STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105484	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Okeechobee Health Care Facility	1646 Highway 441 N Okeechobee, FL 34972

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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, interview, and record review, the facility failed to ensure timely and proper care and services for 3 of 30 sampled residents, as evidenced by: Nursing staff failed to ensure administration of the full dose of an anti-viral medication (Paxlovid) for Resident #10; failed to assess and treat edema for Resident #82; and failed to timely treat constipation for Resident #85. The findings included: 1. Review of the record revealed Resident #10 was admitted to the facility on [DATE], and resided in her current room in the memory care unit since 04/27/23. Review of a progress note dated 02/09/24 at 12:21 AM revealed the resident tested positive for the COVID-19 virus. Review of the audit reports for the pharmacy orders for Paxlovid revealed the following: a) A verbal order was entered on 02/09/24 at 12:13 PM, twelve hours after testing positive for the virus, and electronically signed by the physician on 02/10/24 at 7:35 AM, for the administration of Paxlovid twice daily for five days, and then discontinued on 02/10/24 at 1:20 AM. b) A second verbal order for Paxlovid twice daily for five days, was entered on 02/10/24 at 1:20 AM, electronically signed by the physician on 02/10/24 at 7:35 AM. An entry on this audit dated 02/10/24 at 7:48 AM documented the medication was on hold, Awaiting MD (physician) to sign off for pharmacy. Review of the February 2024 Medication Administration Record (MAR) and corresponding progress notes revealed the following: c) Paxlovid was not administered on 02/09/24 at 9 PM as ordered, with no rationale documented in the corresponding progress notes. d) A progress note on 02/10/24 at 6:07 AM documented Paxlovid was not available. e) Paxlovid was on hold from 02/10/24 at 9 PM through 02/12/24 at 9 AM. f) Paxlovid was not administered on 02/12/24 at 9 PM. The corresponding progress note documented, Unable to give at this time. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g) Paxlovid was administered starting on 02/13/24 at 9 AM through 02/15/24 at 9 AM, indicating the resident received only 5 of the 10 scheduled doses. Corresponding progress notes lacked any rationale. During a side-by-side review of the record and interview on 04/25/24 at 10:19 AM, when asked about the failure to administer the full prescription of Paxlovid for Resident #10, Staff C, Registered Nurse (RN)/Team Leader, stated the first dose scheduled for 02/09/24 at 9 PM was more than likely not yet available. When shown the Paxlovid order audit that documented, Awaiting MD to sign off for pharmacy, Staff C identified and explained there was a medication-to-medication interaction documented on a Medication Reconciliation Form dated 02/09/24, and the pharmacy would not fill the prescription until the interaction form was signed off by the physician as OK to administer. Staff C was able to locate the Medication Reconciliation Form that was signed by the physician, but this form lacked the date the form was signed by the physician. When asked the process for these Medication Reconciliation Forms, Staff C explained the forms are sent to the facility from the pharmacy, staff place these forms in the physician's folder for signature, and staff would then return it to pharmacy. Staff C noted the form was initiated on 02/09/24, which was a Friday, and stated the physician probably did not sign it until his arrival to the facility on Monday 02/12/24, thus the reason Paxlovid was not started until 02/12/24. Staff C further stated staff did not extend the administration time to compensate for the late initiation of the medication, thus the Paxlovid dropped off the electronic MAR after the 9 AM dose on 02/15/24, agreeing Resident #10 only received 5 of the scheduled 10 doses. 2. Review of the record revealed Resident #82 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment documented the resident was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale. This MDS documented the resident needed supervision to touching assistance for putting on footwear, and had diagnoses to include Coronary Artery Disease and Heart Failure. Review of weekly assessments from December 2023 and January 2024 revealed Resident #82 had 2+ pitting edema (swelling of the feet rated on a scale of 0 for none to 3 for severe). Weekly assessments in February and March 2024 lacked the edema. A physician progress note dated 03/13/24 lacked any edema. A current order dated 02/18/24 revealed staff were to assist the resident to her wheelchair at all mealtimes. An order dated 10/15/23 documented the resident was taking Bumex 1 milligram daily for Heart Failure, which contributes to edema. During an observation and interview on 04/22/24 at 1:34 PM, Resident #82 stated her only concern was her puffy feet. The resident had on a pair of slip-on shoes and her feet were noted swollen up out of the shoes, and appeared as moderate edema. A second observation on 04/23/24 at 10:29 AM revealed Resident #82 in her recliner with her feet elevated. The bilateral pedal edema remained. On 04/24/24 at 11:44 AM, Resident #82 was sitting up in her wheelchair getting ready to go to the dining room for lunch. The resident confirmed she had had the edema problem on and off for a long time. The resident stated she elevates her legs in the recliner, but spends the majority of the day up in her wheelchair, as she likes to go to activities and to the dining room for meals. The resident stated she had tried the stockings in the past, but they cut off the circulation. Resident #82 was wearing a different pair of shoes, but the edema remained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/24 at 3:27 PM, Staff H, Licensed Practical Nurse (LPN) / Team Leader, stated the resident had been on Bumex for edema and that it was a chronic condition. During an interview on 04/24/24 at 3:45 PM, Staff G, LPN/MDS Coordinator, stated the edema management intervention and care plan was resolved on 03/01/24, as the edema had resolved at that time. During a supplemental interview on 04/24/24 at 3:54 PM, Staff H stated that no one had brought the resident's edema to her attention this week. Staff H stated Resident #82 was independent with dressing and would only call for assistance when she was in the bathroom, if she needed help with her clothing. During an interview on 04/24/24 at 3:57 PM, Staff I, LPN who had worked all day as the resident's direct care nurse, stated she had not noticed any edema that day as the resident had been out of her room most of the day. The LPN stated the resident gets herself dressed each day. During an interview on 04/24/24 at 4:13 PM, Staff S, Certified Nursing Assistant (CNA) who was the resident's direct care CNA all day, stated she helped the resident get dressed that morning and her feet looked normal. During an interview on 04/25/24 at 10:49 AM, Staff I, LPN, stated she assessed the resident's feet the previous evening, after surveyor questioning, and agreed Resident #82 had bilateral edema. The LPN stated she notified the ARNP (Advanced Registered Nurse Practitioner) the previous evening and received new orders for the edema. 3. Review of the record revealed Resident #85 was admitted to the facility on [DATE], and had resided on the memory care unit since admission. Review of the current MDS assessment dated [DATE] documented the resident was always incontinent of her bowel movements. An order dated 04/07/24 documented to administer 30 milliliters of Milk of Magnesia every 24 hours at bedtime as needed for constipation. Review of the Tasks section of the electronic medical record on 04/22/24, revealed the resident's last bowel movement was on 04/17/24 during the 7 AM to 3 PM shift. A progress note dated 04/22/24 at 8:03 AM documented, Alert Note: No BM in 48 hours. Will monitor for BM and give PRN (as needed) med (medication) if still no BM this morning. Review of the April 2024 MAR lacked any documented administration of the 'as needed' Milk of Magnesium medication for constipation since 04/17/24. During an interview on 04/23/24 at 2:59 PM, Staff F, CNA, stated she was told Resident #85 had had a BM the previous day. During an interview on 04/25/24 at 12:09 PM, Staff C, RN/Team Leader, stated their standing protocol is to provide Milk of Magnesia if a resident does not have a BM in 48 hours. Staff C was informed of the lack of BM for Resident #85 from 04/17/24 until 04/22/24 with no 'as needed' medication provided. Staff C agreed with the concern. 41837

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Okeechobee Health Care Facility	1646 Highway 441 N Okeechobee, FL 34972

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations and interviews, the facility failed to have nurse staffing information posted daily. The findings included: Upon entering the facility on 04/22/24 at 8:30 AM, it was noted that the nurse staffing information was not posted. On 04/22/24 at approximately 1:30 PM, all members of the survey team reported the nurse staffing information was not found during multiple tours of all units of the facility during the initial pool process. Upon returning to the facility on [DATE] at 6:45 AM, the nurse staffing information was not posted. On 04/23/24 at approximately 12:30 PM, all members of the survey team reported the nurse staffing information was not found during multiple tours of all units of the facility during the initial pool process. During an interview, on 04/24/24 at 2:45 PM with the Staffing Coordinator, when asked about the nurse staffing information being posted, the Staffing Coordinator replied, We haven't' been posting it for like a year. I don't have an explanation, I just thought that we weren't doing it anymore.

