STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105492	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Breeze Rehab and Care Center	1626 Davis Rd West Palm Beach, FL 33406

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 - Some	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** 51137 Based on observation, interview, and record review the facility failed to treat Residents with dignity and respect during care for Residents #323, #20, and a Resident that wished to remain anonymous; failed to discuss financial concerns in private for Resident #94; and failed to treat Residents with dignity during dining for Residents #8, #74, #76 and #104. The findings included: Review of the policy titled Guideline: Administrative-Resident Rights-Right to Respect, Dignity and to have Personal Property documented Process: 1. The resident has a right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. 1. Review of the record revealed Resident #323 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #323 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the Resident was cognitively intact. During an interview on 05/05/25 at 10:03 AM when asked if she was being treated with dignity and respect, Resident #323 stated Staff O was rude to her. She always appears to be in a bad mood when I ask for assistance. I don't know what I have done to her for her to be that way towards me. Resident #323 stated, The other day Staff O was upset with me because my colostomy bag had burst and spilt onto my gown. Resident #323 explained that a social worker who came in her room at the moment the Resident's gown was dirty did her the favor of placing the dirty gown in the bathroom near the trash; she continued to state that afterwards Staff O had gotten upset with her and told her she was being messy and dirty for leaving the gown there. Resident #323 stated she told Staff O that it wasn't her who placed the gown there and then Staff O proceeded to call the Resident a liar. During an interview on 05/06/25 at 10:54 AM, Resident #323 stated that last night the colostomy bag burst again on her gown and did not receive a gown to change into. While waiting for a gown she fell asleep and when she woke up she noticed she still was not in a gown. Resident #323 stated she slept with no clothes on that night and was told to use her own clothes instead. Yesterday I felt nauseous, so I put some of my food aside from my lunch tray and when I came back Staff O threw my lunch away. She did not even ask me if I was done. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/25 at 12:33 PM, Resident #323 stated Staff O was not working today she could notice the difference in care and was having a better day. 2. Review of the record revealed Resident #20 was admitted to the facility on [DATE].Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #20 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the Resident was cognitively intact. During an interview on 05/05/25 at 12:51 PM when asked how staff are treating him, Resident #20 stated staff were rude, have an attitude, and don't want to help. I'm sick and old. Resident was visibly upset and did not want to continue participating in conversation. 3. An interview with an alert and oriented resident, who requested to remain anonymous, was completed 5/05/25 at 10:21 AM, when asked if they were being treated with dignity and respect, the Resident stated Some staff are moody, arrogant, and nasty. When asked what shift this mostly happened on and what type of staff it was, the Resident stated that it happened in both shifts and was the CNAs. The Resident stated they were not revealing any names due to fear of retaliation. During a follow up interview on 05/06/25 at 12:31 PM when asked if the staff were still being mean to her, the anonymous Resident stated that she didn't t know why the CNAs don't treat her with respect, They should treat me how I treat them. During an interview on 05/08/25 at 9:12 AM, concerns were made aware to the Director of Nursing (DON) regarding multiple Resident complaints of mean CNAs. All of Resident's #323's concerns were presented to the DON she stated she was not aware this had been going on and would take care of it. The DON asked the surveyor to present findings to the regional nurses in the facility; both regional nurses were made aware and agreed that should not have happened. During an interview on 05/08/25 at 9:34 AM when asked what would you do if a Resident told you that a CNA was being mean to them (yelling, calling them a liar, always in a bad mood; rude) the Social Service Director(SSD) stated, I would write it up as a grievance, speak to the DON and educate the staff. When asked, would you say that the Residents were being treated with dignity and respect in those situations? the SSD stated No, I mean who wants to be talked to like that. The SSD agreed the Residents were not treated in a dignified manner. 52248 4. Record review revealed Resident #94 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status score of 15, on a 0-15 scale, indicating no cognitive impairment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/25 at 9:42 AM Resident #94 stated, The Business Office Manager came to the dining room with another staff person and in front of other residents and staff, she tossed an envelope on the table with $100 cash, which was all single dollar bills. I asked what this was for, shouldn't I receive a paper to sign for this? The Business Office Manager said it was from my social security, then she patted me on the back, and stated, Remember I helped you get this, as she walked away. I asked the Business Office Manager, Can you tell me what I'm getting every month. She continued to walk away. About a week ago the Business Office Manager came to me again in the dining room with $160 cash in an envelope and I also noticed that she had some other money rolled up in her hand. I told her that I would like a paper stating she gave the money to me, and I told her that I would like a statement or something from social security. The Business Office Manager got very nasty and stated, I tell you what, I'll give you $40 more and it will make it $200, she had $40 more in her hand. I still wanted some documentation. I asked, what happened to the other months? The Business Office Manager got very upset and stated, all you had to do was come to my office and get the money. Then she snatched the other money from the table and stated I guess you don't want the money. Again, I told her I wanted something showing she gave me the money and a statement about my social security. She left, then later, the Business Office Manager came back with a piece of paper, and she got very loud with me while she was trying to explain what was on the paper. I asked, Shouldn't you talk to me in my room instead of in front of all these other people? The Business Office Manager stated, these people don't care about what I say to you. She aggressively gave me the form to sign. I told her that I would like to get my funds on a card like everyone else does. During an interview on 05/06/25 at 11:09 AM, when asked do you recall mentioning yesterday that you overheard a conversation in the dining room with another resident and the Business Office Manager, Resident #56, stated Yes, the Business Office Manager confronted Resident #94 from next door because he wanted his social security statements. The Business Office Manager was very loud. It's a conversation that should have been done in private. During an interview on 05/07/25 at 12:20 PM, when asked have you had any conversations with Resident #94 regarding his social security funds, the Business Office Manger stated, Yes, when he came here, he didn't even have a place to stay and was not receiving any assistance. I helped him apply for assistance and insurance. Resident #94 just started receiving funds. He started getting income on 1/16/25. He gets $1183 a month to pay rent, which comes directly to the facility because this is where he lives long term. When asked, where did the conversations take place with Resident #94, the Business Office Manager stated, The first time was in his room on 1/25/25 and the second time on 4/25/25 was in the activities area, which is located in a corner of the dining room. The activities director and social service were present. When asked was anyone else in the room during the conversation regarding Resident #94 funds, the Business Office Manager stated, No just the witnesses. During an interview on 05/07/23 at 5:21 PM, when asked did any conversations occur between you and the Business Office Manager in your room when you were discussing your finances, Resident #94 stated, No, she wouldn't come to my room. During an interview on 05/07/25 at 5:34 PM, when asked where they were located when the forms were signed by Resident #94, the Business Office Manager stated, In the dining room. When she was asked again where they were located when Resident #94 signed the withdrawal receipt, the Business Office Manager stated, In the dining room. They were both signed by him in the dining room. 50895 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A record review of Resident #8 revealed that she was admitted to the facility on [DATE]. She had medical diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified Lack of Coordination, Muscle Weakness, and Dementia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that Resident #8 had a Brief Interview for Mental Status of 00, which indicated that she had severe cognitive impairment. According to this MDS assessment, Resident #8 had the ability to express ideas and wants through both verbal and non-verbal means. The MDS assessment coded this resident as able to feed herself. A record review of Resident #8's most recent care plan for nutrition revealed that she had a history of weight loss. Interventions included encouraging the intake of food and drinks, and honoring food preferences. A review of Resident #8's care plan for activities of daily living included an intervention for staff to praise all efforts at self-care. During an interview with Staff D, a certified nursing assistant (CNA), on 05/08/25 at 11:58 AM, the CNA said that Resident #8 liked to eat with her hands. When asked how long she had exhibited this behavior, the CNA said that she ate with her hands at least the past 6 months. Per Staff D, that was the approximate length of time that he worked at the facility. During a meal observation on 05/07/25 at 5:54 PM, Resident #8 sat at a table in the [NAME] Hall dining room. She fed herself with her hands. The surveyor observed Staff B as he placed his hand on Resident #8's wrist and stopped her from eating with her hands. Resident #8 yelled out loud. Then Staff B removed his hand. While in a standing position, Staff B picked up a spoonful of food and placed it into the resident's mouth. The resident accepted the food. Then Staff B scooped up food with the spoon and placed the spoon into Resident #8's hand. She fed herself one bite with the spoon and then started to feed herself again with her hands. Staff B explained to the surveyor that she always did that. He said that the staff tried to encourage the use of utensils and that she preferred to eat with her hands. 6. A record review revealed that Resident #76 was admitted to the facility on [DATE]. Her room was changed to a room in the [NAME] Hall, memory support unit, on 04/10/25. Her medical diagnoses included Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder, Dementia, Severity, and Cognitive Communication Deficit. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #76 had a Brief Interview for Mental Status of 03. This indicated that she had severe cognitive impairment. During an observation in the [NAME] dining room on 05/07/25 at 12:25 PM, two out of five residents seated at table 1 were served their lunch. Resident #76 was not served yet. Resident #76 ate stuffing from Resident #104's plate. Resident #104, who sat to her right, saw Resident #76 eat from his plate. On 05/07/25 at 12:27 PM, a staff member and the surveyor observed Resident #76 as she ate carrots from Resident #74's plate. Resident #74 sat to the left of Resident #76. The staff member told Resident #76 not to eat from Resident #74's plate while she served Resident #76 her lunch plate. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #104 didn't start eating. He appeared agitated. The surveyor attempted to speak to Resident #104 but was unable to communicate with him effectively. The surveyor notified Staff F that Resident #104 appeared upset. The surveyor explained that Resident #76 ate from the plates of the residents to her right and left, before she was served. Staff F requested a new clean meal plate from the kitchen for Resident #104. After Resident #104 was served a replacement for the plate of food, he ate the food with a good appetite. Resident #74 was not served a new plate of food. Resident #74 ate his lunch after Resident #76 ate from his plate. During an interview with Staff F on 05/07/25 at 12:33 PM, she explained that sometimes residents took food from other residents' plates. When this happened, she said that the staff usually got the resident a new tray.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to honor a resident's choice to have information displayed in the resident's room for 1 of 2 residents reviewed for choices, Resident #117. The findings included: Resident #117 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Admission Minimum Data Set (MDS) with a reference date of 04/13/25, Resident #117's preferred language was Spanish. The MDS documented that Resident #117 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was 'cognitively intact'. Resident #117's diagnoses at the time of the assessment included: Stroke, Non-Alzheimer's dementia, Malnutrition, Depression, Nontraumatic intracranial hemorrhage, Dysphagia, Dysarthria and Spinal stenosis. Resident #117's care plan for communication documented, Resident has a potential communication problem related to language barrier. He is Spanish speaking. Date Initiated: 04/09/2025 Revision on: 04/09/2025. The goal of the care plan was documented as, Resident will have his needs met through the review date. Date Initiated: 04/09/2025 Revision on: 04/24/2025 Target Date: 07/08/2025 Interventions to the care plan included: o Anticipate and meet needs. Date Initiated: 04/09/2025 o OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech. Date Initiated: 04/09/2025 o Provide translator as necessary to communicate with the resident. Translator is: (Spanish) Date Initiated: 04/09/2025 Revision on: 04/09/2025 o Speak on an adult level, speaking clearly and slower than normal. Date Initiated: 04/09/2025 During an observation, on 05/06/25 at 11:30 AM, in Resident #117's room, it was noted that there was a sign over the resident's head of bed that documented Resident #117's preferences, dislikes and contact information for the resident's family members. An interview was attempted with the resident, however the resident did not speak or appear to understand English. During an interview, on 05/06/25 at 3:29 PM, with Resident #117 via an interpreter, it was noted that the sign that was over the resident's head of bed had been removed. When asked about the sign, Resident #117 stated that staff had removed the sign and took it to the office and the resident did not know why it was removed. Resident #117 voiced that he was very upset about the sign being removed and stated that the sign was necessary as he was unable to communicate his needs and preferences without the sign being posted. The resident explained that the sign was created by family members. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview, on 05/07/25 at 10:25 AM, with Resident #117 and his spouse, the resident was upset about the sign being removed from over the head of the bed. The resident stated that Social Services removed the sign and did not tell him why. The resident further stated that he was unable to communicate with staff without the sign due to not being able to speak English. Resident #117's spouse was able to express that she only spoke limited English. During an interview, on 05/07/25 at 10:29 AM, with the Social Services Director (SSD), the SSD denied removing sign. During an interview, on 05/07/25 at 10:32 AM, with the Director of Nursing (DON), when asked about the sign being removed, the DON replied, I don't know who removed it. I saw it there, I don't know who removed it and when. During an interview, on 05/07/25 at 10:36 AM, with the Administrator, when asked about the sign being removed, the Administrator stated that she did not know who took the sign down. During a follow up interview, on 05/07/25 at 10:43 AM, with Resident #117, via an interpreter, Resident #117 stated that the sign was very important to him because he cannot communicate with staff. The resident further stated that he was unable to recall the person that took the sign, however did stated that it was not one of the staff providing care to him. During an interview, on 05/07/25 at 10:45 AM, with Staff H, LPN/Unit Manager, when asked about communicating with Resident #117, Staff H stated that the resident spoke 'some English'.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on policy review, record review and interview, the facility failed to provide a receipt for a financial transaction as evidenced by Resident #94 stating he did not sign or receive a copy of a receipt. The findings included: Review of the policy titled Resident Rights-Personal funds effective 04/01/2022, documented, in part, A resident who requests cash with available funds will be given cash or check and a signed receipt will be provided for both resident and records. Record review revealed Resident #94 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status score of 15, on a 0-15 scale, indicating no cognitive impairment. During an interview on 05/05/25 at 9:59 AM, when asked if everyone is treating you well at the facility, Resident #94 stated, I have an issue with the social worker regarding my social security. They gave me some money in January, but I haven't received any since. They gave me $100 cash in all dollar bills. I don't know why they gave it to me. I don't have nothing on paper that I signed to show they are giving this to me. During an interview on 05/06/25 at 9:29 AM, when asked if he reported his concerns to anyone else, Resident #94 stated, The Business Office Manager came to the dining room with another staff person and in front of other residents and staff, she tossed an envelope on the table with $100 cash, which was all single dollar bills. I asked what this was for, shouldn't I receive a paper to sign for this? The Business office Manager said it was from my social security, then she patted me on the back, and stated, Remember I helped you get this, as she walked away. I asked the Business Office Manager, Can you tell me what I'm getting every month. She continued to walk away. During an interview on 05/07/25 at 12:20 PM, when asked if Resident #94 signed for the funds he received in January, the Business Office Manager stated, Yes. When asked if Resident #94 signed for the funds he received the second time on 04/25/25. She stated Yes. During an interview on 05/07/23 at 5:21 PM, when asked he had seen the withdrawal receipt dated 1/22/25 and if he signed it, Resident # 94 stated No ma'am that is not my signature. All my signatures look the same. When asked if he signed the statement landscape form, Resident # 94, stated, Yes. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/25 5:34 PM, when copies of the receipt of funds signed by Resident #94 were requested from the Business Manager, a copy of a withdrawal receipt dated 1/22/2025 and a resident statement landscape was received from the Business Office Manager. Both forms had signatures on them. When asked if Resident # 94 signed both forms, the Business Office Manger stated, Yes, why? When asked who was present when Resident # 94 signed the forms the Business Office Manager stated, When the withdrawal receipt was signed, the Marketing Manager and I were there and when he signed the statement landscape form myself, the Activities Director and the Social Worker were present. The Business Office Manager was informed that Resident #94 said he did not sign the withdrawal receipt dated 1/22/2025 and he has never seen the form. When asked why she or the Marketing Manager didn't sign the form along with Resident #94, the Business Office Manager had no explanation. When the Marketing Manager was asked if she was present when Resident # 94 received funds and signed the withdrawal receipt dated 1/22/25, the Marketing Manager stated, Yes. When asked why she didn't sign as a witness, the Marketing Manager stated, I don't know. During an interview on 05/08/25 at 10:48 AM, when asked if she is aware of the facility policy for distributing personal funds, does the resident have to sign for the funds, are witnesses supposed to be present when funds are exchanged in the form of cash, the Administrator stated Yes there should be two witnesses. A copy of the withdrawal receipt dated 1/22/25 and the statement landscape dated 4/25/25 was shown to the Administrator. When asked if the signatures looked the same on both forms, the Administrator stated, No, while pointing at the statement landscape, this looks more like the resident's signature. During an interview on 05/08/25 at 1:34 PM, the Administrator had presented some documents from the record of Resident #94, which had his signature on them to show the comparison. The Administrator stated I agree that the signature on the statement landscape dated 4/25/25 looks more like the signature of the other documents that Resident #94 have signed before.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on policy review, record review and interviews, the facility failed to provide the resident with his original documents upon request for 1 of 2 sampled residents (Resident #56); and the facility failed to deliver mail to 1 of 2 sampled residents (Resident #94). Findings included: The review of the policy titled Communication with You and Friends, documented, in part You will receive mail addressed to you delivered at the facility unopened, and as soon as possible. 1. Record review revealed Resident #56 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0-15 scale, indicating no cognitive impairment. During an interview on 05/05/25 12:27 PM, the resident stated the Office Manager brought her these forms last Tuesday and she asked for the originals. The Office Manager said we don't have originals. I know these are not original because the bottom is cut off and there are lines of the form that look like things have been whited out. I don't know why I'm just getting these documents (the documents were dated 02/20/25 and 03/31/25). The Regional Business Office Manager came in with another staff member to explain the documents. I asked her for the originals, and she said you will have to see the Business Office Manager. (Photographic evidence obtained.) During an interview on 05/07/25 at 12:32 PM, when asked are you aware of some forms from DCF that were given to Resident # 56, the Business Office Manager stated, She is applying for Medicaid and in the forms it is saying that she has too many funds in her bank account, so the state is requesting her bank statements for the past four months and she refused to release the information. The Business Office Manager showed the original copies of the forms she had in a folder. When asked if Resident # 56 asked her for the original forms, the Business Office Manger stated, She should have originals DCF usually send out 5 copies. When asked if Resident #56 asked her for originals, the Business Office Manger stated, I gave her a copy, because she should have an original. 2. Record review revealed Resident #94 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status score of 15, on a 0-15 scale, indicating no cognitive impairment. During an interview on 05/05/25 at 9:59 AM, Resident #94 stated I don't receive any mail. I don't know who is responsible for giving out the mail. During an interview on 05/07/25 at 3:36 PM, when asked what is your process for distributing mail, the Activities Director stated. I receive the mail from the receptionist already sorted and I just hand it out to the residents. (continued on next page)

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	105492	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Breeze Rehab and Care Center	1626 Davis Rd West Palm Beach, FL 33406

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 05/07/25 at 3:40 PM, when asked what is your process for sorting mail, the Receptionist stated, When I receive the mail from the postal service, I sort it by resident's name and it is distributed by the activities staff person. When asked how do you determine what mail goes directly to the resident, the Receptionist stated, If it is addressed to the resident it goes to the resident. When asked if it is addressed to the resident and has facility name on it who gets it, the Receptionist stated If it has the resident's name first and then the facility name it goes to the resident and if it is addressed to the facility first then the resident, the mail goes directly to the business office.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, and review of housekeeping records, the facility failed to ensure a safe, clean, and homelike environment for 1 of 4 units ([NAME]) as evidenced by pervasive odors noted on the unit throughout the survey week and maintenance concerns in the dining room. The findings included: 1) During an interview on 05/08/25 at 1:29 PM, when asked how she ensures an odor-free environment, the Housekeeping Manager stated her staff utilize a disinfectant cleaner to wipe down all surfaces, and during a deep cleaning of a room, all linens and curtains were changed out. When asked the process and schedule for deep cleaning the rooms, the Housekeeping Manager explained she had a schedule in which one or two rooms were deep cleaned daily, and when a resident was discharged , that room was also deep cleaned. When asked if there were any additional considerations for the [NAME] unit, which was the secured unit for the memory impaired residents, the Housekeeping Manager stated the housekeeper assigned to that unit remained on the unit the whole day, except during meals, and made continuous rounds, to ensure cleanliness. When asked if the [NAME] unit was part of the deep cleaning schedule, the Housekeeping Manager confirmed that unit was on the schedule. The Housekeeping Manager was asked to provide evidence of the deep cleaning schedule. The [NAME] unit was comprised of rooms 218 through 233. Review of the monthly Deep Clean Schedule documented each room in the [NAME] unit was deep cleaned at least monthly. When asked to provide evidence of the completion of the deep cleaning as per the schedule, the Housekeeping Manager explained she completed a daily QA (quality assurance) round of one room on every unit. When asked how she ensures or tracks the completion of the deep cleaned rooms, the Housekeeping Manager stated that one of the rooms on her audit would be one of the deep cleaned rooms. When asked if she kept any log or evidence of deep cleaning completion, the Housekeeping Manager stated she did not. Upon second request to review the QA documentation, on 05/08/25 at approximately 2:30 PM, the information had not been provided as of the exit conference. During the survey week of 05/05/25 through 05/08/25 the following was observed and noted: a) On 05/05/25 at 2:42 PM, upon entering room [ROOM NUMBER], a urine odor was noted. The odor was stronger in