STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105485	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamlin Place of Boynton Beach	2180 Hypoluxo Road Lantana, FL 33462

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to provide food to residents in a sanitary manner. This had the potential to affect 103 residents who consumed food orally at that time of the survey. The findings included:Observations during the initial tour of the kitchen occurred on 12/08/25 at approximately 9:00 AM. The surveyor was accompanied by the Director of Nutrition who was a Certified Dietary Manager (CDM). The following concerns were observed:1. The interior of the left Manitowoc Ice machine had areas with built-up of white residue. Standing water was observed resting on the flat area where the lid lifted up. The Manitowoc Ice machine that was located to the right of the 1st ice machine had black residue inside the ice machine along the metal and plastic hardware that was related to the opening function of the lid. The CDM agreed with this finding. 2. The rim plates (adaptive equipment) were stored face down in a plastic bin that had yellow, orange, green, and black residue on the interior bottom of the container. The CDM agreed with this finding. 3. The Robocoup food processor had white and orange remnants of food located on the upper interior rim of the Robocoup container, and on the inner edge of the plastic cover. The CDM agreed with this finding. 4. The walk-in refrigerator had a package of sliced turkey that had no date to show the day it was opened. Per the CDM, the sliced turkey was safe to use for 3 days after it was opened. The CDM agreed with this finding. 5. The walk-in refrigerator had a package of sliced turkey that was dated 11/07/25. Per the CDM, the sliced turkey was safe to use for 3 days after it was opened. The CDM agreed with this finding. 6. The dry goods storage room had a 5-pound plastic container of creamy peanut butter. There was residual peanut butter on the top of the cover. A small dead insect with wings was stuck in the residual peanut butter on the exterior of the cover. The CDM agreed with this finding. 7. The Artic refrigerator had a buildup of ice under the area that contained the motor. The CDM agreed with this finding. 8. The drawer that housed the serving scoops had red-brown debris on the handle of the drawer, The CDM and the cook (Staff C) agreed it was barbeque sauce. The tin foil used to line the inside the drawer had red-brown debris under the handles of the scoops. The CDM agreed with this finding. 9. A small creamer, a package of crackers, a packet of sweet ?N low, black debris, and white granular-like debris were on the floor under the shelves in the dry-goods storage room. The CDM agreed with this finding. 1 The Vulcan oven had a build-up of brownish black debris on the interior of the oven. The CDM agreed with this finding. Photographic Evidence Obtained

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to coordinate care for provision of vision and hearing services for 2 of 2 Sampled residents reviewed for vision and hearing. (Resident #73 for vision and Resident #2 for hearing.)The findings included:1) Review of the record revealed Resident #73 was admitted to the facility initially on 04/08/18 with a re-entry date of 11/11/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS indicated Resident #73 had corrective lenses.Review of the active orders included an order for Mobile eye, dental services and podiatry as indicated dated 11/11/25.Review of the care plan dated 09/23/25 did not reveal a care plan related to vision loss.During an interview conducted on 12/08/25 at 10:35 AM when asked how her care was, Resident #73 stated she wished the facility would expedite her requests; she expressed that her eyesight had deteriorated since she was last seen and the glasses she currently has are not helping anymore. She stated the doctor retested her vision a couple months ago but there has been no follow up afterwards. Resident #73 voiced I love to do crossword puzzles, I can't read the puzzles or letters; I can't read the newspaper, it's very frustrating. When asked who she had told, Resident #73 stated she had told the direct care staff, but they always told her they would look into it but had yet to hear back from anyone.During a follow up interview conducted on 12/09/25 at 11:00 AM Resident #73 stated she still had not received an update about the status of her eyeglasses and stated she had tried to address it with administration when she got back from dialysis but had not been able to find anyone to talk to. During an interview conducted on 12/11/25 at 11:32 AM when asked what the process was for coordinating Resident's vision services, the Social Services Director (SSD) stated that her Social Services Assistant would deal with it directly. She stated a mobile eye order is placed, the facility called them, and they gave them the list of residents who needed to be seen. The vision center would email them when they got the list and coordinate with the facility to ensure that the residents were present when services were scheduled. When asked who is responsible for following up to ensure that these services were followed through, the SSD stated she was. When asked if