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	105484	A. Building B. Wing	04/25/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, record review, and policy review, the facility failed to ensure adequate kitchen staff to provide timely meal delivery as per schedule for 2 of 2 meals observed (lunch and dinner on 04/24/24), affecting 11 of 41 sampled residents (Residents #172, #85, #87, #129, #18, #157, #41, #96, #135, #53, and #193). This failure could potentially affected all 196 residents who consume food orally in the facility at the time of the survey. The census at the time of survey was 198 residents. The findings included: 1. Review of the policy, titled, Timely Meal Service and Mealtimes Frequency, (not dated), documented, in part, the following: Policy: Food will be delivered promptly at allotted times to ensure safe, palatable, and high-quality food is serviced at the proper temperature. Review of the Food Services Cart Delivery Schedule provided upon request documented the specific times each food cart was to leave the kitchen to be delivered to the specific unit. Each unit had two to five carts scheduled for delivery, at scattered times, for each meal. The main dining room and the Gardens dining room were open for lunch and dinner. Review of the schedule revealed the following general information and schedule for the A-unit, which was the Memory Care Unit being observed: a) Breakfast carts were to leave the kitchen starting at 6:56 AM, with the last cart at 8:10 AM. b) Breakfast carts for the A-Unit were scheduled to leave the kitchen at 7:00 AM, 7:24 AM, 7:46 AM, and 8:10 AM. The Gardens dining room was not open for breakfast. c) Lunch carts were to leave the kitchen starting at 11:20 AM, with the last cart at 12:40 PM. d) Lunch carts for the A-Unit were scheduled to leave the kitchen at 11:25 AM, 11:48 AM, 12:12 PM (Gardens dining room), 12:21 PM, and 12:40 PM. e) Dinner carts were to leave the kitchen starting at 4:55 PM, with the last cart at 6:15 PM. f) Dinner carts for the A Unit were scheduled to leave the kitchen at 5:00 PM, 5:22 PM, 5:46 PM (Gardens dining room), 5:55 PM, and 6:15 PM. During an interview on 04/23/24 at 11:44 AM, the spouse of Resident #172 stated the lunch trays arrive to the Gardens dining room between 1 and 2 PM. The spouse explained staff start assisting the residents into that dining room around 11:30 AM, and then they sit there for more than an hour. The spouse explained this was the memory care unit for the cognitively impaired residents. The spouse explained while waiting for the food residents get bored and anxious, or simply fall asleep, placing their heads down on the tables. The spouse stated by the time the food arrives, many residents are either no longer interested, or too sleepy to eat. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the lunch meal for the A-Unit and Gardens dining room was made on 04/24/24 beginning at 11:37 AM with continuous observation until 1:15 PM. At 11:37 AM, eleven (11) residents were in the Gardens dining room awaiting lunch. Most of the residents had been served drinks. The first food cart was delivered to the unit at this time for residents who ate in their rooms. The following was also observed: g) At 11:54 AM, fourteen residents were noted in the Gardens dining room with two staff. h) At 12:18 PM, the second lunch cart was delivered to the A-Unit for residents in their rooms. This cart was scheduled to leave the kitchen at 11:48 AM. i) At 12:24 PM, fifteen (15) residents were in the dining room. The daughter of Resident #85 was noted sitting next to her mom, rubbing her arm, and soothing her mother, and talking with the residents at that table. There were 3 to 4 staff in the dining room, sometimes wandering in and out of the room. j) At 1:02 PM, the trays still had not arrived to the Gardens dining room. Resident #172 was sitting up in his wheelchair sleeping. Other random residents had been observed going in and out of the dining room or sleeping at the tables, one with her head down on the table. When asked about the dining room service times, the daughter of Resident #87 stated they were always running late, often not arriving until 1:20 PM or 1:30 PM. The daughter stated, It's hard on these residents because they either get restless or sleepy. j) At 1:04 PM, the third cart arrived to the A-Unit and food was provided to the residents in the Gardens dining room. The Gardens dining room trays were scheduled to leave the kitchen at 12:12 PM. k) At 1:11 PM, the fourth cart arrived to the A-Unit. It was scheduled for 12:21 PM. l) At 1:14 PM, the final tray was delivered. It was scheduled for 12:40 PM. An observation of the dinner meal for the A-Unit and Gardens dining room was made on 04/24/24 beginning at 5:11 PM, with continuous observation until 7:19 PM. The following was observed: m) At 5:11 PM, the first cart arrived for the residents in their rooms. It was scheduled to leave the kitchen at 5:00 PM. n) At 5:49 PM, the second food cart was delivered to the A-Unit. It was scheduled to leave the kitchen at 5:22 PM. An observation of the Gardens dining room revealed it was locked and dark. o) At 6:11 PM, Resident #129 approached the surveyor for the second time, asking for cookies or crackers. Staff had provided ice cream to the resident about 10 to 15 minutes earlier. Staff provided a sandwich to the resident and stated, (Name of Resident #129) your dinner will be here soon. p) At 6:24 PM, Resident #18 went to the nurses' station and asked for ice cream. Staff K, Certified Nursing Assistant (CNA), explained this resident's tray arrives on the last cart that usually arrives to the unit about 6:45 PM. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	q) At 6:34 PM, Staff K and J, both CNAs, explained when dinner does not arrive by 6:30 PM, they close the dining room because the residents get more agitated, and it runs into their rounds before shift change at 7 PM. Staff J stated it was difficult and frustrating, explaining when lunch was late, it runs into our rounding time as well. When asked if they knew why the meals were served late, Staff K stated it was usually because they don't have enough staff in the kitchen. During this observation, it was considerably louder on the unit, with residents in general, more anxious and noisier. r) At 6:39 PM, the third food cart arrived to the A Unit. It was scheduled to leave the kitchen at 5:46 PM. s) The fourth and fifth food carts were delivered at 6:43 PM and 6:45 PM. Another small cart was delivered at 6:52 PM. By 6:55 PM, most residents were eating, and the unit was considerably quieter. t) At 6:58 PM Staff T, CNA, delivered a meal to Resident #157, who was in bed. The resident was sound asleep as per the CNA. Staff T attempted to feed the resident, but at 7:15 PM reported she was kind of waking up, but pocketing her food, so she stopped feeding her as per the nurse's instruction. u) A final cart was delivered to the Unit at 7:02 PM. The cart lacked a tray for Resident #18, who was asking for her food. Resident #18 received her dinner at 7:19 PM. During an observation and interview on 04/25/24 at 9:40 AM, Staff L, CNA, who had just finished feeding Resident #157, stated she had one more resident to feed. When asked about the timing of the meals, Staff L volunteered that one morning recently they did not get the first breakfast tray until 8 AM. The food cart schedule documented the first food cart for the A-Unit was to leave the kitchen at 7:0-0 AM. Staff L stated the evening meal in the Gardens dining room doesn't arrive until 6:30 PM or after. The CNA explained they take the residents into the dining room about 5:15 PM to set them up, but when the dinner is late, the residents get antsy, ask why they are there, or fall asleep waiting. The CNA explained the late meals affect their ability to get their work done timely as they are waiting 45 minutes to an hour for meals, which cuts into their care time. During an interview on 04/25/24 at 10:07 AM, Staff C, Registered Nurse (RN)/Team Leader, explained when the second and later trays are late, it affects the residents who have not been provided a tray yet, as they seek out those that have trays already their food. The RN stated in general, when trays are late, they either get more anxious or they fall asleep, and then they may or may not eat well. On 04/25/24 at 10:47 AM, the Food Service Manager was noted providing a new meal schedule for the A-Unit, and was asked to provide the past 30 days of completed daily food service schedules that documented the scheduled times the food carts were to leave the kitchen and the time the food carts actually left the kitchen. Review of the schedules revealed multiple meals where food service carts were delivered 30 to 45 minutes or more later than scheduled. During an interview on 04/25/24 at 11:09 AM, when asked the reason for the trays being up to an hour late, the Food Service Manager stated, lack of staff. The Food Service Manager stated he has been a cook short, needs 4 or 5 more dietary aids, and wants a person dedicated to special orders and phone orders. The Food Service Manager stated, Its too much (for the current kitchen staff) for the number of residents and requests in this facility. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/25/24 at 1:27 PM, when asked about kitchen staffing and timing of the meal delivery, the Administrator and Consultant Dietician both agreed they needed more staff and were aware of the late meals. The managers volunteered they have had kitchen issues for the past year or more, either with a lack of staff or the need for stronger personnel in the kitchen. 33103 2. Review of the Food Services Cart Delivery Schedule provided the specific times each food cart was to leave the kitchen to be delivered to the specific unit. The residents below (Residents #41, #96 and #135) were on the C-Wing. The Breakfast cart was documented as 9C at 7:58 AM and lunch at 12:32 PM. 2a. Review of Resident #41 records revealed the resident was admitted to the facility 03/03/23 and has a BIMS (Brief Interview for mental Status) score of 15, indicating cognition is intact. During an interview on 04/22/24 at 11:51 AM Resident #41 stated, 'They don't serve us are meal at lunch until 2:00 PM and dinner at 8:00 PM'. Further observations conducted on 02/24/24 nothed the breakfast cart arriving on the C-unit at 8:40 AM and lunch cart at 1:30 PM. On 02/25/24, the breakfast arrived on the C-unit at 8:30 AM; and the lunch arrived on floor