the bathroom. No residents were in the room at that time. b) On 05/05/25 at 3:45 PM a strong urine odor was noted in the bathroom of room [ROOM NUMBER]. c) On 05/06/25 at 8:51 AM, upon entering room [ROOM NUMBER] a very strong urine odor was noted. A resident was in the room eating breakfast, but the odor was pervasive throughout the room. d) On 05/07/25 at 9:27 AM, upon entering room [ROOM NUMBER], a pervasive stale odor was noted in the room. There were no residents in the room at that time. e) On 05/07/25 at 9:30 AM, upon entering room [ROOM NUMBER] a very unpleasant stale odor was noted in the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f) On 05/07/25 at 9:31 AM, a stale urine odor was noted in room [ROOM NUMBER]. g) Upon entering the [NAME] unit on 05/07/25 at 12:13 PM, a strong urine odor was noted in the hallway near rooms 218, 219, 220, and 221. h) On 05/07/25 at 12:15 PM, an odor of urine was noted in room [ROOM NUMBER]. i) On 05/07/25 at 4:10 PM, the pervasive offensive stale odor remained in room [ROOM NUMBER]. j) On 05/08/25 at 1:16 PM the stale urine odor remained in room [ROOM NUMBER]. k) On 05/08/25 at 1:20 PM, upon entering room [ROOM NUMBER], a urine odor was noted. Upon entering the bathroom, the odor was worse. There was no obvious evidence for the reason for the odor. On 05/08/25 at approximately 1:45 PM, a tour of the [NAME] unit was made with the Housekeeping Manager. Upon entering rooms [ROOM NUMBER], the Housekeeping Manager confirmed the unpleasant odors. She immediately smelled the mattresses and stated they were not the reason for the odors. The Housekeeping Manager stated it must be the floors, and stated they needed to be stripped and cleaned. The Housekeeping Manager was made aware of the pervasive odors noted throughout the week and simply stated the rooms needed to be deep cleaned. 2) An observation of the bathroom in room [ROOM NUMBER] on 05/06/25 at 8:49 AM revealed the faucet was oxidized as noted by the green substance on the metal knobs. Photographic evidence obtained. 3) An observation of the [NAME] dining room on 05/07/25 at 4:33 PM revealed a sink along the wall with a corroded metal faucet and handles. The cabinet that housed the sink had four broken doors. The room's window air conditioner was visibly dirty with a black substance on the white unit. Photographic evidence obtained. The photos were shared with the Regional Nurse Consultant who agreed with the concerns.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on interviews and record reviews, the facility failed to develop and implement a care plan for a resident's smoking for 1 of 2 residents reviewed for smoking (Resident #31). The findings included: The facility's Smoking Policy, with no reference date, documented: Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Resident #31 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, the Admission Minimum Data Set (MDS), with a reference date of 04/5/25, Resident #31 had a Brief Interview for Mental Status (BIMS) score of 09, indicating that the resident was 'moderately' cognitively impaired. The assessment documented that Resident #31 required partial/moderate assistance for bed mobility, substantial/maximal assistance for transfers and ambulated via manual wheelchair independently. Resident #31's diagnoses at the time of the MDS included: Cancer, Fracture, Malnutrition, Chronic lung disease, Injury of head, Muscle weakness, Abnormal posture, Lack of coordination. A Smoking evaluation, with a reference date of 05/02/25, documented that the resident required someone to light/extinguish cigarette and Supervision. Further review of resident's electronic health record on 05/05/25 at 1:14 PM revealed that there was no care plan for smoking. During an interview, on 05/05/25 at 12:04 PM, when asked about smoking, Resident #31 stated that he smokes occasionally, a couple of times per day. During an interview, on 05/07/25 at 1:10 PM, the Activities Coordinator confirmed that the resident did smoke with supervision. During a follow up interview, on 05/07/25 at 1:26 PM, Resident #31stated that he only smokes when people that visit him smoke. The resident further stated he is actively trying to quit smoking. During an interview, on 05/08/25 at 12:06 PM, with the Regional MDS Coordinator, I saw they did the assessment, and I saw that they did not do a care plan and I in-serviced that if they smoke and complete a smoking assessment, they need to generate a care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to: 1). Provide alternate means for a resident to communicate with staff for 1 of 2 residents reviewed for communication, Resident #117; and 2). Failed to ensure a resident was provided with appropriate supplies in order to independently maintain their ostomy for 1 of 1 resident reviewed for ostomy status, Resident #323. The findings included: 1). Resident #117 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, the Admission Minimum Data Set (MDS) with a reference date of 04/13/25, Resident #117 was 'Hispanic, Latino or Spanish origin' and preferred language was Spanish. The MDS documented that Resident #117 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was 'cognitively intact'. The MDS documented that Resident #117 required 'Substantial/maximal assistance' for bed mobility, was dependent upon staff for transfers and ambulated via manual wheelchair with assistance. Resident #117's diagnoses at the time of the assessment included: Stroke, Non-Alzheimer's dementia, Malnutrition, Depression, Nontraumatic intracranial hemorrhage, Muscle weakness, Lack of coordination, Dysphagia, Dysarthria and Spinal stenosis. Resident #117's care plan for communication documented, Resident has a potential communication problem related to language barrier. He is Spanish speaking. Date Initiated: 04/09/2025 Revision on: 04/09/2025. The goal of the care plan was documented as, Resident will have his needs met through the review date. Date Initiated: 04/09/2025 Revision on: 04/24/2025 Target Date: 07/08/2025 Interventions to the care plan included: o Anticipate and meet needs. Date Initiated: 04/09/2025 o OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech. Date Initiated: 04/09/2025 o Provide translator as necessary to communicate with the resident. Translator is: (Spanish) Date Initiated: 04/09/2025 Revision on: 04/09/2025 o Speak on an adult level, speaking clearly and slower than normal. Date Initiated: 04/09/2025 During an interview, on 05/06/25 at 9:50 AM, with Resident #117's son, when asked about the resident being able to communicate with staff in the facility, Resident #117's son replied, he understands a little bit. He has been in the country since the 80s. That is the problem, there is a barrier with communication, the therapist does speak Spanish and the Main doctor there dabbles a little in Spanish. The staff just try to get by and he attempts to speak English. He has been complaining to me about the doctors and that are seeing him and he is not understanding what they are explaining. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 05/06/25 at 11:30 AM, in Resident #117's room, it was noted that there was a sign over the resident's head of bed that documented Resident #117's preferences, dislikes and contact information for the resident's family members. An interview was attempted with the resident, however the resident did not speak or appear to understand English. The resident demonstrated that he did not have use of his right arm and hand. It was noted that the resident had bed rails in a raises position on both sides of his bed (at the request of the family). During an interview, on 05/06/25 at 3:29 PM, with Resident #117 via an interpreter, it was noted that the sign that was over the resident's head of bed had been removed. When asked about the sign, Resident #117 stated that staff had removed the sign and took it to the office and the resident did not know why it was removed. Resident #117 voiced that he was very upset about the sign being removed and stated that the sign was necessary as he was unable to communicate his needs and preferences without the sign being posted. The resident explained that the sign was created by family members. Resident #117 stated that communication with staff was not always effective. Resident #117 further stated that he would like a translator. Resident #117 demonstrated that the only way he could move his right hand and arm was to pick it up with his left hand. During the interviews and observations, it was noted that there was no additional device or means for Resident #117 to communicate with staff in the facility (i.e. communication board). During an interview, on 05/06/25 at 11:05 AM, with Staff I, CNA, when asked about communicating with Resident #117, the CNA stated that the resident spoke some English and voiced no concerns with communicating with the resident. During an interview, on 05/07/25 at 10:51 AM, with the Regional Nurse Consultant, the Regional Nurse Consultant stated that she spoke Spanish and was able to communicate with the resident and that the therapy staff spoke Spanish as well and were able to communicate with Resident #117. When asked about being able to communicate with the resident after herself and the therapy staff leave the facility at the end of the day, the Regional Nurse Consultant was unable to acknowledge if staff were able to do so after the Spanish speaking staff had left at the end of their shift(s). On 05/07/25 at 11:02 AM, the Director of Nursing (DON), presented a communication board to this Surveyor and stated that it was on the bedside table. The DON confirmed that the it was kept on the bedside table to the resident's right side of the bed. The DON acknowledged that the resident did not have access to the communication board due to not having use of his right hand and arm and the bed rails being in a raised position. During an interview, on 05/07/25 at 11:03 AM, with the Speech Language Pathologist (SLP). The SLP stated, I have limited Spanish and I was able to communicate to him with the communication board. His son was here, and his wife was here and the son translated for me. During an interview, on 05/07/25 at 12:35 PM, with the Director of Rehab, the Director of Rehab confirmed that Resident #117 was not be able to use his right arm and hand to access the communication board on the bedside table with the bed rails in a raised position. 