STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105506	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Boca Raton Rehabilitation and Nursing Ce	7300 Del Prado Circle South Boca Raton, FL 33433

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review the facility failed to 1) ensure access to call device for 2 of 32 sampled residents (Residents #46 and #94); 2) ensure function of air mattress for 2 of 31 sampled residents provided with air mattress (Residents #80 and #90); 3) provide access to wall light for 7 out of 26 sampled residents on 1 of 2 hallways on the [NAME] unit (Residents #94, #6, #68, #72, #80, #90, #53); 4) provide unobstructed access to bathroom and provide paper towels to 1 of 34 sampled residents (Resident #27); 5) provide clean linen in timely manner for 1 of 34 sampled residents (Resident #86). The findings included: Review of the facility's policy titled, Accommodation of Needs with a revised date of March 2021, included in part, the following: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. In order to accommodate individual needs and preferences, adaptions may be made to the physical environment, including the residents' bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptions may include a) providing access to assistive devices, e) installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible, f) moving furniture or large items in rooms and common areas that may obstruct the path of a resident using a walker. 1) Record review for Resident #46 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 10/18/23 with diagnoses that included in part the following: Paraplegia, and Neuromuscular Dysfunction of Bladder Review of the Minimum Data Set (MDS) assessment for Resident #46 dated 10/13/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 14, indicating a cognitive response. On 12/02/24 at 10:52 AM, an observation was made of Resident # 46 sitting up in bed with the call bell on the floor, a full Styrofoam cup of water and 2 empty two handled sippy cups on the nightstand out of her reach. She said they (staff) moved the water when her breakfast came and never put it back. On 12/03/24 at 8:40 AM, an observation was made of Resident #46 sitting up in bed with her breakfast tray in front of her with one handled cup with no spill lid containing coffee, a two handled cup with a lid that was not secured containing orange juice. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 12/02/24 at 10:52 AM, Resident # 46, stated she is supposed to be checked to see if she needs her [adult incontinent brief] changed every couple of hours, she has been in the same brief since 10:00 PM last night. They usually change her the same time as the other resident, but they have not. She said she normally has a private aid, but the aid is on vacation this week. When asked if she could call for assistance she said yes, but she cannot reach the call bell, it is on the floor. She said she has been in a [soiled adult incontinent brief] for a very long time today. 2) Record review for Resident #94 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Vascular Dementia and History of Falling. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 11/23/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. On 12/05/24 at 9:50 AM, a side-by-side observation with the Director of Nursing (DON) and the Director of Maintenance (DOM) was made of Resident #94, sitting in a wheelchair next to window with the call bell device on her bed and not accessible. The DON attempted to pull the call bell device closer to the resident, but it did not reach, the DOM moved the resident closer to the call device, so it was accessible to the resident. Also observed was the wall light behind the resident's bed with a pull cord of approximately 6 inches long and not accessible to the resident while sitting in the chair or when she is in her bed. 3) Record review for Resident #80 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, the following: Dementia and Delusional Disorders. Review of the MDS assessment for Resident #80 dated 11/10/24 documented in Section C a BIMS score of 6, indicating severe cognitive impairment. Review of the Physician's Orders for Resident #80 revealed an order dated 03/24/23 documented, low air loss mattress in use, check placement and function every shift. Review of the Treatment Administration Record (TAR) for Resident #80 from 12/01/24 to 12/03/24, revealed the status of the low air loss mattress function and settings was documented each shift. Review of the Nursing Progress Notes for Resident #80 from 12/01/24 to 12/03/24 revealed no documentation of issues with the low air loss mattress. 4) Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Acute Chronic Diastolic (Congestive Heart Failure), Chronic Kidney Disease Stage 4, and Glaucoma. Review of the MDS for Resident #90 dated 11/04/24 documented in Section C a BIMS score of 8, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #90 revealed an order dated 10/21/24 for low air loss mattress, check function and settings every shift. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR from 12/01/24 to 12/03/24 revealed the status of the low air loss mattress function and settings was documented each shift. Review of Nursing Progress Notes for Resident #90 from 12/01/24 to 12/03/24 revealed no documentation of issues with the air mattress. During an in interview conducted on 12/03/24 at 9:00 AM with Staff I, Licensed Practical Nurse (LPN) who was asked if she took care of Resident #80 and Resident #90 yesterday as well as today, she said yes. When asked about the low air loss mattress, she said they are checked every day. When asked what she checks, she stated she checks to make sure it is on, and the machine is functioning properly. When asked if there were any issues with the low air loss mattress for either resident yesterday or today, she said no, not that she is aware of. Staff I LPN and the surveyor then did a side-by-side observation of the low air loss mattress for Residents #80 and Resident #90. She stated Resident #80 and #90's mattress was not working, then said the air mattress was not plugged in and said I did not notice this until just now. 5) Record review for Resident #6 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 10/09/24 with diagnoses that included, in part, the following: Infection and Inflammatory Reaction Due to Other Cardiac and Vascular Devices Implants and Grafts, and Chronic Obstructive Pulmonary Disease. Review of the MDS for Resident #6 dated 11/18/24 documented in Section C, a BIMS score of 15, indicating a cognitive response. On 12/02/24 at 9:30 AM, an observation was made in Resident 6's wall light, shared between her and her roommate, with no access to the light to turn it off or on. The privacy curtain was located in the middle of the wall light. 6) Record review for Resident #68 revealed the resident was admitted to the facility on [DATE] with a readmission on 03/31/22. The resident's diagnoses included, in part, the following: Dementia and Anxiety Disorder. Review of the MDS assessment for Resident #68 dated 10/01/24 documented in Section C, a BIMS score of 0, indicting severe cognitive impairment. On 12/05/24 at 11:30 AM, an observation was made of Resident #68 lying in bed with wall light, with no pull cord. Resident #72 (the roommate) to Resident #68 stated they put my light on in the night, if they need any light to help my roommate. When asked if this bothers her, she said I am not saying anything, I don't want to get into trouble. 7) Record review for Resident #72 revealed the resident was admitted to the facility on [DATE]. Review of the diagnoses for Resident #72 revealed the resident had a diagnosis of Post-Traumatic Stress Disorder, dated 11/14/24. Review of the Minimum Data Set assessment for Resident #72 dated 08/14/24 documented in Section C a Brief Interview of Mental Status score of 15, indicating a cognitive response. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/24 11:25 AM, an observation was made of Resident #72 sitting up in bed with the wall light on located at the head of the bed with an approximately 3-inch pull cord. During an interview conducted on 12/02/24 11:25 AM, Resident #72 who was asked if she can put her light on, she stated only if she lays her bed flat, raises her bed height and reaches up behind her. 8) Record review for Resident #53 revealed the resident was admitted to the facility on [DATE] with diagnoses including, in part, the following: Dementia, and Inflammatory Spondylopathy Cervical Region. Review of the MDS assessment for Resident #53 dated 09/17/24 documented in Section C a BIMS score of 8, indicating moderate cognitive impairment. On 12/02/24 at 12:40 PM, an observation was made of Resident #53 sitting up on the side of her bed. The wall light behind the head of her bed was noted having a pull chain of approximately 3 inches long. During an interview conducted on 12/02/24 at 12:40 PM with Resident #53 who was asked if she could put the wall light on behind the head of her bed. She stated no, I can't reach it. 51663 9) Record review showed that Resident #27 was admitted to the facility on [DATE] with diagnosis of Atrial Fibrillation and Malignant Neoplasm. The Minimum Data Set (MDS)quarterly assessment dated [DATE], documented the resident's Brief Interview of Mental Status (BIMS) score as 15, which indicates no cognitive impairment. In an observation conducted on 12/03/2024 at 10:10 AM, Resident #27 was observed unable to wheel herself out of the bathroom, in her wheelchair due to piles of linen/clothing that was located on the floor of her bedroom. Resident #27 had no way of picking up the bag of clothes from the floor without assistance. In a brief interview conducted on 12/03/2024 at 9:30 AM, Resident #27 stated that she has been asking for paper towel for over 3 days and no staff member ever brought it for her. In this interview, no paper towel was observed in the bathroom. 10) Record review revealed that Resident #86 was admitted on [DATE] and readmitted on [DATE] with diagnosis of Dementia, without behavioral disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. The Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident's Brief Interview of Mental Status (BIMS) score as an 8, which indicates moderate cognitive impairment. In an observation conducted on 12/02/2024 at 10:00 AM, Resident #86 was found standing next to his bed with all the linens from the bed piled up on the floor. In this observation Resident #86 stated that he needs the bed to be made with a new set of linen because the ones that he took off were dirty. At this time. the Surveyor advised a staff member that Resident #86 needed his bed linens changed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another observation conducted on 12/02/2024 at 2:00 PM, Resident #86 was found seated in his wheelchair at the room door. Resident #86 asked the Surveyor to please have someone fix his bed because he needed to lay down. Upon observation, the bed was still unmade from the prior observation at 10:00 AM. In an interview conducted on 12/02/2024 at 2:05 PM with Staff B, Registered Nurse (RN), stated that she had already asked the Certified Nursing Assistant on two occasions to fix the Resident #86's bed, but she would ask again. In an interview conducted on 12/05/2024 at 10:20 AM with Staff F, Certified Nurse Assistant (CNA), stated that the bed linens are changed daily and upon request or when the bed is observed dirty. And if Staff are busy, the task is redirected to an available staff member.