she was aware of Resident #73's vision concerns, she stated she was not aware as she had only been at the facility for approximately a month. The SSD stated she would follow up with the surveyor to find out more about Resident #73's vision services. During an interview conducted on 12/11/25 at 12:45 PM when asked if she was aware of Resident #73's vision concerns, Staff D, Registered Nurse (RN) Unit Manager (200 wing) stated she was unaware and stated she would follow up with the SSD. Staff D agreed that the Resident should have been updated timely on their vision service request.During a follow up interview on 12/11/25 at 3:10 PM the SSD stated the resident had last been seen in July of 2025 and no new eye glasses were prescribed. On 12/11/25 at 3:30 PM, upon further, the SSD determined the reason the eyeglasses were not ordered was due to being diagnosed with Macular Degeneration and eyeglasses would not help as she needed shots in her eyes . When asked why it took so long to follow through with the doctor's recommendation, she stated they would have to reach out to see if her insurance covers this service. The SSD also provided the surveyor an outdated eyecare examination form from 06/13/22 for Resident #73 to reference the diagnosis. Review of Resident #73's Medical Record did not reveal an active diagnosis of Macular Degeneration. Review of Resident #73's Eyecare Examination dated 06/13/22 documented Complaint: year old female presented for follow up due to history of diabetes to assess for onset of retinopathy. Ophthalmic Diagnosis: Nonexudative age-related macular degeneration bilateral. Treatment plan: macular degeneration, dry assess in 6 months for neovascular membrane formation. New eyeglasses- Ordered - no Other reasons: will not improve vision. This diagnosis has been made for at least 3 years. 2) Review of the record revealed Resident #2 was admitted to the facility on [DATE] with a re-entry date of 08/22/25. Review of the (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS indicated Resident #2 did not have hearing aids with adequate hearing.Review of the active orders revealed an order that documented audiologist consult dated 08/25/25.Review of the care plan dated 11/20/25 did not reveal a care plan related hearing impairment.During an interview conducted on 12/08/25 at 11:04 AM, Resident #2 requested the surveyor speak close to her ear due to being hard of hearing. When asked how her care was Resident #2 stated she needed hearing aids and that the facility told her it took a couple months. She voiced that about 3 months ago the audiologist came to test her hearing, cleaned her ears, and told her she qualified for 2 hearing aids but she is still waiting for them. During an interview conducted on 12/09/25 at 11:21AM, Resident #2 stated she still had not receive an update on her hearing aids and stated she had given up trying.During a follow up interview on 12/10/25 at 12:45 PM Resident #2 stated I want my hearing aids but they aren't bringing them to me. When the surveyor stated she would follow up with staff regarding the status of hearing aids, Resident #2 stated everyone says that and nothing happens.During an interview conducted on 12/11/25 at 11:47 AM when asked what the process was for coordinating Resident's hearing services, the Social Services Director (SSD) stated that her Social Services assistant would deal with it directly. She stated an audiology order is placed, the facility called them and they gave them the list of residents who needed to be seen, the audiology center would email them when they got the list and coordinate with the facility that the residents were present when services were scheduled. When asked who is responsible for following up that these services were followed through, the SSD stated she was. When asked if she was aware of Resident #2's concerns, she stated she was not aware as she had only been at the facility for approximately a month. The SSD stated she would follow up with the surveyor to find out more about Resident #2's hearing aids.During an interview conducted on 12/11/25 at 12:06 PM, when asked who completed the hearing part of the MDS, Staff A MDS Coordinator stated that upon admission the SSD was in charge of interviewing the resident and updating information into the hearing section of the MDS. Staff A stated that back around Thanksgiving time she and a couple other staff members had talked to Resident #2 and she did not appear to have a hearing issue, so she had not been aware. Staff A stated back in May of 2025 a care plan meeting was held with Resident #2 where with her and her sister and they both refused an audiology consult as she had hearing aides in the past. Staff A was made aware Resident #2 was very hard of hearing and now requested hearing aids.During an interview conducted on 12/11/25 at 12:45 PM when asked how Resident #2 hearing was, Staff D, Registered Nurse (RN) Unit Manager (200 wing) stated she was hard of hearing but not to the point you had to speak in her ears. When asked if she was aware of Resident #2's requests for hearing aids due to difficulty hearing, Staff D stated she was unaware and stated she would follow up with the SSD. Staff D agreed that someone should have followed up with Resident #2's concerns. During