51137 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the policy titled Nursing-Activities of Daily Living (ADLS) effective 04/01/22 documented Procedure: 1. The facility shall ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living. The facility shall provide care and services for the following activities of daily living as needed based on the individual care plan of each resident: C. toileting. Review of the record revealed Resident #323 was admitted to the facility on [DATE].Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #323 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the Resident was cognitively intact. Review of the current care plan dated 04/21/25 documented Resident #323 has a colostomy with the goal of Patency and function of the stoma will be maintained through next review date; Risk of skin breakdown around stoma will be minimized through next review date Review of current orders revealed Ostomy: Colostomy Care Every shift and as needed for leakage, or loose. During an interview on 05/05/25 at 9:53 AM, when asked about her care, Resident #323 stated she had a colostomy bag that she took care of on her own; she said she frequently had to change it out. Resident #323 stated that last night she did not receive assistance with getting ostomy supplies from about 3 AM to just recently when she found an ostomy bag within her own personal belongings. Resident #323 stated this led her to have to use several zip-loc bags throughout the night as a measure to catch her secretions. She stated she was sometimes told by staff that they did not have her correct ostomy size. She stated that her ostomy bag currently needed to be changed again and was waiting on assistance. During an interview on 05/06/25 at 11:02 AM, when asked how often she is not provided supplies to maintain the care of the colostomy bag, Resident #323 stated it was frequently that she had to ask for replacement bags. The Resident voiced that often her skin around her stoma started to burn due to having to wait long periods of time. During an interview on 05/08/25 at 8:39 AM, when asked if there was a shortage of ostomy supplies, the Central Supply Coordinator stated there was not a shortage and proceeded to show the surveyor the supply. He stated there were only 2 current residents that required ostomy supplies in the facility; he made sure the supplies were well stocked. When asked if staff can get into the supply rooms when he was not there, the Central Supply Coordinator stated that all the nurses have access to both supply rooms. During an interview on 05/08/25 at 8:48 AM, when asked who is responsible for providing colostomy care to Resident #323, Staff N, Licensed Practical Nurse (LPN) stated Certified Nursing Assistants (CNAs) were responsible for providing colostomy care and stated she did not perform that. During an interview on 05/08/25 at 08:51 AM, when asked who was responsible for providing colostomy care for Resident #323, Staff O, Certified Nursing Assistant (CNA), stated the nurses were responsible for providing colostomy care and did not perform that. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 9:00 AM, when asked about colostomy care for Resident #323, Staff M, Licensed Practical Nurse (LPN) stated that the Resident cared for her own colostomy bag. When asked if the Resident ever had to wait long periods of time waiting on supplies, Staff M stated she was not aware of that happening and that there were supplies to provide. During an interview on 05/08/25 at 9:12 AM, when asked to clarify who is responsible for providing colostomy care to Residents, the Director of Nursing (DON) stated nurses are responsible for applying the adhesive and bags and CNAs are responsible for emptying the bags. When concerns were brought up to the DON regarding the lack of care Resident #323 had been receiving with her colostomy, the DON agreed with the findings and agreed that should not have occurred.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, interviews, and record reviews, the facility failed to provide activities designed to meet the interests of one resident (Resident #84), to promote the psychosocial well-being of that resident. This had the potential to affect 31 residents in the [NAME] Hall, memory support unit. The findings included: A record review revealed Resident #84 was admitted to the facility on [DATE]. Her history of diagnoses included Dementia, Mood Disturbance, Anxiety, and Mood Disorder due to Known Physiological Condition. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #84 had a Brief Interview for Mental Status (BIMS) score of 10. This indicated that she had moderate cognitive impairment. A review of Section E revealed that Resident #84 exhibited no behaviors that quarter. A review of Resident #84's ongoing care plan initiated 07/30/24 stated that she had a history of trauma; and she required adequate time to make choices related to her care. One intervention was to provide resident centered care. A care plan created 07/26/24 said that Resident #84 was dependent on staff for meeting emotional, intellectual, physical, and social needs. An intervention listed was for staff to provide assistance/escort to Community Life functions (activities). During Resident #84's interview on 05/05/25 at 3:18 PM, Resident #84 said that the activities provided were boring. At that time, residents were watching TV and folding washcloths in the Activity/Dining room. Resident #84 said she liked crossword puzzles and music. She explained that she used to be a piano teacher. During a follow-up interview on 05/06/25 at 9:42 AM, Resident #84 wheeled herself through hallway. She said she wasn't interested in activities in the Activity/Dining room. During an observation on 05/07/25 at 10:50 AM, Resident #84 was asleep in her wheelchair in the hallway. On 05/07/25 at 11:03 AM, Resident #84 was asleep in the Activity /Dining room. On 05/07/25 at 1:02 PM, Resident #84 sat in her wheelchair and another resident pushed her through the hallway. Staff F told the other resident that she could sit down and Staff F pushed Resident #84 in the hallway. During interviews with Staff F and Resident #84 on 05/07/25 at 1:07 PM, the surveyor asked which activities Resident #84 liked. Staff F answered she liked exercise and karaoke. Resident #84 said out loud I want to go to the piano and check on my students. The surveyor asked Staff F if she heard the comment made by the resident. Staff F answered, she wants to check on her students; she used to be a music teacher. Resident #84 repeated that she wanted to go to the piano. Staff F told the surveyor there was a piano located in the park area which was right outside the locked doors of [NAME] Hall. During an interview on 05/07/25 at 2:04 PM, Staff F was asked if Resident #84 was able to use the piano, Staff F said that the residents in [NAME] Hall couldn't leave the unit unless they went out with their family or the therapy department. She added that a few months ago staff used to take the residents out to the park area, the patio, and outside, but now they needed to stay here (in the locked unit). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the evening nurse manager, Staff G, on 05/07/25 at 5:18 PM, the residents used to go off of the unit but they weren't allowed anymore. She said they got a message that a new corporate policy made a change a while ago. During a phone interview with Resident #84's daughter on 05/08/25 at 11:02 AM, the daughter said that her mother would love to go to the piano. The daughter said that she visited her mother weekly, and at each visit Resident #84 requested to go to the piano. During an interview with Staff F on 05/08/25 at 11:38 AM, Staff F was asked if it was possible for staff to escort Resident #84 to the Piano. Staff F said she was told the residents were not allowed to leave the unit. Staff F said that when Resident #84 was in the general population, she used to go to the piano often. Staff F said that Resident #84 played the piano nicely. Staff F said that it had been 1 or 2 months since the residents no longer went outside.

