 at 6:00 AM, the resident's blood pressure was 126/76 as per the MAR. The record lacked any documented blood pressure reading at 9:00 AM, which was the scheduled time of administration for the midodrine. The medication was administered with a systolic blood pressure greater than 120 and no other reading at 9:00 AM. b) On 02/14/26 at 12:00 PM, the resident's blood pressure reading was 123/67 and the medication (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was administered. c) On 02/17/26 at 6:00 AM, the record lacked a blood pressure reading on the MAR. The vital sign report also lacked a blood pressure reading for the 9:00 AM medication dose. The medication was administered without any documented blood pressure reading. Review of the January 2026 MAR revealed the following: d) On 01/09/26 at 12:00 PM, the record lacked a blood pressure reading on the MAR. The 1:00 PM scheduled dose of midodrine was administered. A blood pressure reading at 2:13 PM was documented in the vital sign section of the record as 121/72, after the scheduled dose of medication. e) On 01/09/26 at 6:00 PM, the resident's blood pressure was documented as 124/74 on the MAR. The medication was administered outside of physician ordered parameters. 4. Review of the record revealed Resident #41 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] revealed the resident had a BIMS score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the record revealed the physician order dated 12/03/25 for metoprolol 25 mg was to be given twice daily for hypertension. This order further instructed nursing staff to hold the medication for a systolic blood pressure less than 120. During an interview on 02/16/26 at 11:34 AM, Resident #41 stated her blood pressure had been high that morning. The resident further stated at other times it is very low. The resident stated she could take her blood pressure pill when her reading was over 120, and the resident stated the nursing staff do not always follow the instructions. Review of the current February 2026 MAR for Resident #41 revealed the following: a) On 02/08/26 at 9:00 AM, the resident's blood pressure was 114/76 and the metoprolol was given. b) On 02/10/26 at 5:00 PM, the resident's blood pressure was 118/64 and the medication was given. c) On 02/14/26 at 9:00 AM, the resident's blood pressure was 118/74 and the medication was given. d) On 02/14/26 at 5:00 PM, the resident's blood pressure was 112/62 and the medication was given. e) On 02/15/26 at 9:00 AM, the resident's blood pressure was 109/76 and the medication was given. f) On 02/17/26 at 5:00 PM, the resident's blood pressure was 118/76 and the medication was given. Review of the January 2026 MAR for Resident #41 revealed the following: g) On 01/05/26 at 5:00 PM, the resident's blood pressure was 104/61 and the metoprolol was given. (continued on next page)		

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Printed: 10/09/2026
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No. 0938-0391

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 02/19/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h) On 01/27/26 at 5:00 PM, there was no documented blood pressure reading in the record and the medication was given. During an interview on 02/19/26 at 3:52 PM, the Director of Nursing (DON) agreed with the findings for both Resident #1 and Resident #41.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews and record review, the facility failed to ensure residents with indwelling urinary catheters have care provided for indwelling urinary catheter for 1 of 4 sampled residents reviewed for urinary catheter or UTI (Urinary Tract Infection), Resident #14; failed to ensure indwelling urinary catheters were maintained in a manner to prevent infection for 1 of 4 sampled residents reviewed for urinary catheter or UTI, Resident #68; and failed to ensure proper peri care for 1 of 4 sampled resident reviewed for Urinary catheter/UTI, Resident #41. The findings included: Review of the facility's policy, titled, Catheter Care -Quality of Care, with a revised date of 01/2024, included in part the following: Routine hygiene and care of the peri area is appropriate when providing incontinence care and bathing. Ensure the drainage spigot is not touching the floor. 1. Record review for Resident #68 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, and acute Cystitis. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. Review of the Physician's Orders for Resident #68 revealed in part the following: An order dated 01/28/26 for Suprapubic Urinary Catheter: Monitor every shift. Notify the physician of changes in urinary appearance (color, consistency, odor, etc.) and/or no urinary output. An order dated 01/28/26 for Suprapubic Urinary Catheter: Size 22fr 30ml for Diagnosis of: Obstructive and Reflux Uropathy. During an interview conducted on 02/16/26 at 10:30 AM with Resident #68 who was asked about urinary tract infections (UTI), she said she has urinary tract infections quite frequently. On 02/16/26 at 10:30 AM, an observation was made of Resident #68 sitting up in bed with indwelling urinary catheter drainage bag suspended from the bed frame with the drain out of the drain holder and it was touching the floor. On 02/16/26 at 12:00 PM, a second observation was made of Resident #68 lying in bed with indwelling urinary catheter drainage bag suspended from the bed frame with the drain out of the drain holder and was touching the floor. On 02/18/26 at 8:00 AM a side-by-side observation was made with Staff A, Registered Nurse (RN), who acknowledged Resident #68 had an unsecured indwelling urinary drainage tube and the drain for the urinary drainage bag was out of the drain holder. During an interview conducted on 02/18/26 at 9:15 AM with Staff B, Certified Nursing Assistant (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA), and Staff C, CNA, when asked about the catheter drainage bag and if the drainage tube needs to be secured, they both said yes. When asked if the drain needs to be in the drain holder, they both said yes. Staff B stated you never to leave the drain out. Staff C stated if you leave the drain out it can catch bacteria. 