an interview on 12/11/25 at 3:10 PM the SSD provided the surveyor an audiology report dated 09/15/25 for Resident #2, when asked when they would follow up with the Resident regarding her hearing aids she stated she did not know and would follow up with the surveyor. Review of Resident #2's Audiology chart notes dated 09/15/25 documented Pt seen for audiological evaluation. Based on patients test results, pt tested with hearing loss period patient could benefit from assistive devices to prevent further decline of hearing loss. Benefits: assistive devices can provide - improved hearing clarity in quiet and noisy environments. Better speech comprehension, especially in group conversations and when watching TV. Enhanced sound localization, helping the resident identify where sounds are coming from. Reduce listening fatigue, making communication less tiring. Support for cognitive health, helping maintain attention, memory, and mental sharpness. Improve social participation, reducing isolation and enhancing quality of life. Patient was educated on the benefits and would like to pursue amplification. See professional report for audiogram results patient attributes decline in hearing to worsening multiple sclerosis symptoms.Review of Audiologic Report (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 09/15/25 documented History: . She reports dizziness, secondary to her multiple sclerosis. She reported having trouble understanding conversation and having to ask people to repeat what they've said over the past five years. Results: Right ear-Moderate-severe sensorineural sloping hearing loss; Left ear- severe sensorineural peaked hearing loss. Recommendations: Based on today's testing results patient could benefit from amplification in both ears. Resident would like to pursue amplification to be able to hear more clearly and accurately.During a follow up interview on 12/11/25 at 3:30 PM when asked if she had read the results of the audiologic report for Resident #2' she stated she had glanced at them. SSD made aware of results of Resident #2's related to hearing loss and need for hearing aids. On 12/11/25 at approximately 3:45 PM the SSD provided the surveyor emails stating there was a payment pending from Resident #2 to the hearing center which had recently been cleared and was now on schedule to dispense. This information was found out after surveyor stated Resident #2's concerns and the SSD agreed this should have been followed up with sooner.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promptly notify the physician of a critical laboratory result for 1 of 5 sampled residents, as evidenced by the failure to notify the physician of a critically low blood sugar level for Resident #4.The findings included:Review of the record revealed Resident #4 was admitted to the facility on [DATE] with diagnosis to include diabetes. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 6, on a 0 to 15 scale, indicating the resident had severe cognitive impairment. This MDS also documented that the resident had diabetes.Review of a laboratory report, for a blood sample collected on 08/09/25 at 5:00 AM for Resident #4, documented a blood glucose level of 35, with the normal level of 70 to 99, indicating a critically low value. This blood sample was received by the laboratory on 08/09/25 at 12:12 PM and reported to the facility on [DATE] at 1:04 PM, as per the documentation on the report.Review of the record lacked any evidence the physician was notified of the critical lab value.During an interview and side-by-side review of the record on 12/11/25 at 2:01 PM, the Assistant Director of Nursing (ADON) agreed with the findings. The ADON explained that the nurse who reviewed the laboratory report no longer works at the facility. The ADON also stated she phoned the staff documented on the laboratory report as having received the critical value, and he, the supervisor at the time, reported he recalled getting the call and providing the report to the direct care nurse. The ADON confirmed the direct care nurse was responsible for notifying the physician. The ADON also agreed the blood glucose monitoring was not initiated by the physician until 08/11/25, two days after the critical result.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate care for provision of dental services for 1 of 1 sampled resident reviewed for dental (Resident #73).The findings included:Review of the record revealed Resident #73 was admitted to the facility initially on 04/08/18 with a re-entry date of 11/11/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the active orders included an order for Mobile eye, dental services and podiatry as indicated, dated 11/11/25.Review of the care plan dated 09/23/25 did not reveal a care plan related to dentures.During an interview conducted on 12/08/25 at 10:35 AM when asked how her care was, Resident #73 stated she wished the facility would expedite her requests; she expressed she lost her dentures a couple of months ago when she left them on her lunch tray and never saw them again. She stated the dentist refitted her for new dentures a couple months ago but there had been no follow up afterwards. Resident #73 stated she had told the direct care staff, but they always told her they would look into it but had