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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** 50370 Based on observations, interviews and record reviews, the facility failed to develop a comprehensive care plan for Post-Traumatic Stress Disorder (PTSD), for 2 of 2 sampled residents reviewed for behavior, (Residents #72 and Resident #28); failed to implement care plan interventions for 2 of 5 sampled residents reviewed for unnecessary medications, (Resident #88 and Resident #111); and failed to implement interventions regarding psychotropic medications' side effects for 2 of 2 sampled residents (Resident #111 and Resident #88) reviewed for Psychotropic Medications. The finding included: 1) A review of facility's policy titled, Care Plans Comprehensive, published on 09/25/2024, with document ID # 42867439 revealed the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. It revealed statement #2, under Policy Interpretation and Implementation, explaining the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (admission, annual or significant change in status), and no more than 21 days after admission Additional review of facility's policy titled, Care Planning IDT, revealed a statement explaining the Interdisciplinary team is responsible for the development of resident care plans. It further explained that resident care plans are developed according to the timeframes and criteria established by S483.21 Resident #28 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Post-Traumatic Stress Disorder (PTSD), Dysphagia Following Cerebral Infarction, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. A review of Minimum Data Set (MDS) assessment Section C revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating good mental cognition. A review of electronic care plans initiated on 09/13/24, 09/16/24 and 12/12/24, revealed no care plan was initiated on these dates regarding Resident #28's PTSD. Interview was conducted with a Social Services Staff member on 12/04/24 at 12:21 PM, who has been working in the facility for one year, when asked about Resident #28's care plan for PTSD, she stated, There is no care plan for PTSD. She added that the reason there was no care plan for PTSD was, First upon admission the resident denied anxiety and depression, and secondly, because the resident was evaluated by the psychiatrist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked why she had not created a care plan for Resident #28's PTSD yet, she responded that she planned to keep asking the resident, because she wants to make sure Resident#28 is comfortable with her. She added that she plans to quarterly assess this resident. When this Social Services Staff was asked regarding Resident #28's PTSD diagnosis, she stated it was derived from admission. When asked when is she planning to create a PTSD care plan because three (3) months had passed since resident's admission to the facility, she responded she has not made any evaluation to ask for triggers and insisted that she must make a rapport with the resident first. She added it is a continuous process. In an interview with the MDS Coordinator on 12/04/24 at 4:11 PM, when asked how she demonstrated her knowledge of Resident #28's current behavioral and emotional needs, she stated These are based on care evaluations from Psychiatrist, Psychologist, and Social Services assessments. When asked how often she attends Staff Behavioral in-service training, she stated once a year. When asked about the types of behavioral health training she had completed, she stated it was an annual in-service provided by facility to all Staff. When asked how she demonstrates competent interactions when addressing the resident's behavioral care needs, she responded by providing services based on resident's culture. When asked how she would know if a resident was a trauma survivor, and what would she do differently for that resident, she stated she must create a care plan in the MDS. She added that a section in the MDS has specific space for creating a care plan. She added that baseline care plan for the resident should be done in 2 to 3 days, while the comprehensive care plan should be done in 30 days. When asked regarding PTSD interventions for Resident #28, she stated some examples are approaching resident in a calm manner, assuring resident to prevent him/her from getting anxious. When asked about Resident #28's care plan for PTSD, she responded It must be completed. 41837 2) Record review for Resident #72 revealed the resident was admitted to the facility on [DATE]. Further review revealed the resident had a diagnosis of Post-Traumatic Stress Disorder (PTSD) Unspecified dated 11/14/24. Review of the Minimum Data Set assessment for Resident #72 dated 08/14/24 documented, in Section C, a Brief Interview of Mental Status score of 15, indicating a cognitive response. Review of the care plan for Resident #72 revealed there was no care plan related to PTSD. During an interview conducted on 12/02/24 at 11:25 AM, Resident #72 stated she has PTSD. The resident stated she is seen by a psychiatrist. During an interview conducted on 12/03/24 at 1:40 PM with the Social Service Director (SSD) she stated she has worked at the facility since December last year. When asked about residents with diagnoses of PTSD the SSD stated upon admission we do a stress for life evaluation, refer to psychology and psychiatry services and do monitoring for behaviors and would create a care plan for the PTSD for the resident. When asked about Resident #72 the SSD stated the resident had a stress for life screening upon admission on 02/07/23 and was not positive she had a stress for life screening every quarter with the most recent on 11/12/24 and was positive. The SSD also acknowledged there was no care plan for PTSD for Resident #72 until she created one today, (12/03/24) just before talking with this surveyor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 12/04/24 at 3:20 PM with the MDS Director she stated she has worked at the facility for 6 years. When asked if a resident is admitted with diagnosis PTSD would she be the person to create a care plan for the resident. She said if the resident was admitted with the diagnosis she would. The MDS Director stated if the resident was diagnosed with PTSD after admission, she would want to find out more before creating a care plan such as why the resident was diagnosed , what the triggers were and what to avoid to be able to help the resident. When asked about Resident #72, she said she believes the resident was diagnosed with PTSD after admission. The MDS Director recalled having a conversation with Social Worker and other staff regarding the PTSD diagnosis for Resident #72, but could not recall when she said it. The MDS Director stated she generally does not create care plans if they are related to mood, psychosocial, discharge planning or advance directives. These issues would most likely be created by the Social Worker. 40153 3) A record review revealed that Resident #111 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure, Heart Failure, and Type 2 Diabetes. The 5-day Minimum Data Set assessment dated [DATE] revealed that Resident #111 had a Brief Interview of Mental Status (BIMS) score of 14, which is cognitively intact. A review of the Order Summary Report documented an order for Alprazolam 0.25 milligrams, 1 tablet at bedtime for Anxiety which was dated 11/21/24. No order was noted to monitor the side effects of Alprazolam. The pharmacy recommendation from 10/1/24 to 10/31/24 revealed that the guidelines requires that a side effect needs to be monitored every shift to support the use of Alprazolam. The care plan initiated on 11/22/24 revealed to observe for signs and symptoms of Anxiety, as needed. It further documented to observe the resident for potential side effects such as confusion, forgetfulness, nausea, vomiting, diarrhea, appetite changes, lightheadedness, and drowsiness. A progress note dated 10/21/24 revealed that Resident #111 was prescribed Xanax (anxiety medication) at bedtime and continue to monitor the side effects of the psychotropic medication. In an interview conducted on 12/04/24 at 3:04 PM with the Director of Minimum Data Set, she stated that antianxiety medication should be initiated with a care plan that included monitoring it's side effects. She further said all residents on psychotropic medications need to be monitored for side effects. 51663 4) Record review revealed Resident #88 was admitted to the facility on [DATE] with diagnosis of non-Hodgkin lymphoma and Myelofibrosis. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan dated 11/12/2024 indicated that Resident #88 is prone to side effects related to the use of antidepressant medications, which needs to be observed for potential side effects such as: hypotension, tachycardia, nausea, vomiting, diarrhea, blurred vision, chest pain, rash, drowsiness, lethargy. A review of the physician's orders dated 08/23/24, documented: Sertraline HCl Oral Tablet 25 MG (Sertraline HCl), give 1 tablet by mouth one time a day for depression, give with 100mg tablet to equal a total of 125mg daily. Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) give 1 tablet by mouth one time a day for depression, give with 25 mg to equal total of 125mg daily. A review of the physician orders, the Medication Administration Report (MAR) and the Treatment Administration Report (TAR) indicated that the facility failed to order and implement intervention to monitor side effects related to the use of antidepressant medications for Resident #88.

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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** 41837 Based on observations, interviews and record review, the facility failed to ensure the resident environment remains free of accident hazards including 1 out of 4 emergency carts containing sharps left unlocked and unattended, 1 out of 7 med carts with a broken sharp disposal container, and 2 out of 32 sampled residents with sharps at the bedside (Resident #88 and #108). The findings included: On 12/05/24 from 7:00 AM to 2:30 PM, the Administrator and Director of Nursing were asked several times for a policy regarding sharps or accident/hazards the only policy provided was the facility policy titled, Sharps Disposal undated (printed dated of 12/05/24). Review of the facility's policy titled, Sharps Disposalundated (printed dated of 12/05/24) included in part the following: 3. During use, containers for contaminated sharps will be handled as follows: c) Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container. 1) On 12/02/24 at 1:10 PM, an observation was made of med cart located between rooms [ROOM NUMBERS]. The sharp's container attached to the med cart was broken, containing unsecured sharps (Photographic Evidence Obtained). Staff I, Licensed Practical Nurse (LPN) and Customer Success Representative present at the med cart. During an interview conducted on 12/02/24 at 1:10 PM with Staff I, LPN and the Customer Success Representative who were present at the med cart were asked about the broken sharp's container containing unsecured sharps. Staff I, LPN and the Customer Success Representative stated it was broken. Staff I, LPN unlocked the sharps container holder and acknowledged it was broken. The Customer Success Representative stated maintenance should be contacted, Staff I, LPN locked the sharps container holder and left the med cart. The Customer Success Representative also left the med cart. 2) On 12/03/24 at 7:18 AM, an observation was made of unlocked emergency cart across from the [NAME] nursing station with several safety razors, 2 pair of scissors, and box of lancets (200 count). A side-by-side observation conducted on 12/03/24 at 8:08 AM with Staff B, Registered Nurse (RN) of unlocked emergency cart across from [NAME] nursing station. Staff B, RN acknowledged the unlocked and unattended emergency cart contained 11 safety razors, 2 pair of scissors, and a box of lancets (200 count). An interview was conducted on 12/03/24 at 8:011 AM with Staff B, RN who stated she has worked at the facility for 1 month. Staff B, RN stated emergency carts should be locked at all times. When asked about residents having razors or scissors at the bedside, she said residents should not have razors or scissors stored at the bedside (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Record review for Resident #88 revealed the resident was admitted to the facility on [DATE] with diagnoses including, in part, the following: non-Hodgkin lymphoma, Myelofibrosis, Polycythemia, and Recurrent Depressive Disorders. Review of the Minimum Data Set (MDS) assessment for Resident #88 dated 11/04/24 documented in Section C a Brief Interview of Mentals Status score of 15 indicating a cognitive response. On 12/02/24 at 11:07 AM, an observation was made of Resident #88 sitting in a wheelchair in his room, on nightstand there was a safety razor in a Styrofoam cup. On 12/03/24 at 9:00 AM, a second observation was made of the safety razor in the Styrofoam cup on the nightstand in Resident #88's room. 49060 4) Record review for Resident #108 revealed that the resident was admitted to the facility on [DATE] with a readmission on 11/24/23 with the following diagnoses: Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris; Hyperlipidemia; Tremor; Essential (Primary) Hypertension; Parkinsonism. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #108 had a Brief Interview for Mental Status (BIMS) of 09, which indicated that she had moderate cognitive impairment. Review of Section GG of the same MDS revealed that Resident #108 had functional Range of Motion (ROM) with limitations of the upper and lower extremities. Review of the Physician's Orders showed that Resident #108 had an order dated 11/25/23 for Benztropine Mesylate Oral Tablet 1mg, give 1 tablet by mouth one time a day for Parkinson's disease. Review of the Physician's Orders showed that Resident #108 had an order dated 12/15/23 for Austedo (Deutetrabenazine) Oral Tablet 6 mg, give 1 tablet by mouth two times a day for tardive dyskinesia. Review of the Care Plan dated 10/15/24 documented that Resident #108 has Parkinson's Disease. Goals were to minimize risk of complications though next review date. Interventions were to monitor for risk of falls; Monitor/document/report to doctor as needed sign and symptoms of Parkinsons complications: Poor balance, Constipation, Poor coordination, Insomnia, Dysphagia, Tremors, Gait disturbance, Incontinence, Muscle cramps or rigidity, Decline in ROM, Skin breakdown, Mood changes, Decline in cognitive function. Review of the Care Plan dated 10/15/24 revealed no documentation that Resident #108 was assessed for scissors safety. During the initial tour of the facility conducted on 12/02/24 at 10:10 AM, Resident #108 was observed sitting on her bed using regular size scissors to cut paper towels into squares. When asked if those were her scissors, Resident #108 stated yes and she uses them to cut the paper towels because she does not like waste, so she cuts them into rectangles. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/03/24 at 10:32 AM with the Director of Nursing (DON), in which she stated she was not aware that Resident #108 had scissors in her room. She also stated she will do an assessment of Resident #108 to see whether she is able to safely use the scissors. During an observation conducted on 12/04/24 at 5:24 PM, revealed no scissors in Resident #108's room. During an interview conducted on 12/05/24 at 10:30 AM with Staff M, Certified Nursing Assistant (CNA), she stated she has worked at the facility for 2 years and has cared for Resident #108 before. Staff M stated she has not seen Resident #108 with scissors in the room. She noted that if she finds any sharps in residents' rooms, she is to report it to the nurse manager. During an interview conducted on 12/05/24 at 1:37 PM with Staff K, Activity Aide, she reported she has been working at the facility for 1 1/2 years. Staff K was asked if Resident #108 can safely use scissors on her own, she stated we do not allow residents to use regular scissors or any sharps during activities. She stated she has never seen Resident #108 with scissors in her room and acknowledged that residents are not allowed to have scissors in their rooms. On 12/05/24 at 2:00 PM, an interview was conducted with the DON. She stated Resident #108's scissors were probably brought in by the family. She stated an assessment was conducted on Resident #108 and safety was a concern, therefore, the scissors were removed from Resident #108's room.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to ensure the drainage bag for a resident with an indwelling urinary catheter is maintained in a manner to prevent infection and maintain dignity for 1 of 1sampled resident reviewed for a urinary catheter (Resident #46). The findings included: Review of the facility's policy titled, Catheter Care Urinary with a revised date of August 2022 included in part the following: Purpose: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control: 2. Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility's policy titled, Dignity with a revision date of February 2021 included, in part, the following: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1) Residents are treated with dignity and respect at all times. Record review for Resident #46 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 10/18/23. The resident's diagnoses included in part the following: Paraplegia, and Neuromuscular Dysfunction of Bladder Review of the Minimum Data Set assessment for Resident #46 dated 10/13/24 documented in Section C a Brief Interview of Mental Status score of 14, indicating a cognitive response. Review of the Physician's Orders for Resident #46 revealed, and order dated 03/08/24 for Foley Catheter (type of indwelling urinary catheter) 16 Fr (size of catheter) DX(Diagnosis): Neurogenic Bladder. Review of the Physician's Orders for Resident #46 revealed an order dated 03/12/24 documented, Maintain Foley Catheter to straight drain, keep foley below the level of the bladder, check placement and function every shift, monitor for any kinks in the tubing, keep the urinary drain bag covered every shift. Review of the Physician's Orders for Resident #46 revealed an order dated 03/12/24 documented, Maintain Foley Catheter to straight drain, keep foley below the level of the bladder, check placement and function every shift, monitor for any kinks in the tubing, and keep the urinary drain bag covered every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #46 dated 10/19/23 with a focus on the resident has a 16 Fr. Foley Catheter for Neurogenic bladder due to paraplegia, potential for infection, catheter related trauma and accidental dislodgement. The goals were for infection to be minimized, risk for accidental dislodgement will be minimized and risk for catheter-related trauma will be minimized through next review date. The interventions included, in part, the following: Catheter care every shift and as needed. Empty drainage bag every shift. Provide dignity cover for drainage bag. On 12/02/24 at 10:52 AM, an observation was made of Resident #46 lying in bed with an indwelling urinary catheter drainage bag lying on the floor (not hanging from bed) with no privacy cover. On 12/02/24 at 1:30 PM, a second observation was made of Resident #46's indwelling urinary catheter drainage bag hanging from the bed with no privacy cover. On 12/03/24 at 7:32 AM, an observation was made of Resident # 46 lying in bed with indwelling urinary catheter drainage bag lying on the floor with no privacy cover in place. During an interview conducted on 12/02/24 at 10:55 AM with Resident # 46, she was asked about her indwelling urinary catheter and she stated they told her originally, they would be changing the catheter every 6 months, but she insisted they change it monthly. During an interview conducted on 12/05/24 at 10:58 AM with Staff E, Certified Nursing Assistant, who stated she has worked at the facility for 1 year. When asked about residents with indwelling urinary catheters, she said the catheter care is done daily and documented in POC (Point of Care) for the resident and the bag needs to be hanging and have a privacy cover.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to monitor intake of nutritional supplements for 2 of 3 sampled residents reviewed for Nutrition (Residents #98 and Resident #53). The findings included: The facility's policy titled, Oral Supplements with a reference date of May, 2023, documented: Policy: The Department shall provide nutritional supplements to residents whose nutritional needs cannot be met through three meals per day, as ordered by the physician. Procedures: Nursing staff documents the resident's acceptance/rejection of supplements by amount. Records the amount of nourishment consumed by the resident in EMR (electronic medical record), and notifies the dietitian if the resident refuses the produce consistently. 1). Resident #52 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Medicare 5-day Minimum Data Set (MDS), dated [DATE], Resident #52 had a Brief Interview for Mental Status (BIMS) score of 09, indicating the resident had moderate cognitive impairment. The assessment documented that Resident #52 was dependent upon staff for eating. Resident #52's diagnoses at the time of the assessment included: Heart Failure, Hypertension, Renal Insufficiency, Non-Alzheimer's Dementia, Malnutrition, Chronic Lung Disease, Acute Embolism and Thrombosis, Thryotoxicosis, Atrial Fibrillation, speech and language deficits following cerebrovascular disease, Dysphagia following cerebrovascular disease, Diverticulosis of intestine, Osteoarthritis, and Disorder of Kidney and Ureter. Resident #52's dietary orders dated 11/12/24 included: Regular diet, Puree texture, Nectar Thickened Liquids consistency - 11/08/24 Ensure Plus one time a day - 11/08/24 Weekly weight times one time a day every Tuesday for monitoring. Resident #52's Care plan for nutrition documented, Resident at high nutrition risk diagnoses Urinary Tract Infection (UTI), Chronic Obstructive Pulmonary Disease (COPD), Dementia, Thyrotoxicosis, Deep Venous Thrombosis (DVT), Atrial Fibrillation, Congestive Heart Failure, Hypertension, Chronic Kidney Disease, Diverticulosis. Potential for weight fluctuations, mechanically altered diet. 11/8/24 s/p hospitalization . Impaired skin. + edema to bilateral lower extremities (BLE). Weight gain 11/14/24 Weight loss; - edema BLE 12/2/24 Weight loss r/t (related to) edema Date Initiated: 10/07/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The goals of the care plan included: o Resident will exhibit no signs or symptoms of dehydration as evidenced by good skin turgor, moist mucous membranes, moist lips, no complaints of thirst, free from electrolyte imbalance lab values by next review. Date initiated: 10/07/24. Target date: 01/21/25. o Resident edema will subside Date Initiated: 11/08/2024 Target Date: 01/21/2025 o Resident's pressure injury/wound will improve/heal by next review date Date Initiated: 11/08/2024 Target Date: 01/21/2025 Interventions in the care plan included: o Monitor oral intake of food and fluid Date Initiated: 10/07/2024 o Monitor Skin Integrity Date Initiated: 11/08/2024 o Monitor weight monthly/weekly Date Initiated: 10/07/2024 o Provide > 8 cups fluid per day with meals/between meals Date Initiated: 10/07/2024 o Provide diet as prescribed Date Initiated: 10/07/2024 o Provide fortified foods (specify) Date Initiated: 11/08/2024 o Provide necessary assistance at mealtime and between meals Date Initiated: 11/08/2024 o Provide nourishments/snacks/fluids prn Date Initiated: 10/07/2024 o Provide oral supplements as ordered Date Initiated: 10/07/202 A Nutrition Progress note, dated 12/02/24, documented: Note Text: Wt reviewed: 11/21-117lbs; 11/29-107lbs. reweight completed. Noted with 10lbs/8.5% significant weight loss x 1 week. Regular Diet order with pureed altered texture, nectar liquids. During meal rounds, resident dependent with meals; PO intake ~75% of today's lunch. Nursing documents 50-75% of most meals. Receiving Ensure Plus as ordered with ~50% as per nursing. Resident's family informed of weight status via phone. Resident s/p edema upon readmission. As per nursing, resident with decreased edema. Wound care to sacrum noted; see Wound Evaluation 11/27 for details. Wound care including MVI/Minerals with protein supplementation to aide in healing. MD (Medical Doctor) is aware. Continue with fortified cereal at breakfast meal. Increase Magic Cup to 2x daily at lunch and dinner. Continue to follow as warranted. On 11/07/2024, the resident weighed 123 lbs. On 11/29/2024, the resident weighed 107 pounds which is a -13.01 % Loss. An Admission Progress note dated 11/06/24 documented Resident #52's admission weight of 115 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 11:30 AM, with Staff C, Registered Dietitian (RD), when asked about Resident #52's weight loss, Staff C replied, She came back with edema. She was post status and was on diuretics before. Our weekly weight is due. We got a weight on Tuesday or Wednesday and she was 117 pounds and I requested a re-weigh and today her weight was 115. I requested the re-weight because I was questioning the accuracy. 107 pounds was a re-weight from last week's weights. When she first came back, she had bilateral edema. Reduced edema. I asked for a re-weight on 11/29, and she weighed 107 pounds. Her intake was fine, she was already on supplements, we increased her nourishment. When asked about recommendations for supplements, Staff C replied, When they make a recommendation its placed in order and in the MAR (Medication Administration Record). Magic Cup is in the meal tracker, so it will show in the meal ticket not in the orders. During an interview, on 12/05/24 at 11:51 AM, with Staff Q, RN, when asked about providing the supplements to the residents, Staff Q replied, The supplements come from us (nursing) we document the intake in the progress notes. A side-by-side review of progress notes with Staff Q revealed no documentation of the intake of the supplements in Resident #52's records. During a follow up interview with Staff C, on 12/05/24 at 1:15 PM, when asked about documenting the percentage of intake of meals, Staff C replied, when they do the intake, it includes just the lunch. The supplements are written in the doctors' orders and they give them to the resident and document the percentage consumed in the MAR. Review of the MAR and progress notes revealed no documentation of intake of the supplements. Durine a side-by-side review of Resident #52's electronic health records with Staff C, revealed no documentation of the resident's intake. 51663 2). Record review showed that Resident #98 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Complex Regional Pain Syndrome I and Obstructive and Reflux Uropathy. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score was 8, which indicates moderate cognitive impairment. A thorough review of the weight log for Resident #98 showed the following: 182.2 pounds on 06/13/24 and dropped to 172.0 pounds on 06/27/24. This showed a 5.5% severe weight loss in less than one month. Continued review indicated a weight loss from 172 pounds on 06/27/24 to 161pounds on 07/11/24, which showed an overall severe 12% weight loss in less than 2 months. Resident #98 had an overall trending weight loss of 14% from 06/13/2024 to 11/04/2024 (past 6 months). A review of the Dietary progress note dated 06/28/24 (a day after the 5.5% weight loss was identified) revealed the following: Staff D, Registered Dietitian documented Resident #98 had a non-significant weight loss. Resident #98 received Magic cup (nutritional supplements) once a day and it was recommended to also increase the Ensure Plus (nutritional supplements) from once a day to twice a day. This note revealed that Resident #98 had an intake of meals between 50% to 100% of meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dietary progress note dated 07/12/2024 revealed the following: Staff D, Registered Dietitian documented Resident #98 had significant weight loss. Resident #98 was recommended to increase the Ensure Plus 8 ounces to three times a day (TID) for an additional 1050 calories and 48 grams of protein a day, and the addition of fortified foods at breakfast and lunch meals. A review of Resident #98's Physician's orders showed the following: Ensure Plus 8oz TID was started on 07/13/2024 and discontinued on 09/11/2024. A new order was written for Ensure Plus twice a day and started on 09/11/2024. No orders were noted for fortified meals or Magic Cup. In an observation conducted on 12/04/2024 at 12:35 PM Resident # 98 was observed in the dining room eating. His meal ticket consisted of Mechanically Altered Chopped Orange Glazed Chicken 3oz, Mechanically Altered Chopped Normandy Vegetable blend 4oz, Cream of Rice 4oz, Diced Peaches 1/2Cup, Magic Cup 1/2 Cup and Sugar Free Lemonade 8oz. No fortified foods were noted on the meal ticket or on the actual meal tray. Further observation of the meal tray showed the following: a Magic cup noted on the side table and not on the meal tray, and a regular chocolate ice cream on the side table as well. Resident #98, unassisted, picked the regular ice cream chocolate instead of the Magic cup ice cream. Staff in the room did not ensure that Resident #98 was given the correct nutritional supplements as needed or assisted him with the lunch meal. In an interview conducted on 12/04/2024 at 11:30AM with Staff C, Registered Dietitian stated that when a Magic Cup is recommended it is not added as a physician order but placed directly into the meal tracker to auto populate on the meal ticket. The same process applies for any recommended fortified foods. Staff C said that the percent intake of the Magic Cup is not documented better yet the tray is reviewed as a whole. Unlike for Ensure Plus which is ordered and documented for percentage intake in the Medication Administration Record (MAR). According to Staff C the fortified meal for lunch is Mashed Potatoes which was not provided to Resident #98. In an interview conducted on 12/04/2024 at 4:45 PM with Staff D, she stated that the progress note dated 06/28/2024 said no significant weight loss because she was comparing the weight loss from one week to another instead of seeing the overall weight loss in less than a month. When asked how do you assess the effectiveness of the nutritional supplements not documented in the MAR she did not have an answer. In an interview conducted on 12/05/2024 at 10:20 AM with Staff F, Certified Nurse Assistant (CNA), she reported that she did not know what a Magic Cup was and did not know that it was a nutritional supplement. In another interview conducted on 12/05/2024 at 10:45 AM with Staff G, Certified Nurse Assistant (CNA), she reported that she had no idea what a Magic Cup was, and also asked : Is it a cup?