2. Record review for Resident #14 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Fracture of Unspecified Part of Neck of Right Femur, Unspecified Fall, Anxiety Disorder, and Dementia. The MDS assessment dated [DATE] documented in Section C, a BIMS score of 2 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #14 revealed in part the following: An order dated 02/12/26 to insert Foley every night shift for urinary retention for 1 Day There was no active order for indwelling urinary catheter care. Review of the Medication Administration Record, Treatment Administration Record and progress notes for Resident #14 for the month of February 2026 revealed no documentation of catheter care being performed On 02/16/26 at 11:00 AM, an observation was made of Resident #14 sleeping in bed with indwelling urinary catheter drainage bag suspended from bed frame, with privacy cover in place. On 02/16/26 at 1:14 PM, a second observation was made of Resident #14 sleeping in bed with indwelling urinary catheter drainage bag suspended from bed frame, with privacy cover in place. An interview was conducted on 02/17/26 at 7:45 AM with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who was asked about catheter care. She stated each resident should have an order for the catheter care and the nurse would document the care performed on the Treatment Administration Record. When asked specifically about Resident #14, she acknowledged the resident had an indwelling urinary catheter since 02/12/26 with no catheter care documented from 02/12/26 to 02/17/26. 3. Review of the Incontinence/Perineal (area between the anus and the external genitalia) Care for a Female Competency checklist documented, 12. Washing the genital area, turn the resident to their side, wash the rectal area moving from the front to the back using a clean area of the washcloth each time. Review of the record revealed Resident #41 was admitted to the facility on [DATE] with an admitting diagnosis of ESBL (Extended-Spectrum Beta-Lactamase, an enzyme produced by bacteria that is resistant to many antibiotics) of the urine, indicating a severe urinary tract infection (UTI). Review of the admission MDS assessment dated [DATE] documented the resident had a BIMS score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. This MDS also documented the resident (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was always incontinent of urine with a UTI in the past 30 days. During an interview on 02/16/26 at 11:34 AM, Resident #41 stated she has a UTI and it hurt when she urinated. The record documented Resident #41 was currently on an antibiotic for a UTI. The record lacked any documented excoriation to the perineal area. During an observation on 02/18/26 at 12:06 PM, Staff G, Certified Nursing Assistant (CNA), provided personal care to Resident #41. The resident's groin and buttock were notably red and excoriated overall. During the care Resident #41 stated it was hurting but told the CNA to continue. After cleaning the front of the resident, the CNA cleaned the buttock and anal area of the resident by wiping each time from the back to the front, toward the urethra (area where urine exits the body), and opposite the checklist directions. During an interview on 02/18/26 at 12:40 PM, when asked in what direction she should clean the resident's perineal area, Staff G stated from front to back, and then confirmed she cleaned back to front. When asked about the redness, the CNA stated the resident had been on a zinc ointment treatment for some time.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure care and services for oxygen equipment for 1 of 2 sampled residents as evidenced by the failure to clean the oxygen filter for Resident #77. The findings included: Review of the record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses to include COPD (chronic obstructive pulmonary disease, a progressive lung disease making it difficult to breathe) and shortness of breath. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This MDS also documented the resident was on oxygen therapy. Physician orders documented as of 01/30/26, Resident #77 was receiving oxygen continuously at 2 liters per minute for shortness of breath. The current orders documented instructions for staff to change the oxygen tubing weekly, but lacked any orders related to cleaning of the oxygen canister filter. A current care plan that was initiated on 04/15/25 documented that the resident was at risk for altered respiratory status and difficulty breathing related to episodes of shortness of breath and pneumonia. During an observation and interview on 02/16/26 at 11:21 AM, Resident #77 was lying in bed with oxygen running at 2 liters per minute. The resident stated the oxygen tubing had been changed that day. The filter on the back of the concentrator (the machine that delivered the oxygen to the resident) was dust laden and appeared gray instead of black. During a second observation on 02/17/26 at 10:32 AM, the oxygen filter remained in the same dirty condition. When asked if he