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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** 25404 Based on record review and interview, the facility failed to collaborate with Hospice services for 1 of 1 sampled resident, Resident #95, as evidenced by contradictory code status documentation. The findings included: Review of the record revealed Resident #95 was admitted to the facility on [DATE], with a subsequent admission to Hospice services as of 01/16/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating the resident was cognitively impaired. Review of the same assessment documented the resident had a terminal diagnosis and was on Hospice services. Review of the current electronic medical record (EMR) documented Resident #95 had a full code status, as noted on the banner or general information area of the EMR, meaning cardiopulmonary resuscitation would be initiated should the resident become unresponsive and without a heartbeat. A current order dated 03/19/25 also documented the Full Code status. The current care plan initiated on 05/22/24, and revised on 03/24/25, also documented the resident was a full code. Review of the discontinued orders revealed two orders from 01/24/25 through 03/19/25 that documented a DNR status. Review of the Hospice paperwork revealed a DNR (Do Not Resuscitate) order dated 01/16/25. During an interview on 05/08/25 at 2:16 PM, when asked how she would know the code status of a resident, Staff E, Registered Nurse (RN) stated she would check the banner in the EMR. The RN showed the surveyor the code status location on the banner of a random resident. When asked the code status for Resident #95, the RN looked in the EMR and stated the resident was a full code. When shown the DNR order and form in the Hospice paperwork, the RN was surprised. The RN stated she had never seen that form for Resident #95. When asked the process should a resident change their code status, the RN stated she was not sure as she just enters the code status for a resident upon admission to the facility. Further review of the orders revealed the order to admit Resident #95 to Hospice services was input into the EMR by Staff H, a Unit Manager. The order for the current DNR status was input into the EMR by the Director of Nursing (DON). During an interview on 05/08/25 at 2:40 PM, Staff H, Unit Manager, confirmed she had entered the current Hospice order. When asked if she reviews the code status with a change to Hospice services, the Unit Manager stated she did. During a side-by-side review of the Hospice paperwork, when asked why Resident #95 was not changed to a DNR status as per the DNR form found in the Hospice binder, the Unit Manager stated the form was not in the binder at that time and they did not have a copy of it anywhere. The Unit Manager stated they tried to call the daughter who did not answer or return their call. The Unit Manager also stated they contacted staff at the Hospice provider, who told them they were working on the DNR. When asked why she had changed the order to a DNR status on 02/07/25, the Unit Manager stated she did not recall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked why she changed the DNR status for Resident #95 to a full code status on 03/07/25, the DON stated because the DNR order had not been provided by Hospice as of that date. The Unit Manager and the DON were both unaware the DNR order had been provided to the facility by Hospice personnel. Further review of the record lacked any documented progress notes related to any conversations with the Hospice provider or attempted calls to the daughter related to the code status of Resident #95. The Unit Manager and DON were made aware of the lack of documentation and had no response.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on record review and interviews, the facility failed to ensure that proper protocol was implemented when a resident has a fall, as evidenced by not reporting or following up on a fall for Resident #35. The Findings included: Record review revealed Resident #35 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status score of 03, on a 0-15 scale, indicating severe cognitive impairment. During an interview on 05/05/25 at 10:42 AM, Resident # 56 (who is the roommate of Resident #35), stated My roommate fell out of bed a couple of nights ago, she was trying to change the air conditioner. I had to call for help and it took them a while to get here. I guess they were busy with someone else. I told Resident #35 not to move, because I know what can possibly happen if she moves. When asked who got Resident #35 off the floor, Resident #56 stated Two staff, the nurse and the aide. She fell really hard. I mentioned the fall to the nurse that worked the next morning. I have spoken to the Administrator and other nurses about Resident #35, because I think she should be in a different area of the facility, but I'm just told that these are the type of people we have here. During an interview on 05/06/25 at 09:06 AM, Resident #56, stated the DON came to me and said why didn't I tell her my roommate fell . She came in here with another administration staff confronting me. When asked, do you remember when Resident #35 had fallen, Resident #56 stated last Saturday at around 3:00 AM. When asked who did you report the fall to the next day, Resident #56 stated Staff P, Registered Nurse (RN). Review of a fall risk assessment dated [DATE], documented Resident #35 had not had any falls in the past three months. Further review of the progress notes for Resident #35 failed to reveal any documentation of a fall during the months of April 2025 or May 2025. Review of a care plan dated 3/24/25, documented that Resident #35 is at risk for falling related to her history of impaired mobility function, generalized weakness, impaired cognition with a goal to minimize the risk of falls. During an interview on 05/07/25 at 11:05 AM, when asked if she knows anything about a fall that Resident #35 had, Staff P stated No. When asked if Resident #56 reported to her that Resident #35 had a fall last week, Staff P stated No, who to me. If it was reported to me, I would have to do something. When asked if the nurse that she received report from reported that Resident # 35 had a fall, Staff P stated, No. When asked if she worked on Saturday 05/03/25 in the morning, Staff P, stated Yes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/25 at 12:08 PM, when asked did you have any conversations with Resident #56 about a fall, the DON stated, I'm so sorry I didn't know that Resident #35 had a fall. I asked Resident #56 about her roommate falling, she couldn't tell me the exact date. One time she said Friday and then she told the administrator a different date. I have spoken to the nurse that was working the shift the night that the fall supposedly happened. The nurse that was working said the resident did not fall. When asked what the staff are supposed to do when a resident falls, the DON stated, Report it in writing. I have started my investigation with the staff regarding reporting falls.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide nutrition via enteral method as ordered for 1 of 4 residents reviewed for tube feeding (Resident #5). The findings included: Resident #5 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), with a reference date of 02/06/25, Resident #5 was not assessed for cognition due to 'Resident is rarely/never understood'. Resident #5's diagnoses at the time of the assessment included: Cancer, Hypertension, Diabetes Mellitus, Non-Alzheimer's dementia, Psychotic disorder, Hypothyroidism. Resident #5's orders included: Nothing by Mouth (NPO) - 11/14/24 Enteral Feed - in the afternoon Enteral feeding type: Jevity 1.5 via G tube to run at 60 ml/hr (milliliters per hour) via PUMP. Total volume to be infused:1200ml/20hrs. Up at 2pm and down when Total Volume is infused. AND every shift Check and ensure accurate rate and feeding (Jevity 1.5 via G tube at 60 ml/hr via PUMP for Total Volume of 1200ml/20hrs. - 04/14/25. Resident #5's care plan for Tube Feeding documented, Care plan for Tube Feeding and weight loss: Resident #5 is at nutritional risk as evidenced by NPO, G-tube status. 02/2025 remains with NPO status reliant on nutrition support to meet hydration nutrient needs Date Initiated: 11/09/2022 Revision on: 02/21/2025. The goals of the care plan included: o Resident #5 will have no symptom of intolerance, inadequacy, dehydration. Date Initiated: 05/18/2023 Revision on: 12/10/2024 Target Date: 05/15/25. o Resident #5 will not experience a significant weight loss through next review date Date Initiated: 10/04/2021 Revision on: 12/10/2024 Target Date: 05/15/2025. Interventions to the care plan included: o Jevity 1.5 60ml/hour TVL 1200ml a day. 20 hours daily Date initiated: 02/21/25. At a rate of 60 ml/hr, the supplement would have need to be dispensed for 20 hours (until approximately 10:00 AM depending on interruptions in feeding for ADL care, etc) in order for the resident to receive the 1200 ml as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 7:08 AM, Resident #5 was observed in bed with Tube Feeding not initiated and no supplement in the room. Resident #5 was awake and it was determined that the resident was not interviewable, as evidenced by the resident only smiling and mumbling when being greeted. On 05/06/25 at 9:23 AM, Resident #5 was observed in bed sleeping with TF not initiated. On 05/06/25 at 10:50 AM, Resident #5 was being provided care by Staff I, CNA. When Staff I was done providing care to the resident, it was noted that the tube feeding had not been restarted and there was no supplement in the room. During an interview, on 05/06/25 at 11:05 AM, with Staff I, when asked about the tube feeding not being active, Staff I replied, at 2:00 the tube feeding will be put back up. When I came in this morning, the night nurse (referring to Staff J, RN) took her off of the tube feeding. When I was making my rounds at 7 AM, the night nurse had already stopped the tube feeding. On 05/07/25 at 7:23 AM, Resident #5 was observed in bed with tube feeding running at 60 ml/hr. The date mark on the 1000 ml container documented that it was initiated on 05/06/25 at 1300 (1:00 PM). At the time of the observation, there was approximately 100 ml of supplement remaining in the 1000 ml container. During additional observations throughout the day, it was noted that there was no additional supplement provided to Resident #5 to meet the order for 1200 ml until the next session was implemented. During an interview, on 05/08/25 at 6:38 AM, with Staff J, RN, when asked about the tube feeding being stopped as described by Staff I, the RN replied, once the tube feeding is complete at 1200 ml the tube feeding is stopped until the next dosage. The machine will indicate 1200 ml completed. When asked about the information in the pump being at zero at the beginning of the dosage, Staff I replied, The pump should be cleared out at the beginning of the next session. The RN acknowledged that it would have taken 20 hours for the resident to receive the full 1200 ml of the supplement. The RN stated that he does not change the flow rate during his shift. The RN further stated that the feeding would be paused for up to 15 minutes at a time for ADL care (ADLs - changing, repositioning, etc.) should the resident require and then started from that point once the CNAs have completed the ADL care.