after 1:10 PM. 2b. Review of Resident #96 records revealed the resident was admitted on [DATE] and has a BIMS score of 15, indicating cognition is intact. An interview was conducted on 04/22/24 at 12:00 PM with Resident #96, who stated they usually don't get dinner until 8:00 PM. A secondary interview was completed on 02/24/24 at 2:40 PM with Resident #96 who was asked about how they know what is being served. She stated that they had it on channel 2 but that it has not been working since Christmas. She pulled up the TV (television) to show the surveyor, and stated that they use to have the phone number to the kitchen as well and the times to call the kitchen to put a special order in but it got to a point that they stopped answering the phone and it is no longer on the TV. When asked how they know what is on the menu for the day, she stated that unless you get out of bed and are in the hallway you don't know. She stated it is very frustrating. 2c. Review of Resident #135 record revealed the resident was admitted to the facility on [DATE] and has a BIMS score of 15, indicating cognition is intact. During an interview with Resident #135 on 04/22/24 at 11:27 AM, he stated we don't get breakfast until 9:00 AM. I think it's supposed to come round 7-8 AM, I have called the kitchen and complain. 39167 3. Clinical records review revealed Resident #53 was admitted to the facility on [DATE] with diagnosis included: Malnutrition. The admission Minimum Data Set (MDS) assessment, reference date 03/19/24, recorded a BIMS score of 14, indicating Resident #53 was cognitively intact. The care plan dated 03/15/24 documented Resident #53 was at risk for malnutrition and dehydration due to malignant cancer of the large intestine. Intervention included to provide diet as ordered. On 04/22/24 at 12:56 PM, an interview process was started with Resident #53, who stated a concern with the facility's food, saying the food was always served late. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Clinical records review revealed Resident #193 was admitted to the facility on [DATE] with diagnoses including: Septicemia, Anemia, and Cirrhosis. The admission MDS assessment, reference date 02/03/24, recorded a BIMS score of 11, indicating Resident #193 was moderately cognitively impaired. The care plan dated 01/28/24 documented Resident #193 was at risk for malnutrition and dehydration due to Sepsis. Intervention included to provide diet as ordered. On 04/22/24 at 10:35 AM, an interview with Resident #193 revealed a concern with the facility's food department. He voiced the food was always being served late and cold. He further stated the facility did not provide enough food and provided wrong orders. Resident #193 divulged that he has reported his concern to the food department, they sat in his room and asked questions, he went over the day-by-day concerns with them, and he was still receiving the wrong food, and things he didn't order were put on his tray. He is not getting what he has ordered. On 04/25/24 at 1:27 PM, an interview was conducted with the Nursing Home Administrator and the Dietitian who were made aware of the food concerns of Resident #53 and Resident #193.

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	105484	A. Building B. Wing	04/25/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, and policy review, the facility failed to ensure palatable food and food served at a proper temperature for 9 of 41 sampled residents, Residents #172, #25, #109, #193, #195, #96, #135, #182, and #17. The findings included: 1. Review of the policy, titled, Timely Meal Service and Mealtimes Frequency, (not dated), documented, in part: Policy: Food will be delivered promptly at allotted times to ensure safe, palatable, and high-quality food is serviced at the proper temperature. Review of the Food Preparation Guidelines, reviewed 09/22/23, documented, in part: Policy Explanation and Compliance Guidelines: . 3. Food and drink shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: a. Providing meals that are varied in color and texture. b. Using spices or herbs to season food in accordance with recipes. c. Serving hot foods/drinks hot and cold foods/drinks cold. d. Addressing resident complaints about foods/drinks. During an interview on 04/23/24 at 11:44 AM, the spouse of Resident #172, explained her husband resides in the memory care unit, and her main complaint is that the meals are late, and the food is cold. The spouse explained her husband eats finger foods and she tastes them first as she would not feed her husband something she would not eat herself. The spouse stated the other night the kitchen served steak fries that were ice cold. The wife stated she just pushed them aside. The spouse finally volunteered that at times the meat is tough, stating that she had seen staff and residents having difficulty cutting the meat at times. During a supplemental interview on 04/24/24 in the afternoon, the spouse of Resident #172 volunteered she was assisting her husband with a peanut butter and jelly sandwich and noted the strangest thing and I just don't understand. The spouse stated one side of the sandwich was toasted and the other side was not. An interview was conducted on 04/24/24 at 6:34 PM, with Staff K, Certified Nursing Assistant (CNA), who stated she had worked at the facility for years, volunteered the food quality and variety has declined since the change in ownership. The CNA stated the repetition of the meals had also increased. Staff J, CNA, stated she sometimes eats meals at the facility, and she always needs to add salt and pepper. During an interview on 04/25/24 at 9:40 AM, Staff L, CNA, who has worked at the facility for 5 years, stated the quality of food is not as good as before the change in ownership. A test tray was provided on 04/24/24 at 1:15 PM, on the second to last food cart. The side of chopped spinach lacked any type of seasoning. 