knew if anyone cleaned or changed the oxygen filter, the resident stated he was unsure. Photographic Evidence Obtained. During an interview and observation on 02/19/26 at 1:30 PM, when asked who was responsible for cleaning the oxygen filters, the Assistant Director of Nursing (ADON) stated she thought it was the Central Supply staff. When asked if she was responsible for the cleaning of the oxygen filters, the Central Supply staff person stated she was. When asked about the process, the Central Supply staff person stated she just knew who had oxygen. She further explained she washes the filters weekly but often gets asked to do something else or find something else from multiple staff and gets distracted. When asked about the filter for Resident #77, she agreed it had been missed, was dirty, and was unsure exactly what happened. Photographic Evidence Obtained.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and interview, the facility failed to ensure pain management for 1 of 4 sampled residents, as evidenced by the failure to provide pain medication as per physician's orders for Resident #66. The findings included: Review of the policy, titled, Medication Administration, issued on 10/2020 and revised on 01/2024, documented in part, 22. Medications, including narcotics, will be reordered as needed with practitioner approval unless otherwise indicated (auto-refill from pharmacy, emergency medication supply use). Review of the record revealed Resident #66 was admitted to the facility on [DATE] with a diagnosis that included Alcohol Dependence, Chronic Obstructive Pulmonary Disease (COPD), Opioid Dependence, Chronic Pain Syndrome, Pain in Right and Left Knees, and Other Low Back Pain. Review of the most current Minimum Data Set (MDS) assessment documented that Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of physician order, dated 12/02/25, documented, in part, Oxycodone HCl Oral Tablet 5 MG, give 1 tablet by mouth every 4 hours for break through pain. Review of the Medication Administration Record (MAR) for 02/16/26 and 02/17/26 revealed missing doses with code 12, Medication on order from pharmacy. Further review of the MAR revealed that Resident #66 had a pain level of 5/10 on the night shift of 02/16/26 after the 3rd dose of 5 MG Oxycodone was not given. Resident #66's pain level had been at zero when the medication was given as prescribed. An initial interview was conducted on 02/16/26 at 12:50 PM with Resident #66 who stated that the facility ran out of his pain medication today. I have three vertebrae that are destroyed. An interview was conducted on 02/18/26 at 9:20 AM with Resident #66 who stated he had only received one dose of the pain medication when they ran out of it on Monday night and Tuesday morning, I felt pain, and was sleepy, and cold. An interview was conducted on 02/19/26 at 12:57 PM with Staff D, Licensed Practical Nurse (LPN), Manager for Unit 1, who stated that she was not working on 02/16/26 but was advised of the issue with Resident #66's medication and that the Manager for Unit 2 ended her employment with the facility on Friday 02/13/26, and there was a nurse who typically was assigned to Resident #66 who also ended her employment on 02/13/26 and nobody had contacted the pain management doctor to renew the medication order until Staff D was advised. Staff D was asked if the medication could have been given to the resident from the Medbank machine and Staff D stated that if the prescription is not current, the Medbank machine does not provide the code needed to get the narcotic medication. Staff D confirmed that the facility should have contacted the physician prior running out of the pain medication.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents who were trauma survivors had triggers identified and implemented in the care plan in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 sampled resident review for Post Traumatic Stress Disorder (PTSD), Resident #7. The findings included: Review of Resident #7's records revealed Resident #7 was admitted to the facility on [DATE] and readmitted [DATE] from the hospital, with diagnoses that included PTSD (Post Traumatic Stress Disorder), Major Depressive Disorder, Generalized Anxiety, Insomnia, Type II Diabetes, Coronary Artery Disease, Alcoholic Cardiomyopathy, Migraines, Muscle Weakness and Chronic Obstructive Disease. (COPD). Review of Resident #7 MDS (Minimum Data Set) Medicare 5-day assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 indicating the resident had moderate cognition impairment. Review of the resident's care plan documented the resident has experienced a traumatic event which has impacted the resident's emotional health as evidence by the diagnosis of PTSD. The interventions in place included: Refer to psychiatric/psychological services as needed, Alert MD/designee of any significant changes in behavior, Encourage and assist resident with activities of choice, Encourage and assist the resident to have contact with family/friends as able, Encourage expression of feelings/concerns/thoughts, Provide a quiet, non-threatening environment as indicated, and Respect resident's space and privacy. The care plan did not mention anything about his triggers. Review of a Psychiatric note dated 02/12/26 documented a history of PTSD and the history suggests that this resident had suffered from significant trauma resulting in nightmares, flashbacks, and hypervigilance in the past, with the symptoms having caused significant distress and functional impairment to the resident, having lasted for more than one month and have occurred without any substance use or