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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** 51137 Based on observation, interview, and record review the facility failed to perform a respiratory assessment on a resident with respiratory treatments for 1 of 2 sampled residents (Resident #54). The findings included: Review of the record revealed that Resident #54 was admitted [DATE] with the primary diagnosis of Chronic Obstructive Pulmonary Disease (a lung disease causing restricted airflow and breathing problems.) Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #54 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 documented: Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 ml inhale orally via nebulizer every 8 hours for shortness of breath Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puff inhale orally two times a day related to Chronic Obstructive Pulmonary Disease. Rinse mouth with water after use, then spit out water. Check lung sounds Pre Nebulizer administration every 12 hours related to Chronic Obstructive Pulmonary Disease, and every 8 hours and one time a day. Respiratory: Check Lung Sounds Post Nebulizer Administration every 12 hours related to Chronic Obstructive Pulmonary Disease, and every 8 hours AND one time a day. Check Pulse and Respirations Pre-Nebulizer administration every 12 hours related to Chronic Obstructive Pulmonary Disease, and every 8 hours AND one time a day. Check pulse and respiration rates Post Nebulizer administration every 8 hours related to Chronic Obstructive Pulmonary Disease, and every 12 hours AND one time a day. Review of the care plan dated 03/21/25 documented Resident #54 will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date with an intervention of Administer medication/puffers as ordered. Monitor for effectiveness and side effects. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication administration observation was conducted on 05/06/25 at 9:41 AM, Resident #54 was scheduled to receive a nebulizer treatment, an inhaler and oral medications. Staff A, Licensed Practical Nurse (LPN) performed hand hygiene and donned gloves; she stated she had taken the blood pressure and pulse already and then proceeded to administer the oral medications to the Resident. When the inhaler was administered, Resident #54 was not provided water to rinse their mouth out and spit it out as stated per order. The nebulizer treatment was started afterwards, Staff A prepped the supplies, placed the solution into the mask and placed it on the Resident. Lung sounds were not checked prior to administration of the nebulizer treatment as stated in the order; Staff A was not observed assessing for respirations. During the duration of the treatment Staff A stepped off to the side of the Resident's bed and waited until his treatment was over. Again, lung sounds or respirations were not assessed after the treatment was over. During an interview on 05/06/25 at 9:57 AM, when asked how to perform a respiratory assessment, Staff A stated she would watch for respirations and listened to lung sounds. When asked when she would perform it, Staff A stated every shift, when you pass meds, and especially if they have a nebulizer treatment. When asked if there was any reason why she did not perform a respiratory assessment for Resident #54, Staff A stated that she should have done it but forgot because she was nervous. When asked if other vitals should have been taken for Resident #54, Staff A stated she should have checked their oxygen level but also forgot. Review of the record revealed Staff A had documented assessment of lung sounds and respirations for the observed medication administration. During an interview on 05/08/25 at 9:08 AM, when asked how to perform a respiratory assessment, the Director of Nursing (DON) stated that you should listen to lung sounds, measure oxygenation levels and count for respirations before and after respiratory treatments such as nebulizers and inhalers. The DON stated she was already aware of the situation with Staff A and agreed she should have performed the respiratory assessments stated on Resident #54's orders for the nebulizer treatment. The DON also agreed that the inhaler should have been followed with a mouth rinse and spit as per order.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, interviews, and record reviews, the facility failed to have sufficient staff to intervene when 2 residents (#92, #76) ate or drank from 5 other residents' cups or plates, and when 1 resident who preferred to remain anonymous, reported that the [NAME] Hall was chaotic on the weekends. This had the potential to affect 31 residents in the [NAME] Hall, memory support unit. The findings included: During an interview conducted on 05/06/25 at 9:20 AM, as a part of the initial screening process, a resident who wanted to remain anonymous said that [NAME] Hall needed more staff during weekends. She described the environment on the weekends as chaotic. A record review revealed that Resident #92 was admitted to the facility on [DATE]. Her medical history included Alzheimer's Disease, Unspecified Dementia, Anxiety Disorder, Oral Dysphagia, and Cognitive Communication Deficit. These diagnoses were present on admission. A review of the Minimum Data Set (MDS) annual assessment dated [DATE] revealed that Resident #92 had severe cognitive impairment. A review of Section E in the MDS assessment showed no changes in behaviors since the prior quarterly assessment was conducted. During observations in the Activities/Dining room in [NAME] Hall, on 05/07/25 at 4:50 PM Resident #92 took Resident #76's cup of ice water off the front table, and she drank from it. She placed the cup of ice water back on the table. On 05/07/25 at 4:55 PM, Resident #92 walked to the back table and took a cup of ice water from Resident #18. Resident #92 drank from his cup and then returned the cup to him. Resident #18 picked up his cup of water and he also picked up the cup of his friend who sat to his left, Resident #97. He held both cups close to his chest to prevent Resident #92 from taking their drinks. No staff members were in the Activity/Dining room at that time. This occurred prior to the service for the dinner meal. The surveyor called the attention of a CNA, Staff C, who was in the hallway. The surveyor explained that Resident #92 drank from the cups of Resident #76 and Resident #18. The CNA discarded the three cups. On 05/07/25 at 5:27 PM Resident #92 took a cup of water from Resident #111 and drank it. The surveyor notified Staff B, a CNA who was in the hallway between both Activity/Dining rooms, about the cup that Resident #92 drank from. Staff B threw out the cup. During an interview with Staff D, on 05/08/25 at 11:58 AM, the CNA was asked to describe Resident #92. Staff D said that Resident #92 liked to sit on the floor and to eat with her hands. He also said that she picked up other Residents cups of water. When asked how long he observed that behavior, Staff D said that the behavior was present for all of the time that he worked in the facility (approximately six months). Staff D said that the staff had to look at every resident that was on the unit. When Staff D was asked if there was enough staff, he explained that there were usually 4 CNAs for 32 residents. That was 8 residents each. Staff D continued: when 1 CNA was inside a resident's room providing care, it was difficult for that CNA to watch her other 7 residents. Per Staff D, a staff member from the activities department, helped to provide supervision. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on 05/08/25 at 12:10 PM with the Activities assistant, Staff F, revealed that an activities staff member worked in [NAME] Hall every weekday, and every other weekend. She said that the activities department needed more help because there were 2 Activity/Dining rooms, and 1 activity staff member couldn't be in both rooms at the same time. She said that especially in [NAME] Hall, the residents needed more attention. Staff F added that the activities staff members helped to watch for falls, and they redirected residents when they became combative. An interview was conducted on 05/08/25 at 8:50 AM with Staff E, a Registered Nurse who was assigned to [NAME] Hall. When asked about adequate staffing, Staff E said that sometimes [NAME] Hall had 3 CNAs to cover 32 residents, and sometimes [NAME] Hall had 4 CNAs. She said it was better when [NAME] Hall had 4 CNAs. In addition, Staff E said that they needed more staff from the activities department, because activities staff helped the unit run more smoothly. A record review revealed that Resident #76 was admitted to the facility on [DATE]. Her room was changed to a room in the [NAME] Hall, memory support unit, on 04/10/25. Her medical diagnoses included Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder, Dementia, and Cognitive Communication Deficit. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #76 had a Brief Interview for Mental Status of 03. This indicated that she had severe cognitive impairment. During an observation in the [NAME] dining room on 05/07/25 at 12:25 PM, two out of five residents seated at table 1 were served their lunch. Resident #76 was not served yet. Resident #76 ate stuffing from Resident #104's plate. Resident #104, who sat to her right, saw Resident #76 eat from his plate. On 05/07/25 at 12:27 PM, a staff member and the surveyor observed Resident #76 as she ate carrots from Resident #74's plate. Resident #74 sat to the left of Resident #76. The staff member told Resident #76 not to eat from Resident #74's plate while she served Resident #76 her lunch plate. Resident #104 didn't start eating. He appeared agitated. The surveyor attempted to speak to Resident #104 but was unable to communicate with him effectively. The surveyor notified Staff F that Resident #104 appeared upset. The surveyor explained that Resident #76 ate from the plates of the residents to her right and left, before she was served. Staff F requested a new clean meal plate from the kitchen for Resident #104. After Resident #104 was served a replacement for the plate of food, he ate the food with a good appetite. Resident #74 was not served a new plate of food. Resident #74 ate his lunch after Resident #76 ate from his plate.