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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** 41837 Based on observations, and record review, the facility failed to ensure a resident receiving oxygen has a physician's order for 1 of 4 sampled residents reviewed for respiratory affecting Resident #111 and failed to ensure respiratory supplies are cared for in a manner to prevent infection for 4 of 4 sampled residents for respiratory affecting Residents #17, # 111, #6 and #8. The findings included: Review of the facility's policy titled, Department (Respirator Therapy) -Prevention of Infection with no date (just a printed date of 12/05/24) included in part the following: Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators among residents and staff. Infection Control Considerations Related to Oxygen Administration: 7. Change the oxygen cannula and tubing every seven (&) days, or as needed. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. 1) Record review for Resident #111 revealed the resident was admitted to the facility on [DATE] with readmission on 03/17/24 with diagnoses that included, in part, the following: Acute and Chronic Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease. Review of the Minimum Data Set assessment for Resident #111 dated 11/19/24 revealed in Section C a Brief Interview of Mental Status score of 14, indicating intact cognition. Review of the Physician's Orders for Resident #111 revealed no evidence of an order for oxygen. On 12/02/24 at 12:04 PM, an observation was made of Resident #111 sitting up in bed wearing oxygen, the oxygen concentrator was set at 2 liters. 2) Record review for Resident #6 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 10/09/24 with diagnoses of Infection and Inflammatory Reaction Due to Other Cardiac and Vascular Devices, Implants and Grafts, and Chronic Obstructive Pulmonary Disease. Review of the Minimum Data Set for Resident #6 dated 11/18/24 revealed in section C a BIMS score of 15, indicating intact cognition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #6 revealed an order dated 11/21/24 documented to change the nebulizer mask and tubing weekly; date and place in dated plastic bag (Fri 7-3). Place in dated bag when not in use every day shift every Friday On 12/02/24 at 9:30 AM, an observation was made of Resident #6's nebulizer mask on top of a personal cart (mask not in a plastic bag). On 12/02/24 at 5:50 PM, an observation was made of Resident #6's nebulizer mask, laying on the nightstand next to a plastic bag. During an interview conducted on 12/02/24 at 5:52 PM with Resident #6, who was asked if she receives breathing treatments, she said oh yes, she needs them. 3) Record review for Resident #17 revealed the resident was admitted to the facility on [DATE] with a diagnoses that included, in part, the following: Acute On Chronic Diastolic (Congestive Heart Failure), Primary Pulmonary Hypertension, Anxiety Disorder, Dementia, and Presence of Cardiac Pacemaker. Review of the MDS for Resident #17 dated 11/13/24 documented in Section C a BIMS (Brief Interview for Mental Status) score of 9, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #17 revealed an order dated 09/10/24 for oxygen 2 Liters/min per nasal cannula continuously every shift for Shortness of Breath. Review for Nursing Progress Notes for Resident #17 from 11/24/24 to 12/01/24 revealed no documentation of oxygen tubing being changed. On 12/02/24 at 10:35 AM, an observation was made of Resident #17 sitting up in bed wearing oxygen via nasal cannula. The nasal canula had a label with the date of 11/11/24. During an interview conducted on 12/03/24 at 11:31 AM with the Director of Nursing (DON). She stated she has been working at the facility for 2 months. When asked about administering oxygen, she said the resident needs an order. When asked about oxygen tubbing being changed, she said it should be changed weekly and as needed. When asked about storage of nebulizer masks, she said they should be in a plastic bag at the bedside when not in use. 50370 4.) Resident # 8 was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (a lung condition requiring low level of oxygen administration to allow better lung perfusion), Atrial Fibrillation, and Dependence on Supplemental Oxygen. A review of Minimum Data Set (MDS) Section C revealed a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of physician orders dated 11/21/24, revealed oxygen at 2 Liters by nasal cannulae to keep oxygen saturation equal or greater than 90% every shift. Another order revealed to change nebulizer mask and tubing weekly, place in plastic bag on (Friday between 7:00AM-3:00PM), place in plastic bag when not in use every AM shift, and every Friday. A review of nursing progress notes dated 04/26/24 revealed to administer and monitor the effectiveness of treatments{(see current physicians orders), (such as oxygen -incentive spirometer -nebulizer treatments)}. A review of a nursing care plan revealed Resident #8 has alteration in breathing patterns related to Chronic Obstructive Pulmonary Disease with goals: to prevent acute therapy tasks and equipment including ventilators, among residents and staff, respiratory distress, and complications; with interventions requiring resident to have oxygen through nasal cannula at bedtime, and with staff administering, and monitoring the effectiveness of treatments {(see current physicians orders) (such as oxygen, incentive spirometer, and nebulizer treatments)}. During observation on 12/02/24 at 11:30 AM, Resident #8 was wearing oxygen nasal cannula on both nares at the end of long clear oxygen tubing with a tape tag black marked 11/18. The oxygen flow meter was set at 3 Liters per minute on the portable oxygen box machine. During the following day observation on 12/03/24 at 2:00 PM, Resident #8's oxygen cannulae and tubing were observed with an attached tape tagged and black marked 11/18. Resident was sitting on his bed, and not wearing the oxygen nasal cannula on both nares. Further observation revealed some parts of the oxygen cannula and tubing were under the portable oxygen box machine on the floor. The nasal cannula portion and the tubing were not inside any plastic containment. During another observation on 12/04/24 at 9:21AM, Resident #8 was asleep on his left side in bed, wearing nasal oxygen cannula on both nares of a clear oxygen tubing attached to the portable oxygen box machine. The tubing was tape tagged and black marked 11/18. The oxygen level was at 3 Liters per minute. During an interview with Resident #8 on 12/02/24 at 11:30 AM, he stated he uses oxygen when he sleeps. When asked about the oxygen tubing, he stated the facility provides him with long tubing. When asked about the frequency of oxygen tubing changes, he stated that Sometimes, the facility staff change the oxygen tubing.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Boca Raton Rehabilitation and Nursing Ce	7300 Del Prado Circle South Boca Raton, FL 33433

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews the facility failed to identify triggers for residents diagnosed with Post-Traumatic Stress Disorder (PTSD), for 2 of 2 residents sampled for mood and behavior, (Resident #72 and Resident #28). The finding include: 1.) Review of the facility's policy titled, Trauma Informed Care Proc with Document ID #98875710, published on 05/19/2023 revealed the following: Purpose: a. To guide Staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice: and b. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. General Guidelines: Triggers are highly individualized. Some common triggers may include: a. experiencing a lack of privacy or confinement in a crowded or small space. b. exposure to loud noises. c. certain sights such as objects; and or d. sounds, smells, and physical touch Resident Screening included the following: 1. Perform universal screening of residents, which include a brief, non-specialized identification of possible exposure to traumatic events, 2. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant, and sensitive. 3. Screening may include information such as : 1. Perform universal screening of residents, which include a brief, non-specialized identification of possible exposure to traumatic events, 2. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant, and sensitive. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Screening may include information such as : a. trauma history, including type, severity and duration. b. depression, trauma-related or dissociative symptoms. c. risk for safety (self or others); d. concerns with sleep or intrusive experiences. e. behavioral, interpersonal or developmental concerns. f. historical mental health diagnosis. g. substance use. h. protective factors and resources available; and i. physical health concerns, 4. Utilize initial screening to identify the need for further assessment and care. Resident Care Planning: 1. Develop individualized care plans that address past trauma in collaboration with the resident ad family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. Review of the facility's documentation, titled, Stressful Life Experiences Evaluation submitted by the MDS Coordinator on 12/04/24 at 3:00 PM, revealed the following: A. Stressful Life Experiences: INSTUMENT: Please indicate how much you have been bothered by each problem in the past month. For these questions, the response options are Not at All, A Little Bit, Moderately, Quite a Bit, or Extremely. An individual is considered to have screened positive if the sum of these items is 14 or greater. There was no question indicating triggers for PTSD. 1) Resident #28 was admitted to the facility on [DATE], with diagnoses including, Diabetes Mellitus without Complications, Post-Traumatic Stress Disorder (PTSD), Dysphagia Following Cerebral Infarction, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. A review of the Minimum Data Set (MDS) Section C revealed a Brief Interview of Mental Status (BIMS)score of 14, indicating intact cognition. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of progress notes dated 09/14/24 revealed a behavior code number 1 (one) labelled as depressed or withdrawn and to document number of times behavior occurred on each shift. Additional progress notes written by Social Services Staff, dated 09/24/24 revealed Resident #28 will demonstrate adjustment to nursing home placement by/through review date. A review of Physician Progress Notes dated 09/16/24 revealed a doctor tried to complete a psychology assessment, but was unable to locate Resident #28. A review of Psychiatry Referral Progress Notes dated 09/19/24 revealed the chief complaint for the consultation was for Resident #28's history of depression. There was no consultation related to PTSD. During an observation and interview with Resident #28 on 12/12/24 at 12:18 PM, he stated he is not happy. He was observed with a contracted left hand, and left elbow bandage. Resident #28 stated he wants to get out of the facility, because staff do not answer call lights when he needed them the most. In an interview with Staff N, a Certified Nursing Assistant (CNA), on 12/04/24 at 10:11 AM, when asked how he addresses residents who are exhibiting distress, he responded that he observes body shaking, and resident's state of confusion about time, place and events, and resistance to care. When asked about the common signs of resident's distress, he stated agitation, or being scared. When asked how he manages resident's distress, he stated he checks the residents regularly and familiarizes himself with resident's needs. When asked how he knows if a resident was a trauma survivor, and what does he need to do differently for that resident, he stated when a resident is unable to move any body parts, and have dressing on the head, he would know based on his visual observation. This staff added that his eyes can detect if a resident was a trauma survivor. He added that residents might be constipated, and not going to the bathroom, not responding to his questions and always lying down in bed. He added he will read resident's records, calm resident's anxiety, and try to understand them. When asked about the types of behavioral health training he has completed, he responded he had some, but does not remember the date or the name of the training. In an interview with a Social Services Staff on 12/04/24 at 12:21 PM who has been working in the facility for one year, when asked about Resident #28's care plan for PTSD , she stated, There is no care plan that has been created. She added that the reason there was no care plan for PTSD was, first upon admission the resident denied anxiety and depression, and secondly, because the resident was evaluated by the psychiatrist. When asked regarding the resident's triggers, she stated she did not identify triggers on 09/13/24 upon admission, because she wanted to do a continuing process of building rapport with the resident. She added she is quarterly monitoring the resident and maybe next time she will be able to ask for triggers. When asked when is the next time, she did not give a specific date. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked how she proposes caring for residents with PTSD with no information about his triggers, she stated it was a continuing process, but she is planning to eventually ask about the resident's triggers. When asked why she has not created a care plan for resident #28's PTSD yet, she responded that she plans to keep asking the resident, because she wants to make sure Resident#28 is comfortable with her. She added that she plans to quarterly assess Resident #28. When asked regarding Resident #28's PTSD diagnosis, she stated it was derived from admission. When asked when she is planning to create a PTSD care plan because 3 months had passed since the resident's admission to the facility, she responded she has not made any evaluation to ask for triggers and insisted that she must make a rapport with the resident first. She added it is a continuous process. When asked about a Psychiatry Evaluation of Resident #28 related to PTSD, she stated she will provide the documentation to the Surveyor, but until the end of this survey, no Psychiatry Evaluation was presented. In an interview with the MDS Coordinator on 12/04/24 at 4:11 PM, when asked how she demonstrated her knowledge of Resident #28's current behavioral and emotional needs, she stated these are based on care evaluations from Psychiatrist, Psychologist, and Social Services assessments. When asked how often she attends Staff Behavioral in-service training, she stated once a year. When asked about the types of behavioral health training she had completed, she stated it was an annual in-service provided by facility to all Staff. When asked how she demonstrates competent interactions when addressing the resident's behavioral care needs, she responded by providing services based on resident's culture. When asked how she evaluates resident's anxiety, she responded by checking resident's appearance and verbalization. When asked how she would know if a resident was a trauma survivor, and what would she do differently for that resident, she stated she must create a care plan in the MDS. She added that a section in the MDS has specific space for creating a care plan. She added that baseline care plan for the resident should be done in 2 to 3 days, while the comprehensive care plan in 30 days. When asked regarding PTSD interventions, she stated some examples are approaching the resident in a calm manner, assuring the resident to prevent him/her from getting anxious. When asked who is responsible for completing the Stressful Life Events documentation, she stated a Social Worker, but the MDS Coordinator inputs clinical assessments, plans, goals and interventions with the Social Services Staff, then both establish a care plan meeting based on the completed admission evaluation. When asked regarding a required time frame to complete a resident's care plan meeting , she stated approximately 2 weeks after the admission evaluation. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked who completes the Stressful Life Events, she stated the MDS Coordinator with data and update information, assessment and intervention from the Social Services Staff. She added that during a care plan meeting, staff discussed the content of the admission evaluation including the Stressful life events form. There is a time frame for completion of Stressful life events form which is approximately 2 weeks after admission. When asked the facility's process for identifying residents with possible Mental Disability (MD), Intellectual Disability (ID), or related condition prior to admission to the facility, this staff responded that she assesses resident, follows admission and nurses' interventions, supervises resident and follows doctor's orders on admission. In an interview with Staff P, a Registered Nurse (RN) on 12/05/24 at 11:30 AM, when asked how the facility identifies residents with newly evident or possible serious MD, ID or related condition after admission, she responded by speaking with the resident and watching the resident's behaviors. This staff added that changes in behaviors are important indicators of new behavioral symptoms and stressing that any complaints of pain must be assessed. 41837 2) Record review for Resident #72 revealed the resident was admitted to the facility on [DATE]. Review of the diagnoses for Resident #72 revealed the resident had a diagnosis of Post-Traumatic Stress Disorder (PTSD) Unspecified dated 11/14/24. Review of the Minimum Data Set for Resident #72 dated 08/14/24 documented in Section C a Brief Interview of Mental Status score of 15, indicating intact cognition. Review of the Stress for Life Screening for Resident #72 dated 02/07/23 and 11/12/24 revealed no documentation of triggers (related to PTSD) being asked or discussed with the resident. Review of the Social Service Progress Notes for Resident #72 dated from 02/07/23 to 12/01/24 revealed no documentation of triggers (related to PTSD) being asked or discussed with the resident. During an interview conducted on 12/02/24 at 11:25 AM with Resident #72, who stated she has PTSD, but was not able to clearly articulate to the surveyor what her triggers were. She stated she does have triggers, and they are related to others controlling her or taking her items. The resident stated she is seen by a Psychiatrist. An interview was conducted on 12/03/24 at 1:40 PM with the Social Service Director (SSD), who stated she has worked at the facility since December last year. When asked about residents with diagnoses of PTSD the SSD stated upon admission we do a stress for life evaluation, refer to psychology and psychiatry services and do monitoring for behaviors and would create a care plan for the PTSD for the resident. When asked about Resident #72 the SSD stated the resident had a stress for life screening upon admission on 02/07/23 and was not positive. She had a stress for life screening every quarter with the most recent on 11/12/24 and was positive. When asked if the stress for life screening addresses or asks about triggers, she stated it does not. When asked if she asks the resident about triggers, she said they do not ask residents about their triggers, usually the resident would just tell them. The SSD acknowledged there were no triggers documented for Resident #72.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and review, the facility failed to ensure the controlled substance medication reconciliations were accurate for 6 of 12 sampled residents reviewed during the controlled substance record review (Residents #10, #51, #73, #88, #345, and #346). The findings included: Review of the facility's policy titled, Controlled Substances, dated November 2022, included the following: Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Dispensing and Reconciling Controlled Substances: 1.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2.The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 1) Record review for Resident #10 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Dementia, Osteoarthritis, Anxiety Disorder, Cognitive Communication Deficit, and Chronic Pain Syndrome. Review of the Physician's Orders showed that Resident #10 had an order dated 11/29/23 for Percocet (oxycodone-Acetaminophen) Tablet 10-325 mg, give 1 tablet by mouth four times a day for moderate to severe pain. On 12/04/24 at 5:15 PM, a review of Resident #10's Controlled Drug Disposition sheet was conducted. The disposition sheet documented Percocet 10-325 mg (24 tablets), to be given four times daily for moderate to severe pain, was received by the facility from the pharmacy on 11/26/24. There were 11 tablets left in the controlled substance box. Further review of the disposition sheet revealed the last Percocet tablet was given on 11/29/24 at 9:30 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's November Medication Administration Record (MAR) revealed the Percocet 10-325 mg tablet was documented as administered to Resident #10 on 11/30/24 at the scheduled times of 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. 2) Record review for Resident #51 revealed that the resident was admitted to the facility on [DATE] with a readmission on 09/17/24 with the following diagnoses: Fracture of Shaft of Left Fibula, Anxiety Disorder, Psoriatic Arthritis Mutilans, Dementia, and Osteoarthritis. Review of the Physician's Orders showed that Resident #51 had an order dated 09/24/24 for Oxycodone HCl Oral Capsule 5 mg, give 5 mg by mouth every 6 hours as needed for pain. Review of Resident #51's Controlled Drug Disposition sheet revealed Oxycodone HCL 5 mg (28 capsules) was received at the facility from the pharmacy on 10/01/24. Resident #51 was given the medication on 10/01/24, 10/11/24, 10/18/24, 10/22/24, and 10/25/24. Further review of the Disposition sheet revealed that there were 23 Oxycodone HCL 5 mg capsules left in the controlled substance box with the last one administered on 10/25/24 at 3:35 PM. Review of Resident #51's October MAR revealed that Resident #51 was administered Oxycodone HCL 5 mg on all the above dates and on 10/03/24 at 1:25 PM (which was not documented in Resident #51's Controlled Drug Disposition sheet). The resident's controlled substances was not reconciled. 3) Record review for Resident #73 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Sequelae of Cerebral Infarction, Hypertension, Atherosclerosis of Aorta, and Gastro-Esophageal Reflux Disease. Review of the Physician's Orders showed that Resident #73 had an order dated 10/24/24 for Temazepam Oral Capsule 15 mg, give 1 capsule by mouth at bedtime for insomnia. On 12/04/24 at 4:59 PM, a review of Resident #73's Controlled Drug Disposition sheet was conducted. The disposition sheet documented Temazepam15 mg (10 capsules), to be given at bedtime for insomnia, was received by the facility from the pharmacy on 12/01/24. There were 8 capsules left in the controlled substance box with the last capsule administered on 12/02/24 at 8:13 PM. Further review of the Disposition sheet revealed that a signature, date and time was added after the 12/02/24 entry (on 12/03/24 at 10:12 PM). However, the count on the Disposition sheet matched with the amount left in the controlled substance box (8 capsules). Review of Resident #73's December MAR documented that Resident #73 was administered Temazepam on 12/03/24, as scheduled (no exact time was recorded in the MAR). On 12/05/24 at 1:34 PM a side-by-side review of Resident #73's Controlled Drug Disposition sheet was conducted with Staff L, Licensed Practical Nurse (LPN). She acknowledged that there were 7 capsules left of the Temazepam in the controlled substance box and one capsule was administered on 12/04/24. When asked if she received any report from the night nurse regarding the documentation for 12/03/24 (which the amount given was left empty), Staff L stated she did not receive any information and was not sure what happened. However, the amount of the medication was correct in the controlled substance box, and she was not concerned. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Record review for Resident #88 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: non-Hodgkin lymphoma, Myelofibrosis, and Polycythemia Vera. Review of the Physician's Orders showed that Resident #88 had an order dated 08/03/24 for Morphine Sulfate Extended Release (ER) 15 mg tablet, give 1 tablet by mouth every 12 hours for pain. Review of Resident #88's Controlled Drug Disposition Sheet revealed Morphine Sulfate ER 15 mg (28 tablets) was received at the facility from the pharmacy on 11/28/24. Resident #88 was given the medication on 11/28/24 at 10:57 PM, 12/03/24 at 10:09 PM, and 12/04/24 at 9:00 AM. Further review revealed that there were 25 Morphine Sulfate ER 15 mg tablets left in the controlled substance box which matched the Disposition sheet count. Review of Resident #88's December MAR documented Resident #88 was administered Morphine Sulfate ER 15 mg from 12/01/24 to 12/03/24 at 9:00 AM and 9:00 PM. The resident's controlled substance was not reconciled. 5) Record review for Resident #345 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 3B, and Urinary Calculus. Review of the Physician's Orders showed that Resident #345 had an order dated 11/07/24 for Tramadol HCl Oral Tablet 50 mg, give 1 tablet by mouth every 6 hours as needed for Pain Control for 7 Days, end date 11/14/24. Review of the Physician's Orders showed that Resident #345 had an order dated 11/22/24 for Tramadol HCl Oral Tablet 50 mg, give 1 tablet by mouth every 6 hours as needed for Back Pain for 3 Days, end date 11/25/24. Review of Resident #345's Controlled Drug Disposition sheet revealed Tramadol HCl 50 mg (24 tablets) was received at the facility from the pharmacy on 11/08/24 and revealed Resident #345 was given the medication on 11/22/24 at 9:59 PM, 11/23/24 at 7:00 PM, 11/24/24 at 8:51 PM, and 11/25/24 at 1:39 PM. Further review of the Disposition sheet revealed that 18 tablets remained, which matched the count in the controlled substance box. Review of Resident #345's November MAR revealed no nurse initialed for the administered Tramadol HCl 50 mg on 11/25/24 at 1:39 PM (which was recorded in Resident #345's Controlled Drug Disposition sheet). The resident's controlled substances were not reconciled. 6) Record review for Resident #346 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Parkinson's Disease Without Dyskinesia, Other Chronic Pain, Dementia, and Anxiety Disorder. Review of the Physician's Orders showed that Resident #346 had an order dated 12/01/24 for Oxycodone HCl Tablet 15 mg, give 1 tablet by mouth three times a day for moderate to severe pain for 3 days, end date 12/04/24. Review of the Physician's Orders showed that Resident #346 had an order dated 12/05/24 for Oxycodone HCl Tablet 15 mg, give 1 tablet by mouth three times a day for moderate to severe pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #346's Controlled Drug Disposition sheet revealed Oxycodone HCL 15 mg (9 tablets) was received at the facility from the pharmacy on 12/01/24. Resident #346 was given the medication on 12/02/24 at 9:53 AM and 5:44 PM, on 12/03/24 at 11:12 AM, 2:00 PM, and 5:49 PM, and 12/04/24 at 9:00 AM and 12:30 PM. Further review revealed that there were 2 Oxycodone HCL 15 mg tablets left in the controlled substance box which matched the count on the Disposition sheet. Review of Resident #346's December MAR revealed that Resident #346 was administered Oxycodone HCL 15mg on all the above dates, in addition to 12/01/24 and 12/02/24 at 5:00 PM (which were not documented in Resident #346's Controlled Drug Disposition sheet). The resident's controlled substances were not reconciled. During an interview conducted on 12/05/24 at 1:10 PM with Staff J, Registered Nurse (RN), she stated she is one of the weekend supervisors and picks up shifts sometimes during the week. She stated if a resident is scheduled for a controlled medication, such as a pain medication, she is to follow Physician's orders which she can view on the computer (PCC). Staff J stated she would evaluate pain level, dispense and administer the medication. After the resident takes the medication, she stated that's when she signs in PCC and almost at the same time sign the Controlled Drug Disposition sheet with the time from PCC. Staff J acknowledged that reconciliation of controlled substance stored in the medication cart is done by the nurses during the change of shift. An interview was conducted on 12/05/24 at 1:34 PM with Staff L, LPN. She acknowledged after administration of a controlled medication is when she documents in PCC and the Controlled Drug Disposition sheet of the medication. In addition, Staff L stated that the entered times in both places (PCC and Disposition sheet) need to match. During an interview conducted on 12/05/24 at 1:43 PM with the Director of Nursing (DON), she stated she has been working at the facility for 2 months. She stated nurses are to do reconciliation of the controlled medications during the change of shift. In addition, two weeks ago, she and the managers started to perform audits of medication carts and controlled substance reconciliation daily. She stated the audits consisted of checking the medication blister sheets and Disposition sheets count matched and in-service education was provided for discrepancies. The first week she did the audits daily and the managers took over the following week and she was confident that it was done at least several times a week for each medication cart. The DON also stated education was provided to the nurses to report any discrepancies at any time to her. The 6 residents' Disposition sheets (Residents #10, #51, #73, #88, #345, and #346) were reviewed with the DON and she acknowledged the plan in place is not working.