organic brain pathology. Care Plan for PTSD diagnosis: Trauma: [Name] war, Triggers: Loud noises - stranger. Care Plan: Medications management refer to psychology for psychotherapy. Review of the resident's admission dated 12/24/25 did not document the resident has PTSD. Review of the Social Service assessment dated [DATE] documented under the Trauma screen 'no PTSD' and 'no military experience', as the baseline; and for 12/25/26 it did not document any PTSD. When he was readmitted from the hospital on [DATE], there was documentation of PTSD. During an interview with the resident on 02/16/26 at 1:30 PM, he was asked about PTSD and asked about his triggers. He was unable to verbalize what his triggers were but did say that he was in the military. During an interview on 02/17/26 at 2:26 PM with Staff I, LPN (Licensed Practical Nurse), she was asked about Resident #7 having PTSD. She stated she knew he had PTSD but when asked what his triggers were, she stated she did not know what they were. She then stated he had a change in condition (had a stroke). During an interview on 02/18/26 at 11:20 AM with Staff M, LPN, she was asked about Resident #7's PTSD, and stated she knows he has it. When asked what his triggers were, she stated she didn't know. During an interview on 02/18/26 at 11:24 AM with Staff E, LPN MDS Coordinator, she was asked about the resident and his PTSD. The surveyor asked if they were supposed to document his triggers in the care plan, and she stated they should, but it is Social Services person that does the assessments and the care plan for PTSD. She stated that 'right now we don't have a Social Service Director'. She acknowledged that she did not see any care plans that document his triggers though he does have a PTSD care plan.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure adequate monitoring of side effects and behaviors for residents receiving psychotropic medications for 1 of 5 sampled residents reviewed for unnecessary medications, Residents #9. The finding included: Review of the facility's policy titled, Medication Utilization and Prescribing - Clinical Protocol, with a revised date of 01/2024, included in part the following: The physician and staff will identify situations in which a resident is taking medications associated with potentially significant medication-related problems such as allergies, drug-drug interactions, drug-food interactions and adverse drug reactions. The physician and IDT (Interdisciplinary Team) will identify significant factors that may affect medication effectiveness and medication related problems. Risks and benefits of utilization of psychotropic medications will be reviewed with resident and/or responsible party prior to initiation or increased dose as indicated. Record review for Resident #9 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Generalized Anxiety Disorder, Cognitive Communication Deficit, Dementia, Unspecified Mood (Affective) Disorder, Bipolar Disorder, and Major Depressive Disorder. The Minimum Data Set, dated [DATE] documented in Section C, a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #9 revealed in part the following: An order dated 09/24/25 for Lithium Carbonate oral capsule 300mg give 300 mg by mouth two times a day related to Bipolar Disorder. An order dated 09/24/25 for Zoloft oral tablet 100mg (Sertraline HCl) give 100mg by mouth one time a day related to Major Depressive Disorder. An order dated 09/24/25 for Nuedexta oral capsule 20-10mg (Dextromethorphan HBr-Quinidine Sulfate) give 1 capsule by mouth one time a day related to Pseudobulbar Affect. An order dated 09/24/25 for Behavior: Enter # in Supplementary Documentation: 0 No behaviors; 1 Aggressiveness 2 Wandering; 3 Agitated; 4 Angry Comments; 5 Anxiety; 6 Avoidance/Resisting Care; 7 Compulsive Actions; 8 Crying; 9 Delusion/Paranoia; 10 Depressed/Withdrawn; 11 Fear/Panic; 12 Hallucinations; 13 Insomnia; 14 Jittery/Nervous; 15 Mood Changes; 16 Noisy/Yelling; 17 Pacing; 18 Pulling Tube (NG, Cath, IV); 19 Other enter note every shift for Use of Psychoactive Medication Non-Pharm Intervention: 0 Not applicable; 1 1.; 2 Activity; 3 Back-rub/Touch; 4 Change Position; 5 Change Environment 6 Give Fluids; 7 Food; 8 Redirect; 9 Toilet; 10 Other - enter nurses note. Effectiveness I Improved, NC No Change, W Worse An order dated 09/24/25 for Side Effects of psychotropic Medications - Including: Sedation, Insomnia, increased agitation, dry mouth, increased thirst every shift for Medication Side Effects Observations Select 'Y' if monitored and none of observed Select 'N' if monitored and side effect WERE observed. Select chart code Medication Side Effects Observation' and document behaviors in progress note. Review of the Medication Administration Record for Resident #9 for month of February 2026 documented in part the following: On 02/06/26, day shift, behaviors of 1, 3, and 7 indicating aggression agitated and compulsive action with an intervention as 19 indicating other see notes. On 02/08/26, night shift, 1 and 6 indicating agitated and avoidance/resisting with the intervention as N/A (not applicable). On 02/01/26, day and evening shift, on 02/06/26 day shift, on 02/09/26 day, evening and night shift, and on 02/10/26 day shift, all documented an N indicating side effects observed. Review of Progress Notes for Resident #9 from 02/01/26 to 02/10/26 revealed no documentation of notes related to behaviors or side effects. During an interview conducted on 02/18/26 at 4:30 PM with the Director of Nursing (DON), the DON confirmed the documentation for behaviors and side effects for Resident #9 were incomplete.		