39167 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105484	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Okeechobee Health Care Facility	1646 Highway 441 N Okeechobee, FL 34972

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105484	A. Building B. Wing	04/25/2024

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Okeechobee Health Care Facility	1646 Highway 441 N Okeechobee, FL 34972

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #135 records revealed the resident was admitted to the facility on [DATE] and has a BIMS score of 15, indicating cognition is intact. During an interview with Resident #135 on 04/22/24 at 11:27 AM, the resident stated the food is cold for all 3 meals. 7. Review of Resident #182 records revealed resident was admitted to the facility on [DATE] and has a BIMS score of 13, indicating cognition is intact. During an interview on 04/22/24 at 11:34 AM, Resident #182 stated that his food is cold for all 3 meals. He stated he goes to the dining room for lunch and it may be a bit warmer. He stated this has been going on for sometime, but can't give exact time frame. I told someone who was in dining room. 38893 8. Record review documented Resident #17 was admitted to the facility on [DATE]. According to the residents most recent full assessment, an annual MDS, dated [DATE], Resident #17 had a BIMS score of 15, indicating that the resident was cognitively intact. Resident #17's diet orders included: Regular diet, Regular texture, Regular/Thin consistency - 1:1 assist with meals. Double Portions For Breakfast - 09/20/22. During an interview with Resident #17, on 04/23/24 at 9:22 AM, when asked about the food served in the facility, Resident #17 replied, Breakfast is really good, but that's about it. It is nasty. You gotta be really hungry to eat it. I hardly ever eat lunch because it doesn't taste good. I am always telling them (referring to staff that assist with eating). 9. Record review documented Resident #38 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, Resident #38 had a BIMS score of 15, indicating intact cognition. Resident #38's diet orders included: Regular diet, Regular texture, Regular/Thin consistency - Extra sauce/gravy on side, distant supervision/periodically - 10/28/22. During an interview with Resident #38, on 04/22/24 at 10:41 AM, when asked about the food being served at the facility, Resident #38 replied, Terrible - You don't get what you order half of the time. The pasta is always undercooked. I fight with them all of the time. I fought with them yesterday. You never know what you get because the owners are so cheap, the quality of the food has gone way down and I always tell them that it is cold. 10 On 04/22/24 at 11:40 AM, lunch arrived to the 200-unit via a metal cart that was not insulated and had no additional heat source. One staff member immediately began removing trays from the cart and served them to the residents in their rooms. It was noted that the pellet plates used to keep food at proper temperatures was cold to the touch. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. On 04/23/24 at 7:30 AM, during an observation of breakfast served to the residents in their rooms on the 200-unit, that the pellet plates used to keep foods at proper temperatures were cold to the touch. 12. During an observation in the kitchen, on 04/23/24 7:35 AM, Staff O was observed placing pellet plates on a pellet warmer and then placing them on a tray for staff to place plates of food on. The pellet plates were cold to the touch and the plates that the food was being plated on were lukewarm to the touch. Further observation revealed that the pellet warmer was not working and was showing an error message that was ignored by staff. When asked about the plates being lukewarm, Staff N, Dietary aide, replied, we keep it (referring to the plate warmer) at a low setting because the plates get too hot and burn staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 foods prepared in a safe and sanitary manner in accordance with professional standards for food safety. The findings included: 1. During the initial kitchen tour, on 04/22/24 at 8:50 AM, accompanied by the Dietary Consultant and the Food Service Manager, the following observations were noted: a. Upon entering the kitchen and approaching the hand washing sink to perform hand hygiene, there was 'used ice' in the hand washing sink. Staff M, Dietary Aide, stated ice was used as a cooling medium for cold holding of cartons of milk in a bus tub and then dumped in the hand washing sink. b. There was an accumulation of food residue