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Encore at Boca Raton Rehabilitation and Nursing Ce	7300 Del Prado Circle South Boca Raton, FL 33433

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review the facility failed to ensure medication error rate was below 5 percent; a total of 32 opportunities were observed with 4 medication errors identified which yield a medication error rate of 12.50 percent, affecting 2 of 5 sampled residents reviewed for medication administration, Resident #63 and Resident #32. The findings included: Review of the facility's policy titled, Administering Medications, dated April 2019, included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4.Medications are administered in accordance with prescriber orders, including any required time frame. 1) Record review for Resident #63 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Acute Leukemia of Unspecified Cell Type in Remission, Drug Induced Subacute Dyskinesia, Anxiety Disorder, and Major Depressive Disorder. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed Resident #63 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that she was cognitively intact. Review of Section N revealed Resident #63 was on antipsychotic, antianxiety, antidepressant and Antipsychotics were received on a routine basis. During a medication administration (med pass) on the [NAME] unit conducted on 09/24/24 at 9:28 AM, with Staff B, Registered Nurse (RN), she was observed preparing the following medications to administer to Resident #63: Buspirone HCl 5 mg tablet, give 1 tablet by mouth two times a day for Anxiety. Lactulose Solution 20 GM/30ml, give 30 ml by mouth two times a day for Constipation. Metoprolol Tartrate 25 mg tablet, give 1 tablet by mouth two times a day for Hypertension. Omeprazole 20 mg capsule delayed release, give 1 capsule by mouth two times a day for Gastroesophageal Reflux Disease (GERD). Sennosides-Docusate Sodium Tablet 8.6-50 mg, give 2 tablets by mouth two times a day for Constipation. Vitamin C (Ascorbic Acid) 500 mg tablet, give 500 mg by mouth two times a day for nutrition supplement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam (Zanax) 0.5mg tablet, give 1 tablet by mouth one time a day for Anxiety. Reconciliation of Resident #63's physician's orders and Medication Administration Record (MAR) revealed Resident #63 was scheduled to receive the above medications at 9:00 AM, plus 3 other medications which were not observed as administered during the med pass: Ingrezza (Valbenazine Tosylate) 60 mg capsule, give 1 capsule by mouth one time a day for Tardive Dyskinesia. Polyethylene Glycol 3350 Powder, to give 17 grams by mouth two times a day for Stool Softening. Ferrous Sulfate 325 mg (65 Fe) tablet, give 1 tablet by mouth one time a day for Anemia. Further review of Resident #63's December MAR revealed Staff B initialed as administering all the medications scheduled for 9:00 AM. On 12/03/24 at 9:35 AM (after the med pass observation), Resident #63 was observed in her wheelchair, in the hallway between [NAME] and Windsor units wheeling herself towards the Windsor unit for an activity event. During an interview conducted on 12/03/24 at 10:23 AM with Staff B, she stated she has been working at the facility for 1 month. When asked about the 3 medications that were not observed during med pass observation, she stated she administered the Ingrezza 60 mg and the Polyethylene Glycol 3350 Powder to Resident #63 after med pass observation was done. Staff B stated Resident #63 sometimes complains that she is getting too many medications therefore she administered the medications afterwards. However, Staff B realized the Ferrous Sulfate 325 mg (65 Fe) needed to be ordered and currently the facility has not received it. When asked why she documented the Ferrous Sulfate 325 mg as administered, she stated she forgot that the medication had to be ordered. Review of the Medication Administration Audit Report (time stamp) revealed Staff B documented Resident #63 received the 9:00 AM scheduled medications between 9:32 and 9:40 AM including the Ingrezza 60 mg (9:32 AM), Polyethylene Glycol 3350 Powder (9:34 AM) and Ferrous Sulfate 325 mg (9:33 AM). The last medication observed during the med pass was Lorazepam 0.5 mg, which according to the time stamp, the documentation time was 9:40 AM. An interview was conducted on 12/03/24 at 1:50 PM with the Director of Nursing (DON) and review the time stamp report for Resident #63. She acknowledged that the medications (Ingrezza 60 mg, Polyethylene Glycol 3350 Powder, and Ferrous Sulfate 325 mg) were omitted from the med pass and Staff B documented them as being administered while the med pass was observed. 41837 2) Review of the manufacturer's prescribing information for Fiasp FlexTouch insulin injector pen at https://www.novo-pi.com/fiasp.pdf included in part the following: Priming your FIASP(R) FlexTouch(R) Pen: Step 7: oTurn the dose selector to select 2 units (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Step 8: oHold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: oHold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. oA drop of insulin should be seen at the needle tip (See Figure J). o If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. o If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9. Record review for Resident #32 revealed the resident was originally admitted to the facility on [DATE] most recent readmission on 08/11/19 with diagnoses that included, in part, the following: Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus, Parkinson's Disease, and Dementia. Review of the Minimum Data Set for Resident #32 dated 11/01/24 documented in Section C, a Brief Interview of Mental Status score of 12, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #32 revealed an order dated 04/21/24 for Fiasp FlexTouch 100 UNIT/ML Solution pen-injector, Inject subcutaneously before meals for Diabetes. Inject as per sliding scale: if 60 - 150 = 0; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400. On 12/03/24 at 8:30 AM, an observation of a med pass was conducted with Staff B, Registered Nurse (RN) for Resident #32. Staff B, RN prepared the Fiasp FlexTouch 100unit/ml insulin pen to give 6 units subcutaneously to the resident. Staff B, RN primed the insulin pen by holding the pen upside down (needled pointing to the floor). An interview was conducted on 12/03/24 at 8:33 AM with Staff B, RN who stated she has worked at the facility for 1 month. When asked about priming the insulin pen, she said she did, she turned the dial and saw the liquid insulin come out of the tip of the needle. When asked why the needle was facing down instead of up, she said that is how she was shown by another nurse to do so. An interview was conducted on 12/03/24 at 2:15 PM with Consultant Pharmacist who was asked if Fiasp FlexTouch 100 UNIT/ML Solution pen-injector dosage would be accurate if the insulin pen was not properly primed. She stated she could not say the dose would be accurate or not accurate if the insulin pen was not primed according to manufacturer's instructions. She acknowledged the Fiasp FlexTouch 100 UNIT/ML Solution pen-injector should be primed with the needle pointing up.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to secure medications at bedside for 3 out of 34 sampled residents; (Residents #49, # 72, 115) and failed to secure 1 of 7 med carts; failed to secure medication left on top of 1 of 7 med carts; and failed to properly dispose of medication(s) during 2 out of 5 medication observations. The findings included: Review of the facility's policy titled, Medication Labeling and Storage with a published date of 05/19/23 included in part the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Review of the facility's policy titled, Self-Administration of Medications with a Published date of 05/19/23 included in part the following: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 8. Self-administering medications are stored in a safe and secure place, which is not accessible by other residents. Review of the facility's policy titled, Discarding and Destroying Medications with a revised date of November 2022 included in part the following: Medications that cannot e returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. 6. e)The collector is responsible for managing the collection receptacles, including picking up and properly disposing of medications collected in the receptacles and training facility staff on the procedures associated with collection and storage of controlled substances awaiting disposal. 7.For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: b) Mix medication, either liquid or solid with an undesirable substance. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) On 12/03/24 at 8:26 AM, during an observation with Staff B, Registered Nurse (RN), left a Fiasp FlexTouch 100unit/ml insulin pen on top of the unlocked and unattended med cart ([NAME] unit) to obtain insulin pen needles. An interview on 12/03/24 at 8:26 AM , Staff B, RN, revealed she has worked at the facility for 1 month. When asked about leaving the insulin on the unlocked and unattended med cart she said she did not know why she did that, but meds and the med cart should always be locked up. 2) Record review for Resident #49 revealed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, in part, the following: Atrial Fibrillation, and Essential (Primary) Hypertension. Review of the Minimum Data Set (MDS) for Resident #49 dated 11/09/24 documented in Section C a Brief Interview of Mental Status (BIMS) score of 7 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #49 revealed no order for Tums (calcium carbonate). Record review for Resident #49 revealed no evaluation for self-administration of medication. On 12/02/24 at 10:18 AM, an observation was made of Resident #49 in bed with a bottle of Tums on her nightstand. 3) Record review for Resident #72 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Post Traumatic Stress Disorder. Review of the Minimum Data Set for Resident #72 dated 08/14/24 revealed in Section C a Brief Interview of Mental Status score of 15, indicating intact cognition. Record review for Resident #72 revealed no evaluation for self-administration of medication. Review of the Physician's Orders for Resident #72 revealed an order dated 11/20/23 for Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin-Hypromellose-Polyethylene Glycol 400) Instill 2 drop in both eyes every 2 hours as needed for eye drop. Review of the Medication Administration Record for Resident #72 from 11/01/24 to 12/01/24 revealed no documentation of Artificial Tears being administered. On 12/02/24 at 11:25 AM, an observation was made of Resident #72 sitting up in bed with 2 bottles of artificial tears on her overbed table. On 12/03/24 at 9:30 AM, a second observation was made of Resident #72 sitting up in bed with 2 bottles of artificial tears on her overbed table. During an interview conducted on 12/02/24 at 11:25 AM with Resident #72, who was asked about the eye drops at her bedside, she stated one is a backup, and she has dry eye syndrome, so she uses the drops several times a day. She stated her doctor gave orders for her to have them at the bedside and give them to herself. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) On 12/03/24 at 7:59 AM, a med pass observation was conducted with Staff A, Licensed Practical Nurse (LPN), who was working on Windsor med cart #2 and passing medications to Resident #84. After resident tool all medications orally, Staff A, LPN noticed a small pink pill on the floor next to the resident's bed. Staff A, LPN picked up the pill and disposed of it in the sharp container in the resident's bathroom. An interview was conducted on 12/03/24 at 8:02 AM with Staff A, LPN who stated she has worked at the facility for 10-[AGE] years. When asked about medication disposal, she said she should have disposed of the pill in the drug buster solution, not put it into the sharp's container in the resident's bathroom. An interview was conducted on 12/03/24 at 11:31 AM with the Director of Nursing (DON) who stated she has been at the facility for 2 months. When asked if residents can have medications at the bedside, the DON stated normally not unless the resident specifically has a of plan of care for self-administration. When asked what is needed for the resident to self-administer medication, the DON stated they would need to be evaluated for self-administration and have a care plan for that as well. When asked about med carts, treatment carts and emergency carts being locked, she said they all should be locked at all times unless the nurse is using them. When asked about medication disposal, she stated they should be disposed of per their policy. 49060 5) Record review for Resident #115 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Parkinsonism, Hypertension, Anxiety Disorder, Malignant Neoplasm of Central Portion of Female Breast, Dysphagia, and Insomnia. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #115 had a Brief Interview for Mental Status (BIMS) of 12, which indicated that she was moderately cognitively impaired. Review of Section N revealed that Resident #115 was on antipsychotic, antianxiety, and received antipsychotics on a routine basis. During an initial observational tour conducted on 12/02/24 10:22 AM, Resident #115 was noted to have a few over the counter (OTC) medications on top of her nightstand table, visible and easily accessible to other residents, employees and visitors. Further observation revealed the OTC medications were two used bottles of Nasal sprays (one with an expiration date of 06/2022), a Neosporin ointment tube, Preparation H ointment tube and a large bottle of Probiotic chewable supplement. Review of the Physician's Orders showed that Resident #115 had no orders for self-administer medications, and no orders for any of the above OTC medications. An interview conducted on 12/02/24 at 10:24 AM with Resident #115, she revealed that she had been looking for the OTC medications and felt someone moved them to her nightstand. She stated she has used the nasal spray because sometimes she feels congested. During a second initial observational tour conducted on 12/03/24 10:13 AM, Resident #115 was still noted to have the OTC medications on top of her nightstand table, visible and easily accessible to other residents, employees and visitors. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 12/03/24 at 12:35 PM with the Director of Nursing (DON), she stated she has been working at the facility for 2 months. She stated she has been inspecting all the residents' rooms and educating the nursing staff to make sure no medications are in the residents' rooms. She acknowledged that it has been difficult since residents' families bring in medications for the residents. She stated she was surprised that there were OTC medications in Resident #115's room. The management team had just inspected the units. A follow-up interview was conducted on 12/05/24 at 2:02 PM with the DON. She stated that the OTC medications at the bedside of Resident #115 were brought in by the resident's [family member]. She stated she had a plan in place for medications at the bedside. The first week the plan went in place she audits the second floor and was done with residents' permission. The DON acknowledged that there are still concerns with OTC medication in the residents' rooms. 6) During a medication administration (med pass) observation conducted on 12/03/24 at 9:28 AM in the [NAME] unit with Staff B, Registered Nurse (RN), a Senna Plus bottle was observed not closed and spilled into the drawer and the hallway floor. Staff B picked up the tablets in the drawer with a tissue, while the wound care nurse (WCRN) helped to pick up the tablets that went onto the floor. Staff B was about to discard the tablets in the sharp container (attached to the medication cart), and was stopped by the WCRN which the WCRN noted would discard them in the drug buster located at the medication room. After the med pass, the surveyor pointed out another Senna Plus tablet on the floor which was missed. Staff B picked up the tablet with a glove and discarded it into the sharp container. When Staff B was asked if that is the proper practice to discard medications, she stated if it was a controlled substance, she would need another nurse to sign the waste and the manager would discard the medication in the drug buster. However, for medications like this one, they can be discarded in the sharp container. An interview was conducted on 12/04/24 at 1:50 PM with the DON. She stated as per policy, nurses are to dispose of medications using the drug buster that is in the medication room. She acknowledged discarding the medications in the sharp container is a bad habit by the nurses.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40153 Based on observations, interviews, and record review, the facility failed to follow the Menu Planning, in accordance with established national standards, for one week out of three menu cycles. This had the potential to affect all residents that consume their meals prepared by the facility. The findings included: A review of the facility's policy titled, Menu Planning dated 07/17/24, documented the following: The nutritional needs of individuals will be provided in accordance with the established national standards adjusted for age, gender, activity level, and disability. Through nourishing, well-balanced diets unless contraindicated by medical needs. All current menus will be written to provide an adequate amount for each meal to satisfy recommended daily allowances and written using an acceptable standard meal planning guide. Further review revealed that the menus at the facility were used based on a 2000-calorie/day diet with the following: Dairy/Milk: 2 to 3 cups equivalents per day. Fruits: 2 to 2.5 cups equivalents per day. Vegetables: 2.5 cups equivalents per day. A review of the facility's Spring Summer Menu 2024, Week 1, showed the following fruit exchanges each day: Sunday, 12/1/24, showed no fruit serving for breakfast, no fruit serving for lunch, and 1/2 cups of fruit serving for dinner. This provided only 1/2 of the fruit serving a day, not the needed 2 cups as per the facility's menu guidelines. Monday, 12/2/24, showed was no fruit for breakfast, 1/2 cup of fruit for lunch, and 1/2 cup of fruit for dinner. This provided only 1 cup of fruit a day, not the needed 2 cups as per the facility's menu guidelines. Tuesday, 12/3/24, showed no fruit for breakfast, 1/2 cup fruit serving for lunch, and 1/2 cup fruit serving for dinner. This provided only 1 cup of fruit serving a day and not the needed 2 cups of fruit serving as per the facility's menu guidelines. Wednesday, 12/4/24, showed no fruit serving for breakfast, 1/2 cup of fruit serving for lunch, and no fruit serving for dinner. This provided only 1/2 of the fruit serving a day, not the needed 2 cups as per the facility's menu guidelines. Thursday, 12/5/24, showed no fruit serving for breakfast, no fruit serving for lunch, and 1/2 cups of fruit serving for dinner. This provided only 1/2 of the fruit serving a day, not the needed 2 cups as per the facility's menu guidelines. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Friday 12/6/24 showed no fruit serving for breakfast, no fruit serving for lunch, and 1/2 cup of fruit serving for dinner. This provided only 1/2 of fruit serving a day, and not the needed 2 cups of fruit serving as per facility's menu guidelines. Saturday 12/7/24 showed no fruit serving for breakfast, no fruit serving for lunch, and 1/2 cup of fruit serving for dinner. This provided only 1/2 of fruit serving a day, and not the needed 2 cups of fruit serving as per facility's menu guidelines. In an interview, conducted on 12/3/24 at 1:36 PM with Staff C, the Registered Dietitian, it was stated that the facility's menus were created and reviewed by the Corporate Dietitian. In another interview conducted on 12/4/24 at 9:32 AM, Staff C stated that the facility's menus were created to provide a 2000 calories-based diet with the following: 2 to 3 cups per day of dairy, 2 to 2.5 cups of fruit, and 2 to 2.5 cups of vegetables. She further acknowledged that the facility's Spring Summer Menu 2024 did not meet the needed serving of fruits daily as per established national standards. Staff C reported that fruit servings are also provided upon request from residents and that it may show on their meal tickets as a preference.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide food that meets residents' preferences, allergies and intolerances for 6 of 6 sampled residents observed during dining observation (Resident's #122, #54, #39, #69, #44, and #46). The findings include: 1) Record review revealed that Resident #122 was admitted to the facility on [DATE] with diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side and Non-traumatic Intracranial Hemorrhage. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score of 11, which indicates slight cognitive impairment. In an interview conducted on 12/02/2024 at 10:45 AM Resident #122 stated that breakfast was okay, but it would be great if only she could really get what is on her meal ticket. For example, this morning she didn't get the grits that were on the meal ticket. In a second interview conducted on 12/02/2024 at 1:30 PM Resident #122 stated that she asked staff for a turkey sandwich instead of what was on the menu today. The staff answered that there were no more turkey sandwiches. Resident #122 did not touch her plate because this food tastes like dog food. 2) Record review revealed that Resident #54 was admitted ot the facility on 10/07/2024 with diagnosis of Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting the left non-dominant side. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 11. In an observation conducted on 12/02/2024 at 1:10 PM Resident #54's meal ticket consisted of a No Added Salt diet with the following: Beef & Vegetable Stir Fry 6oz, Steamed Rice 4ounces (oz), Mandarin Orange 1/2 Cup, Ginger Ale 1Can, Apple Juice 8oz. And the tray consisted of Beef & Vegetable Stir Fry, Steamed Rice, 2 Cups of Mandarin Orange, and 2 Cans of Cola and was missing the Apple Juice and the Can of Ginger Ale as noted on the meal ticket. 3) Record review revealed that Resident #39 was admitted to the facility on [DATE] with diagnosis of Parkinson's Disease without Dyskinesia, without mention of fluctuations and multi-system Degeneration of the Autonomic Nervous System. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score of 13, which indicates intact cognition. In an observation conducted on 12/02/2024 at 1:15 PM, Resident #39's meal ticket consisted of a Regular Diet with the following: Egg Salad Sandwich 3oz, Lettuce/tomato Slice 1 serving (Srv), Tossed [NAME] Salad 1/2 Cup, Dressing 2 Packets (Pkt), Diet Ginger Ale 8oz, Fruit Cup 1/2 Cup. And the tray consisted of Egg Salad Sandwich, Lettuce/tomato Slice, Tossed [NAME] Salad, dressing 1 Pkt, 1 Can of Cola and was missing the Fruit Cup and the Diet Ginger Ale. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Boca Raton Rehabilitation and Nursing Ce	7300 Del Prado Circle South Boca Raton, FL 33433

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Record review revealed that Resident #69 was admitted to the facility on [DATE] with diagnosis of Type 2 Diabetes Mellitus without complications and unspecified Dementia, unspecified severity without behavioral. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the Brief Interview of Mental Status (BIMS) score of 8, which indicates Moderate Cognitive Impairment. In an observation conducted on 12/02/2024 at 1:21 PM, Resident #69's meal ticket consisted of a Regular Diet with the following: Beef & Vegetable Stir Fry 6oz, Fortified Mashed Potatoes 4oz, Ice Cream of Any flavor 4oz, Sugar Free Lemonade 8oz. And the tray consisted of Beef & Vegetable Stir Fry 6oz, Fortified Mashed Potatoes 4oz, Mandarin Orange and was missing the Sugar Free Lemonade and the Ice Cream. In a brief interview conducted on 12/02/2024 at 1:22 PM, Resident #69's Private Aid stated that the meal tickets almost never match the tray and when she asks the staff for missing items on the tray, or about the meal tickets not matching the tray the answers she usually gets are: the meal ticket was printed wrong, or they get it confused. 5) Record review revealed that Resident #44 was admitted to the facility on [DATE] with diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left the non-dominant side. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score of 10, which indicates Moderate Cognitive Impairment. In an observation conducted on 12/02/2024 at 1:30 PM, in the second-floor dining room, Resident #44's meal ticket consisted of a No Added Salt Diet with the following Chef Salad 1 Each (Ea.), Crackers 1 Package (Pkg), Mandarin Oranges 1/2 Cup, Diet Ginger Ale 8oz. And the tray consisted of Chef Salad, 1 Can of Cola and was missing the Crackers, Mandarin Oranges and the Diet Ginger Ale. In an interview conducted on 12/04/2024 at 5:00 PM with the facility Food Service Assistant, she stated that she gets the residents' preferences by interviewing them, and she also gives them ideas of what they carry on the facility's menu and asks them what they usually eat at home. She also stated that some residents go with facility's food choices that are on the menu and other ones pick different things. As soon as the food preferences are obtained, she adds them on the meal tracker. If the residents have ingredients/food that they dislike, she adds them in the categorical refusal as part of the electronic system and the program automatically substitutes and gives them their picked preferences. The Food Service Assistant also explained the process of quality control of the tray line and the accuracy of the meal tickets is regulated by a staff member (starter) and another staff member(checker) to monitor the accuracy of the food items on the trays to ensure that the correct food items are placed on the trays. For residents who do not like the food choices on their tray, they will offer sandwiches and then said, there is no such thing as being out of sandwiches. 40153 6) Review revealed that Resident #46 was admitted to the facility on [DATE] with diagnoses of Paraplegia and Chronic Obstructive Pulmonary Disease. The Minimum Data Set assessment dated [DATE] showed a Brief Interview Status (BIMS) score of 14, which is cognitively intact. A review of the list of food items posted outside the main dining room for the Tuesday breakfast meal dated 12/3/24 listed the following: pancakes, turkey sausage, oatmeal, and banana. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #46's meal ticket for Tuesday 12/3/24, revealed the following: pancakes, cereal, orange juice, coffee, creamer, whole milk and Splenda. The breakfast meal tray did not have banana on the tray. An interview was conducted on 12/03/24 at 9:36 AM with the Food Service Assistant (FSA), who stated she has been working at the facility for about 3.5 weeks. When asked about food preferences, she said food preferences and likes/dislikes are addressed at the time of admission and are documented in the meal tracker system. When asked about the posted breakfast for 12/03/24 that included a banana, she said they had substituted grapes. When asked about Resident #46, the FSA acknowledged there were no preferences, likes, or dislikes for fruit for the resident in the meal tracker system.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to provide special eating equipment (adaptive devices) who need them when consuming meals and snacks for 1 of 1 sampled resident reviewed for adaptive equipment, affecting Resident #46. The findings included: Review of the facility's policy titled, Adaptive Equipment Policy and Procedure with no dated (just the printed date of 12/05/24 included in part the following: Adaptive equipment refers to any device or tool that assists residents in performing activities of daily living (ADLs), mobility, or other functional tasks. This policy aims to ensure that residents receive appropriate adaptive equipment and that staff members are trained in its proper use. 3. Equipment Acquisition and Inspection a. The facility should maintain a designated inventor of commonly used adaptive equipment. b. Upon receipt of newly ordered equipment, it should be inspected for any damage, defects, or missing parts. c. Any concerns or issues with the equipment should be reported to the appropriate personnel for resolution. 5. Poper Fit and Adjustment a. Adaptive equipment should be properly fitted and adjusted to ensure the resident's safety, comfort and optimal function. 6> Maintenance and Cleaning a. Regular maintenance and cleaning schedules should be established for all adaptive equipment b. Equipment should be inspected for wear and tear, damage, or malfunctioning parts on a routine basis. Record review for Resident #46 revealed the resident was originally admitted to the facility on [DATE] with a readmission on 10/18/23 with diagnoses included, in part, the following: Paraplegia, and Neuromuscular Dysfunction of Bladder. Review of the Minimum Data Set assessment for Resident #46 dated 10/13/24 documented in Section C a Brief Interview of Mental Status score of 14, indicating intact cognition. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #46 revealed an order dated 03/05/24 for plate guard, spill-proof cup and lid with two handles, and weighted utensils with all meals Review of the Care Plan for Resident #46 dated 04/14/23 with a focus on the resident is at nutrition risk related to PMH (past medical history) Paraplegia, Metabolic Encephalopathy, Anemia, CKD (Chronic Kidney Disease) 4, intermittent confusion hx (history) of poor/fair appetite and dietary supplements refusals, also hx of ordering meals from outside facility The goals were for the resident to consume >75% of meals and show no signs/symptoms of dehydration and the resident will maintain weight of +/- 10% of CBW through next review date. The interventions included in part the following: Adaptive Device: Plate Guard, Spill-proof cup and lid with handle, and weighted utensils will all meals On 12/02/24 at 10:52 AM, an observation was made of Resident #46 sitting up in bed with the call bell on the floor, a full Styrofoam cup of water and 2 empty two handled sippy cups on the nightstand, all were out of her reach to the resident. She said they moved the water when her breakfast came and never put it (the water or cups) back on her tray (over bed table). On 12/03/24 at 8:40 AM, an observation was made of Resident #46 sitting up in bed with a breakfast tray in front of her, with one handled cup with no spill lid containing coffee, a two handled cup with a lid that was not secured containing orange juice (Photographic Evidence Obtained). An interview was conducted on 12/03/24 at 8:50 AM with Staff G, Certified Nursing Assistant (CNA), who stated she has worked at the facility for a couple of months. When asked about the adaptive equipment for the resident, she said she gets two handled no spill cups, built up utensils and plate guard. When asked about the one handled coffee cup with no spill lid and orange juice in a two handled cup with loose fitting lid, she said she will put them in the two-handled cups with sippy lids that the resident has at the bedside. When asked do the 2 handled cups and lids go to the kitchen to be washed, she said no, whoever assists the resident with meal, will wash the cup. An interview conducted on 12/03/24 at 9:36 AM, with Food Service Assistant (FSA), who stated she has been working at the facility for about 3.5 weeks. When asked about adaptive equipment for a resident, she said the therapy department will give an order and the kitchen will ensure the adaptive equipment ordered gets on each meal tray for the resident. When asked about Resident #46, the FSA stated she gets built up utensils, a plate guard and two handled spill proof cup for beverages. When the FSA was shown the photo of Resident #46's breakfast tray form 12/03/24, she acknowledged the resident did not receive the appropriate adaptive equipment (two handled spill proof cups). An interview was conducted on 12/03/24 at 1:56 PM, with the Director of Rehab, who stated she has worked at the facility for 12 plus years. She stated adaptive equipment should all come from the kitchen including cups, plates and utensils. When asked what is ordered for Resident #46, she stated built up utensils, two handled spill proof cups and plate guard. When asked why the resident needs the adaptive equipment, she stated the resident has tremors and depends on needs of stability to pick up the cup and need spill top to keep from spilling liquids on her, to maintain dignity and safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observations and interviews, the facility failed to prepare foods in a manner consistent with standards for food safety. The findings included: 1). During the initial kitchen tour, on 12/02/24 at 9:28 AM, accompanied by the Certified Dietary Manager (CDM), it was noted that there was a leak at the filter from the steamer. The CDM stated that she was aware of the leak and Maintenance would be making repairs. 2). Upon approaching the entrance to the kitchen, on 12/03/24 at 9:35 AM, Staff R, Dietary Aide, answered and opened the door with gloved hand and then proceeded to rinse off her gloved left hand in a food preparation sink before handling ready to eat lettuce. Staff R was instructed to remove the gloves and perform hand hygiene. 3). During the follow up tour, on 12/05/24 at 6:34 AM, accompanied by the CDM, the following were noted: a. Staff R was observed stacking bowls on the food service line with her bare hands and fingers directly in the food contact surface of the bowls. Staff R was instructed to place the bowls in the dishwashing area to be washed and sanitized, perform hand hygiene and don single use and disposable gloves. b. The internal temperatures of pork roasts that were to be used for pulled pork as the dinner meal was 76 degrees Fahrenheit (F) and 66 degrees (F). It was noted that the roasts were in 6-inch deep full sized hotel pans, with a layer of parchment paper and covered with 2 layers of aluminum foil. At the time of the observation, the CDM confirmed that the roasts were cooked the previous day and acknowledged that they were not cooled properly. c. Staff R, Dietary Aide, was observed at the dedicated hand sink rinsing her gloved hands. When asked the purpose of washing the gloves, Staff R stated that she was washing the gloves because there was stuff on it. The CDM instructed Staff R to remove the gloves and perform hand hygiene and to don a pair of new disposable gloves. At the conclusion of the tour, the CDM acknowledged the findings from the tour of the kitchen.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40153 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F755, Pharmacy services, procedures, pharmacist, records; and F810, assistive devices, eating equipment, utensils. These repeated deficient practices have the potential to affect all 146 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited F755 and F810 during the Recertification survey with an exit date of 08/24/23. During an interview with the facility's Administrator on 12/5/24 at 3:30 PM, the Administrator was apprised that these 2 deficiencies will be cited again on this current survey. The Administrator stated she will be working to remedy this issue.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, record reviews and interviews, the facility failed to follow Standard Infection Control procedures while performing perineal care for 1 of 1 sampled resident (Resident # 28); failed to safely dispose of contaminated lancets used for glucose monitoring; and failed to maintain personal drink on a medication cart, in a manner to prevent contamination. The findings included: 1) A review of facility's policy (with no date) titled,Handwashing/Hand Hygiene, revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Page one of the policy, with letter c for Indications for Hand Hygiene, explained that hand hygiene is indicated after contact with blood, body fluids, or contaminated surfaces; and letter g, explaining hand hygiene is indicated immediately after glove removal. Review of the facility's policy titled, Perineal Care : Level II, revealed the purposes of perineal care procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Record review revealed Resident # 28 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Dysphagia following Cerebral Infarction, Benign Prostatic Hyperplasia without lower urinary tract symptoms, and Post-Traumatic Stress Disorder. A review of Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 14, indicating intact cognition. During a perineal care observation on 12/04/24 at 9:54 AM, Staff N, a Certified Nursing Assistant (CNA), was starting to perform care to Resident # 28. Staff N was wearing a blue protective gown, a white N 95 mask covering his mouth and nose areas, and a set of blue gloves on both hands. This Staff touched Resident #28's privacy curtain on the foot part of the bed, then touched the resident's left leg. Staff then removed the set of gloves from both hands and put on a new set of gloves. He did not perform hand hygiene. Staff N started touching Resident #28's other leg and made a comment about the long reddish marks noted. Staff N informed Resident #28 that he will perform a bed bath. This staff washed and rinsed the front chest, neck, stomach and the front perineal area (including penis, and scrotum). This staff then towel dried these areas, and with the same set of gloves touched the resident's hands, put on the resident's shirt, and finally washed and dried the resident's feet. He did not change his gloves after these tasks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff N turned Resident #28 to the left side, touched and pressed the bed control and manipulated the bed using the same gloves he used on the front perineal area of Resident #28, This Staff told Resident #28 he will clean the bottom perineal area. Staff N wiped the fecal matter on the bottom perineal area after dipping the cloth wipes inside the water basin, then with another cloth wipe cleaned the resident's inner thighs. This staff dried the areas with a towel after getting 2 wet wipes from the basin with water using the same set of gloves. Staff N touched the bed linen on the foot part of the bed, touched the resident's shirt, and turned the resident on the right side with the same set of gloves. Staff N removed both gloves from both hands after removing the resident's brief that was full of fecal matter. This staff did not perform hand sanitizing. He grabbed a box of gloves from the wall next to the bathroom, and put it on top of Resident #28's [NAME] drawer. He put on a new set of gloves, touched the bed control, and told the resident he will wash his upper back. This Staff used the same water he used to wash and rinse the back anal region with fecal matter, to wash the upper portion of Resident #28's back. Staff N grabbed a cloth wipe, soaked inside the water basin and washed, rinsed, and towel dried the resident's upper back area. 41837 2) On 12/03/24 at 8:24 AM, a blood glucose monitoring observation was conducted of Staff B, Registered Nurse (RN). After the RN checked the blood glucose for the resident, she disposed of the used lancet by encapsulating the lancet in the used glove she had been wearing and placed it in the open trash container next to the resident's bed. An interview was conducted on 12/03/24 at 8:30 AM with Staff B, who stated she has worked at the facility for 1 month. When asked about used lancets that have come into contact with the resident's blood being disposed of in the resident's open trash container, she stated it is okay because there is no needle sticking out, it retracts. 3) On 12/03/24 08:24 AM, an observation was made of med cart on [NAME] unit with a Starbucks cup sitting on the side of the med cart in the section with the spoons, straws, cups and medication cups used for the residents. An interview was conducted on 12/03/24 at 8:26 AM with Staff B, who was asked about the Starbucks cup, on the med cart in with the spoons, straws, cups and medication cups used for the residents, she acknowledged that it was hers and said she needed her coffee, it probably should not be here.