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on observations, record reviews and interviews, the facility failed to meet nutritional needs for 1 of 8 sampled residents, as evidenced by not providing all the food items on Resident #56 meal ticket. The findings included: Record review revealed Resident #56 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0-15 scale, indicating no cognitive impairment. A physician order dated 02/20/25, documented that Resident #56 is on a regular diet. During an interview on 05/07/25 at 11:55 AM, when asked how your evening was, Resident #56 revealed a picture of her dinner tray from 05/06/25, which consisted of mashed potato, green peas, sliced bread and no protein. Resident #56 stated When the tray was brought to me and it was being set up, the staff stated that's all you got. When asked if she requested something else Resident #56 stated, I asked the nurse for a peanut butter and jelly sandwich but never got it. During an interview on 05/07/25 at 5:51 PM, when asked if she was familiar with Resident #56, the Food Service Manager stated, Yes, very, because she dislikes a lot of foods. When asked, do you know why Resident #56 did not receive protein with her dinner on 05/06/25, the Food Service Manager stated I'm not sure, maybe it was something she dislikes or can't have. The Food Service Manager provided a list of Resident #56 dislikes. During an interview on 05/08/25 at 10:01 AM, when asked if she has a dislike for beef, Resident # 56 stated Yes, I can't have it because it's hard for me to digest. When asked do you have a dislike for pork, Resident # 56 stated, No, I eat pork. I have told the kitchen several times to change that. I don't know why the other night I didn't get protein with my dinner because they usually give me fish if I can't eat the other meat. During an interview on 05/08/25 at 11:20 AM, when asked why Resident # 56 didn't receive a protein on her dinner tray, if the other entree on the menu for 05/6/25 was chicken, the Food Service Manager stated, I'm not sure. The Food Service Manger volunteered to print out the meal ticket for Resident #56 on 05/06/25. The meal ticket provided revealed that Resident #56 should have gotten the chicken on her dinner tray on 5/6/25, because it was the other entree. When asked if she knows what happened, the Food Service Manager stated, I don't know it must have been overlooked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105492	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Breeze Rehab and Care Center	1626 Davis Rd West Palm Beach, FL 33406

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations and interviews, the facility failed to follow proper sanitation practices in the provision of food for the residents. This had the potential to affect 109 Residents on oral diets. The findings included: A). A tour of the main kitchen was conducted on [DATE] at 9:30 AM. The surveyor was accompanied by the Food Service Director (FSD) and the Registered Dietitian. The following was observed: 1. The [NAME] Convection oven had brown residue on the exterior of the oven in the area near the door hinge and on the door handles. 2. The Sunfire oven had brown residue on the exterior of the oven, the door's handle, and on an open ledge located beneath the turn on/off control knobs. 3. The Cleveland Steamer had brown residue stuck on the valve open/close knob. 4. The meat slicer was dirty with debris located on the interior surface below the blade. 5. In the walk-in refrigerator the following items were expired: a. Two one-pound boxes of butter were dated [DATE] (brand: Challenge). b. A package of Swiss Cheese expired on [DATE]. c. One container of Mighty Shake expired on [DATE]. 6. A stack of sheet pans was ladened with brown residue. When asked what the pans were used for, the FSD said they were used to make chicken, fish. The FSD agreed with the above findings. B). A tour of the nourishment rooms was conducted on [DATE] at 10:30 AM . The following was observed: 1. The thermometer in the East wing refrigerator was 58' F. The refrigerator contained 4x ,d+[DATE] pint containers of milk and other labeled food items in bags. The RD said the thermometer must be broken. The RD moved the thermometer to the freezer and in a couple of minutes (estimated), the temperature dropped 3 degrees. 2.On [DATE] at 11:45 AM, the East wing, [NAME]/[NAME] refrigerator was observed with the DON. The thermometer revealed the temperature of the refrigerator was 54' F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The temperature of the refrigerator was too warm to promote food safety. The regulation specifies the refrigerator temperature should have been 41' F or below.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 38893 Based on interviews and record reviews, the facility failed to review and update the Facility Assessment accurately and in a timely manner. The findings included: During the entrance conference for the annual recertification survey, on 05/05/25 at 8:41 AM, with the Administrator, the Surveyor requested a copy of the Facility Assessment. The Administrator retrieved a copy of the assessment from a binder and handed it to the Surveyor and confirmed that it was the most recent copy. The Facility Assessment provided by the Administrator documented: Requirement: Nursing facilities will conduct, document, and annually review a facility-wide assessment which includes their resident population and the resources the facility needs to care for their residents. Guidelines for conducting the assessment: 3. The facility must review and update this assessment annually or whenever there is, or the facility plans for any change that would require a modification to any part of this assessment. For example, the facility decides to admit residents with care needs who were previously not admitted , such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc, meet the needs of those residents and any areas requiring attention, such as training or supplies. Date(s) of assessment or update 01/05/23 Date(s)assessment reviewed with QAA/QAPI committee 01/18/23. *At this time due to the current pandemic of COVID-19, all measure are in place to provide quality care for residents that become positive. Page 10 of the Assessment documented, CDC is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including the United States. The virus has been named SARS-CoV-2 and the disease it causes has been named 'coronavirus disease 2019' (abbreviated COVID-19). The Facility Assessment provided by the Administrator also documented the governing body as a former Administrator that had not been in the facility since 07/31/23, a former Director of Nursing (DON) that had not been in the facility since 02/03/23, and a former Medical Director. (continued on next page)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	The Facility Assessment provided by the Administrator further documented the names and titles of the persons involved in completing the facility assessment as: A former Administrator that had not worked in the facility since 07/31/23. A former DON that had not worked in the facility since 02/03/23. A former Medical Records staff that had not worked in the facility since 05/29/23. A former Social Services Directo that had not worked in the facility since 04/14/23. A former MDS (Minimum Data Set) Coordinator that had not worked in the facility since 08/15/23. Per CDC.gov, The federal COVID-19 PHE (Public Health Emergency) declaration ended on May 11, 2023. During an interview, on 05/08/25 at 2:30 PM, with the Administrator, the Administrator again confirmed that the copy provided was the most current. During a side by side review of the Facility Assessment that was provided, the Administrator was made aware of the inaccuracies and the date of the Assessment, the Administrator requested an opportunity to review it and provide an updated copy. On 05/08/25 at 2:43 PM, the Administrator provided the Survey team with an updated copy of the Facility Assessment. The Facility Assessment provided documented the same as the previous one except for having some of the references to the COVID-19 pandemic removed, while still documenting the same staffing inaccuracies related to the documentation of the governing body. This second copy of the Facility Assessment documented the date of the assessment or update as 02/25/25 and the date the assessment was reviewed with QAA/QAPI Committee as 02/27/25. Page 10 of the second copy of the Assessment again documented, CDC is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including the United States. The virus has been named SARS-CoV-2 and the disease it causes has been named 'coronavirus disease 2019' (abbreviated COVID-19). During a follow up interview, on 05/08/25 at 2:53 PM, with the Administrator, when asked about the changes that she had made to the facility assessment, the Administrator replied, I updated and I put my name as the Administrator. When the inaccuracies of the second copy of the assessment were brought to the Administrator's attention, she asked for the assessment and began leafing through it and came across the page that documented the governing body and uttered, I missed that. While continuing to go through the Assessment, the Administrator stated she needed to update multiple areas as she came across them. The Administrator requested an opportunity to review this second copy of the Facility Assessment to identify additional changes that needed to be made and provide another copy to the Survey team. (continued on next page)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	On 05/08/25 at 3:51 PM, the Administrator provided a third copy of the Facility Assessment to the Survey team. This third copy of the Assessment had the date of the Assessment update as 02/25/25 and the date the Assessment was reviewed with QAA/QAPI Committee as 02/27/25. This third copy of the Facility Assessment documented again on Page 10, CDC is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including the United States. The virus has been named SARS-CoV-2 and the disease it causes has been named 'coronavirus disease 2019' (abbreviated COVID-19).