in the blades of produce slicers. c. There was an accumulation of food residue on the underside of the stand mixer d. The internal temperature of a 6-inch deep one third sized pan of gravy was 46 degrees Fahrenheit (F). The pan of gravy was in the process of cooling from the previous day's dinner meal, as reported by Staff N, Dietary Aide e. Upon entering the dish washing area from the hallway, it was noted that there was an apron lying over the basin and faucet of the hand washing sink. There was no soap at the hand washing sink for staff to perform hand hygiene. Staff N stated that she uses the hand sink in the main kitchen to perform hand hygiene and then comes over to the dish washing room. f. On a cart located just inside of the door to the dishwashing room, there were an employee's watch, a set of keys on a key chain, and a cellular phone on top of an open box of single use gloves. At the conclusion of the initial kitchen tour, the Consultant Dietitian and the Food Service Manager acknowledged findings and understanding of the concerns. 2. During a follow up visit to the kitchen, on 04/23/24 at 7:35 AM, while staff were plating the breakfast meal, Staff N was observed putting pellet plates on the pellet warmer, and placing on the plates on the trays for staff to put a plate of food on. It was noted that the pellet plates were cold to the touch. Upon further observation, the pellet warmer was found to be malfunctioning and flashing an error message and not warming the pellet plates. 3. During an observation of the unit pantries, on 04/24/24 at 8:20 AM, accompanied by the Food Service Manager, it was noted that there were no metal-stemmed probe style thermometers available for staff to ensure that foods are prepared and/or reheated to safe temperatures in the microwave ovens on the four units. At the conclusion of the observation, the Food Service Manager acknowledged the findings and understanding of the concern. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During the follow up tour of the kitchen, on 04/24/24 at 10:52AM, accompanied by the Consultant Dietitian and the Food Service Manager, the following observations were noted: a. There was a 6-inch deep 1/3 sized hotel pan of broccoli and cauliflower and a 6-inch deep 1/3 sized hotel pan of green beans that Staff O, Cook, was processing. When asked Staff O stated that the items were leftovers that were intended to be pureed, reheated and served at another meal service later in the week. b. The Consultant Dietitian was noted to be using disinfectant wipes with a 1-minute dwell time. After taking the temperature of the chicken, the Consultant Dietitian wiped the probe of the thermometer with the disinfectant wipe and immediately placed it into the next item without allowing for the one minute dwell time. c. Staff P, Dietary Aide, and Staff Q, Dietary Aide, were observed handling open foods while wearing a watch. d. A portion of the chicken that was being served to residents with orders for Regular diet with regular texture was 5 ounces, while a portion of the puree chicken for residents on a pureed diet was 2.5 ounces. At the conclusion of the follow up tour, the Consultant Dietitian and the Food Services Manager acknowledged the findings and understanding of the concerns.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observation, interview, and record review, the facility failed to develop and incorporate an integrated care plan for the hospice services for 1 of 1 sampled resident reviewed for Hospice, Resident #506. The findings included: Review of the facility's Hospice-Nursing Facility Services Agreement dated 08/30/22 included in part under Agreements, the following: 2. Responsibilities of Facility (e) Coordination of Care - For Routine Care (i) Design of Hospice Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Hospice Plan of Care for each Hospice Patient that is consistent with the hospice philosophy and is responsive to the unique needs of each Hospice Patient and his or her expressed desire for hospice care. Hospice retains primary responsibility for determining each Hospice Patient Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Hospice Plan of Care. Facility shall ensure that Facility's care plan for each Hospice Patient reflects both the most recent Hospice Plan of Care and a description of the Facility Services furnished by Facility in accordance with its applicable regulations. Record review for Resident #506 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Hypertensive Heart Disease with Heart Failure, and Essential (Primary) Hypertension. Review of the MDS for Resident #506 dated 10/12/23 revealed in Section O under hospice care was 'yes while a resident'. Review of the MDS for Resident #506 dated 01/12/23 revealed in Section O under hospice care was 'yes while a resident'. Review of the MDS for Resident #506 dated 04/13/23 revealed in Section C a BIMS score of 0 indicating severe cognitive impairment. Section O documented under hospice care, 'yes while a resident'. Review of the Care Plan for Resident #506 revealed there was no integrated plan of care for Hospice care including End of Life or Terminal Diagnosis. Review of the Hospice Binder for Resident #506 located at the nurse's station on A-Wing indicated the Hospice start of care (SOC) date was 07/14/23. The last documentation from any member of Hospice was dated on 10/23/23. (continued on next page)