yet to hear back from anyone.During a follow up interview conducted on 12/09/25 at 11:00 AM, Resident #73 stated she still had not received an update about the status of her dentures and stated she had tried to address it with Administration when she got back from dialysis but had not been able to find anyone to talk to. During an interview conducted on 12/11/25 at 11:32 AM, when asked what the process was for coordinating resident's dental services, the Social Services Director (SSD) stated that her Social Service Assistant would deal with it directly. She expressed a dental order was placed with [name of company] Dental Services the facility called them, and they gave them the list of residents who needed to be seen, the dental center would email them when they get the list and coordinate with the facility to ensure that the residents were present when services were scheduled. When asked who is responsible for following up to ensure that these services are followed through, the SSD stated she was. When asked if she was aware of Resident #73's concerns, she stated she was not made aware, as she had only been at the facility for approximately a month. The SSD stated she would follow up with the surveyor to find out more about Resident #73's dentures.During an interview conducted on 12/11/25 at 12:45 PM Staff D, Registered Nurse (RN) Unit Manager (200 wing) stated she was unaware that Resident #73 had lost her dentures a couple months ago and stated she would follow up with the SSD. Staff D agreed that someone should have followed up with Resident #73's requests sooner.Review of Resident #73's progress notes from [name of company] Dental Services dated 11/20/25, documented Patient presents for evaluation if candidate for upper denture. Patient has upper edentulous arch, lower natural teeth. Patient is asymptomatic I'm eating well. Patient expresses interest in upper denture. Clinical exam reveals limited gum and bone level, and patient understands this will affect final denture fit. Patient understands and wants to proceed with impressions. SDS office will follow up for approval.Review of Resident #73's follow up progress note from [name of company] Dental Services dated 11/25/25, documented Resident is interested in upper denture. We received authorization to proceed with dental treatment from POA resident.No further update related to Resident #73's dental services was provided by the SSD.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, policy review, and a review of professional standards of protocol, the facility failed to meet the needs of 2 of 2 Sampled residents (Resident #80 & Resident #128) who were on puree diets. This had the potential to affect 11 residents who were on puree diets. The findings included:A review of the facility's policy on the Dysphagia Puree (Level 1) Diet, from the Diet Manual dated 2011, specified that puree foods must be the consistency of moist mashed potatoes or pudding. The diet is used for people who have severe chewing and/or swallowing problems. A review of the International Dysphagia Diet Standardization Initiative (IDDSI, referenced www.iddsi.org) included an informational handout for adults on a puree diet. For safety, the IDDSI recommended avoiding foods with skins or outer shells. Peas was included on the list of foods to avoid on the pureed diet. 1) A record review revealed that Resident #128 was admitted to the facility on [DATE]. She was on Hospice Services since 12/08/25. Her diagnoses included Alzheimer's Disease, Unspecified, Vascular Dementia, and Weakness. The Nursing assessment dated [DATE] documented that the resident had difficulty speaking and she was unable to understand others. Her diet orders dated 12/05/25 were for a Regular diet, with Pureed texture, and Regular consistency fluids. 2) A record review revealed that Resident #80 was admitted to the facility on [DATE]. Her diagnoses included Oropharyngeal Dysphagia (difficulty swallowing), and Unspecified Dementia. An annual MDS assessment dated [DATE] documented that her Brief Interview for Mental Status score was 01. This indicated she had severe cognitive impairment, Her diet orders dated 07/17/25 were for a Regular diet, with Pureed texture, and Regular consistency fluids. An interview was conducted with the cook, Staff C, during the initial tour of the kitchen on 12/08/25, at approximately 9:30 AM. When asked to describe the puree diet, the cook said that pureed foods should be smooth. An observation of the tray line, on 12/10/2025 at approximately 11:45 AM, revealed that a dietary aide was about to place the meal tray for Resident #128 onto the pushcart for delivery to the residents. The pureed food looked lumpy. The surveyor requested that the plate be held in the kitchen until the Certified Dietary Manager (CDM) and the surveyor, together, evaluated the food texture. The cook was made aware of the concern that the pureed meat and vegetables were not smooth. An interview was conducted with the CDM on 12/10/2025 at 11:52 AM. The CDM and the surveyor tasted the pureed Salisbury Steak. The texture of the pureed Salisbury Steak had small lumps in it; It was not smooth. When the CDM was asked to describe it, she said to the surveyor, this is puree, but if you want it smoother, I'm going to have