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	105484	A. Building B. Wing	04/25/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospice documentation for Resident #506 revealed no concerns. The resident was last seen by hospice nursing staff on 04/24/24. An interview was conducted on 04/25/24 at 12:15 PM with Staff A, Certified Nursing Assistant/CNA, who stated she has been working off and on at the facility since 2019. When asked if she was taking care of Resident #506, she said yes. When asked if the resident was on hospice services, she said she is not aware, but the resident may be, and she is just not aware. An interview was conducted on 04/25/24 at 12:20 PM with Staff B, Licensed Practical Nurse (LPN), who stated she has worked at the facility for just over a year and normally does not work on a cart [medication cart] but she is a weekend supervisor. When asked which residents she cared for today, she listed the room numbers (Resident #506 was included in her assignment). When asked if any of the residents she is assigned today are under Hospice services, she said no. An interview was conducted on 04/25/24 at 12:30 PM with Staff C Registered Nurse/RN Team Leader who stated she has been working at the facility for 5.5 to 6 years and in the team leader role for the past 2 months and she works on the A-Wing. When asked if there are any residents on A-Wing on hospice services, she said yes, Resident #506. When asked if they have any issues for Resident #506 what do they do, she said they contact hospice to obtain orders. When asked how often hospice staff visit Resident #506, she said nursing comes every 2 weeks she believes, and the aide comes a couple of times a week. When asked where the documentation for hospice is kept, she showed the surveyor a hospice binder for Resident #506 located at the A-Wing nursing station. She acknowledged there was no collaborated hospice documentation in the hospice binder since 10/23/23. She said the resident was recently transferred to A-Wing on 04/09/24 and maybe there was documentation on one of the other wings that the resident had been on. When asked about the care plan for the resident, she acknowledged there was no collaborated care plan for hospice, end of life or terminal diagnosis that included any delegation for hospice staff. An interview was conducted on 04/25/24 at 12:43 PM with Staff D, MDS Coordinator who stated he works on the A wing. When asked if Resident #506 is on hospice services, he said no. The MDS Coordinator acknowledged the MDS for Resident #506 dated 04/13/24 documented in Section O under 'hospice care -no while a resident'. The MDS Coordinator was then asked to check the payor source and acknowledged the payor source for Resident #506 was Hospice Medicaid. When asked if Resident #506 ever had a collaborated hospice care plan had, he said it would be an end of life or terminal diagnosis. The MDS Coordinator acknowledged there was no collaborated hospice, end of life or terminal diagnosis care plan. The MDS Coordinator stated the MDS Coordinator initiates and updates the care plan for residents as well as other staff such as nursing or social services. An interview was conducted on 04/25/24 at 12:50 PM with the Administrator who verified that Resident #506 was on hospice services and is the only resident in the facility on hospice services. When asked about the hospice documentation for Resident #506, the NHA stated hospice staff thought their office was emailing the hospice documents to the facility, the hospice staff brought over the documents withing 2 hours. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/25/24 at 1:10 PM with the Director of Nursing (DON) who stated she has worked at the facility for [AGE] years. When asked if they have any residents who are on hospice services, she said they have 1 and it is Resident #506. The DON stated she has been on hospice pretty much since the day she was admitted to the facility. When asked if they have an issue with the hospice resident who do they would contact, she said they contact hospice. When asked how often hospice staff visit the resident, she said the nurse comes once a week and the aide comes a couple of times a week. When asked about the hospice's visits documentation, she said they have a hospice binder at the nursing station for the resident and it should be there, but the hospice does not always provide them with the documentation timely, they are inconsistent. The DON acknowledged they do not have a collaborated hospice care plan for this resident. On 04/25/24 at 3:20 PM, the Administrator provided recent hospice documentation that the hospice provider had just given to the facility. The Administrator also informed the surveyor that the MDS for Resident #506 was updated to reflect the resident was on hospice care. An interview was conducted on 04/25/24 at 3:25 PM with Staff E, MDS Coordinator who stated she has worked at the facility for [AGE] years. The MDS Coordinator stated they have 1 resident on hospice services, and she acknowledged there was no integrated plan of care for Hospice.