to go with a different machine. She also said: meat is just that way. The CDM and the Surveyor tasted the pureed peas and carrots. The Surveyor showed the separation of the pureed peas from the pieces of skin after eating a spoonful of the vegetable. The CDM agreed with this finding. An interview was conducted with the cook, Staff C, on 12/10/2025 at 12:00 PM. The cook said that he was unable to prepare a smoother puree on that day, He said he would prepare smoother foods on the following day. The cook did not modify the texture of the pureed lunch meal on 12/10/25. The plate of pureed food was sent to Resident #128. On 12/10/25 at 12:30 PM, Resident #80 was observed seated in the restorative dining room. Her meal plate had pureed Salisbury Steak, pureed peas and carrots, and pureed scalloped potatoes. The meat and the vegetables were lumpy. Staff B, a restorative CNA, helped Resident #80 with feeding. An interview was conducted on 12/10/25 at 12:40 PM with Staff B. When asked if the texture of the meat was a similar to the texture of pudding, the restorative CNA said that it was more watery than pudding. She described the texture of the meat as gritty. Photographic Evidence Obtained.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the provision of the influenza vaccine for 1 of 5 sampled residents (Resident #17).The findings included:Review of the record revealed Resident #17 was admitted to the facility on [DATE]. Review of the record revealed a Consent Form for Pneumococcal, Influenza and COVID-19 Vaccines dated 11/19/25. This form signed by the resident's family member documented the desire and consent for Resident #17 to receive the influenza vaccine.Review of the Immunization Details in the electronic medical record (EMR) documented the status for Resident #17 to receive the vaccine was pending immunization with the same consent date of 11/19/25.During an interview and side-by-side record review on 12/11/25 at 11:17 AM, the Assistant Director of Nursing (ADON) confirmed she had received the influenza vaccine from the pharmacy for the current season and had been administering them to the residents who had consented. When asked the process and timeframe to obtain the consent and administer the vaccine, the ADON explained the nurses and or managers get the consents each season and provide them to herself to be scheduled. The ADON further clarified for newly admitted residents, the admissions nurse would obtain the consent and put the information into the immunization tab in the EMR. Upon review of the immunization tab in the EMR, the ADON stated the admission nurse had obtained the consent for Resident #17 and had entered the information into the EMR. The ADON further described the information is sent to a dashboard in the EMR that she would routinely review. Upon review of this dashboard, the ADON confirmed Resident #17 was listed as needing the vaccine. When asked the turn-around time to obtain the vaccine after receipt of consent, the ADON stated no more than three days. When asked why Resident #17 had not received the influenza vaccine as per the request of the family on 11/19/25, the ADON was unsure.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure of accurate Minimum Data Set (MDS) assessments for 2 of 6 sampled residents, as evidenced by the failure to include all administered medications on the assessments for Resident #4 and #129.The findings included:1) Review of the record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses to include a stroke and mood disturbance. Review of current physician orders revealed Resident #4 was on Eliquis, an anticoagulant (blood thinner) twice daily since 08/16/25, related to her stroke. Resident #4 was also taking Divalproex, an anticonvulsant also used for a mood disorder, twice daily since 09/13/25. Review of the current MDS assessment dated [DATE] lacked the documented use of the anticoagulant and the anticonvulsant for Resident #4 During an interview and side-by-side review of the MDS on 12/11/25 at 12:20 PM, with Staff A, MDS Coordinator, she agreed with the findings. 2) A record review of Resident #129's medical record revealed that she was admitted to the facility on [DATE]. Her diagnoses included Heart Failure and Unspecified Atrial Fibrillation, Unspecified Atrial Fibrillation, and Hyperlipidemia. Resident #129 had a physician's order for Eliquis, an anticoagulant, dated 12/01/25. The facility had a care plan for Resident #129, last revised on 12/02/25, that focused on the use of an anticoagulant and the risk of adverse effects related to anticoagulant therapy. A review of Resident #129's MDS Medicare-5 Day assessment dated [DATE] revealed it was performed during the resident screening process on 12/09/85. One question on the assessment asked if the resident used an anticoagulant in the past 7 days. The answer NO was circled and signed on 12/06/25. An interview was conducted on 12/11/2025 at 3:18 PM with Staff A (MDS Coordinator). When asked to examine the question about anticoagulants on the MDS assessment for Resident #129 dated 12/06/25, she said that the anticoagulant should have been triggered for Resident #129. She said that Resident #129 was on Eliquis, and it should have been checked off. The MDS Coordinator agreed with the findings.