STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105516	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Darcy Hall of Life Care	2170 Palm Beach Lakes Blvd West Palm Beach, FL 33409

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on interview and record review, the facility failed to honor a resident's choices related to showers for 1 of 3 sampled residents reviewed for choices (Resident #16). The findings included: A review of Resident #16's medical records revealed she was admitted to the facility on [DATE], with diagnoses to include Hemiplegia (paralysis of one side of the body) and Hemiparesis (one-sided muscle weakness) following a Cerebral Infarction (stroke), affecting the right dominant side, Muscle Weakness and Diabetes. A review of Resident #16's Quarterly MDS (Minimum Data Set) assessment documented her BIMS (Brief Interview for Mental Status) score as a 9, indicating moderate impaired cognition. The assessment (Section GG) documented Resident #16 is dependent on showers/bathing and she has upper and lower impairment on one side of her body. A review of care plans documented Resident #16 requires assistance by staff with showering and bathing. During an interview on 01/28/25 at 12:31 PM, Resident #16 was asked if she receives showers or bed baths. She stated that she wants a shower but only receives bed baths. She was asked when her last shower was, however, she could not recall. She stated that she had been telling everyone she would like a shower but has not received one. A review of Resident #16's task sheet for showering/bathing for the last 30 days (12/31/24-01/29/25), documented she received one shower in the last 30 days, which was on 12/31/24. The other 29 days documented she received a sponge bath. During an interview on 01/29/2025 at 1:00 PM with Staff E, CNA (Certified Nursing Assistant), she was asked if she works with Resident #16, and she stated yes. She was asked how she knew when to give this resident a shower. She stated, when she asks for one. Staff E, CNA was asked what Resident #16's shower days are, but she didn't know. The Surveyor and Staff E, CNA, went to Resident #16's room. The Surveyor asked the resident, Do you want someone to give you a shower?, she stated yes, I want it when you can do it today. The RN for Resident #16 was in the hallway and overheard the conversation, and responded by saying, we will get her one (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon request on 01/29/25 at 2:05 PM, the unit nurse presented the Surveyor with the shower assignment book, which included documentation that Resident #16 is assigned to receive a shower on Tuesdays and Fridays, on the 7:00 AM-3:00 PM shift.

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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** 36734 Based on record review and interview, the facility failed to document an accurate Advance Directive care plan for 1 of 39 sampled records reviewed (Resident #121). The findings concluded: Record review revealed Resident #121 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and was dependent for activities of daily living (ADL). The assessment further documented the resident was receiving hospice services. A review of Resident #121's care plan revealed a care plan dated [DATE] that documented the resident had an Advance Directive for CPR (Cardiopulmonary Resuscitation) and was a full code (a medical term that indicates a resident's preference for resuscitation and all life saving measures during a medical emergency). A review of Resident #121's orders revealed an order dated [DATE] for DNR (Do Not Resuscitate). Further review of Resident #121's records revealed a State of Florida DNR order form dated [DATE]. An interview was conducted with the Central Unit Manager (UM) on [DATE] at 12:00 PM. The UM stated the care plan for Resident #121 reflecting the resident being a full code, was entered in error.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, interviews, and record reviews, the facility failed to provide proper care and treatment, as evidenced by not providing a communication board, to maintain the resident's communication abilities for 1 of 1 sampled resident, Resident #75, reviewed for Activities of Daily Living (ADLs). The findings included: Record review revealed Resident #75 was admitted to the facility on [DATE]. The resident was admitted to Hospice Services on 08/02/24 with diagnoses that included Anxiety Disorder, Major Depressive Disorder, Persistent Mood Disorder, Panic Disorder, and Dementia. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident needed or wanted an interpreter to communicate with a doctor or health care staff. Resident #75 was dependent on assistance with activities of daily living which included care for incontinence. Review of Resident #75's care plans noted that she had a communication problem. The intervention for the communication problem since 05/21/23 was to have a communication board at the bedside as needed. An observation was conducted on 01/27/25 at 4:26 PM revealed Resident #75 was laying down in bed when she motioned for the surveyor to move closer to her. She requested assistance and pointed towards her incontinence brief. She said the words: water, water, and she lifted her right hand with extended fingers over the brief. She swept her fingers downward. The resident indicated she wanted her brief to be changed. Resident #75 then pulled her blanket off to expose her stomach and brief. The resident moved her open fingers in sweeping down motion over her brief and again said water, water. The surveyor suggested she press the call bell for assistance from nursing. Staff G, Certified Nursing Assistant (CNA), answered the call bell. After Staff G entered the room, during an interview with the CNA, the surveyor asked how she communicated with this resident. The CNA answered that Resident #75 spoke a different language, but she speaks to the resident in English. The resident lifted the plastic along the top edge of the brief. She moved her fingers above the brief and motioned from the top to the lower part of the brief. She said water, water. The CNA told the resident she was on her way to get her a drink of water when she heard the call bell. The CNA said that she would be back with water. The surveyor asked the CNA how she knew the resident wanted to receive water. Again, the resident motioned her fingers in the same way as before. With non-verbal communication, Resident #75 requested to be cleaned because she was wet. The CNA answered she would be right back with a drink of water. After the CNA exited the room, the resident threw her arms up in the air. There was no communication board observed in the resident's room. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 5:40 PM, Resident #75 was observed sitting in a wheelchair in the hallway just outside her bedroom door. Staff H, CNA, approached the surveyor and Resident #75. In an interview on 01/29/25 at 5:48 PM, Staff H was asked how she communicated with this resident, and responded the resident spoke some English. Staff H stated when she didn't understand the resident, she would ask the resident to try and clarify what she meant. The CNA said that she listened until she understood what the resident wanted. Resident #75 looked at the CNA and touched her fingertips to her mouth. She said the word food. The CNA excused herself and went to get her the dinner tray.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to address a skin condition in a timely manner for 1 of 1 sampled resident (Resident #27); failed to provide blood pressure medications as ordered, as evidenced by nurses randomly holding medications for a low heart rate, without parameters and failure to notify the physician of held medications for 1 of 1 sampled residents (Resident #45); failed to follow parameters for physician orders for blood pressure medications for 1 of 1 sampled resident (Resident #57); and failed to provide a pillow between the legs of a resident as ordered by the physician for 1 of 1 sampled resident (Resident #77), to prevent knee abduction and lower body contractures. The findings included: 1) Record review revealed Resident #27 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented that the resident was cognitively intact and was dependent for activities of daily living. Further record review revealed Resident #27 was care planned for potential for skin impairment related to fragile skin. A review of Resident #27's physician orders revealed an order dated 12/26/24, to apply Zinc to upper/lower back at bedtime for Heat Rash; an order dated 01/07/25 for Hydrocortisone Cream to upper/lower back every day and evening shift for Rash; and an order dated 01/07/25 for a dermatology consult (consultation) for rash to upper and lower back. An interview was conducted with Resident #27 on 01/28/25 at 11:00 AM in the resident's room. The resident stated his back had been itchy for about 3 weeks now. The resident stated they (staff) put cream on his back twice a day, but the cream only helps for a little while. Resident #27 further stated he was supposed to see a dermatologist for the itching, but did not know when. The resident stated he was in agony over the itching. An interview was conducted with Resident #27 on 01/30/25 at 10:00 AM. The resident stated his back was itching so bad that he could not take it. The resident stated they continue to put a cream on his back twice daily, but it is not working. An interview was conducted with Staff Z, a Licensed Practical Nurse, on 01/30/25 at 11:00 AM. Staff Z stated Resident #27 was being treated for a heat rash to his back with Hydrocortisone Cream (steroid) twice daily. Staff Z further stated the resident had a dermatology consult ordered, but did not know when he would be seen. Staff Z stated the Social Worker arranges the consultations. An observation of Resident #27's back was conducted with Staff Z on 01/30/25 at 11:30 AM. The resident had dried scaly patches to his back. Resident #27 stated he felt like he was being tortured as the itching was so bad. Again, the resident stated it had been going on for about 3 weeks now. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Service Director (SSD) on 01/30/25 at 12:00 PM. The SSD stated the dermatologist comes to the facility on ce a month, at different times. There was no set date. The SSD stated the dermatologist already came to the facility on [DATE] to see residents. The SSD stated Resident #27 was not on the list to be seen. The SSD acknowledged Resident #27's order for a dermatologist consult on 01/07/25. The SSD stated she did not put the request in for the dermatologist to see Resident #27 until 01/14/25. The SSD stated she believes that was when it was brought to her attention that Resident #27 had a consult ordered for a dermatologist. The SSD stated Resident #27 would not be seen by the dermatologist until next visit in 02/25, but did not have a set date. 25404 2) Review of the record revealed Resident #45 was admitted to the facility on [DATE]. Review of the current physician orders revealed the resident was prescribed two medications for high blood pressure, to include Amlodipine 2.5 mg (milligrams) once daily, and Lisinopril 10 mg once daily. Resident #45 was also prescribed Carvedilol 6.25 mg twice daily for Coronary Artery Disease. Further review of the orders lacked any type of blood pressure or heart rate parameters for holding any of the three medications. Review of the current January 2025 Medication Administration Record (MAR) revealed all three medications were held on 01/06/25 for the 9 AM dose because of the resident's heart rate of 55 beats per minute. The Carvedilol was held on 01/17/25 for the 5 PM dose, with a corresponding progress note that documented, hold per BP (blood pressure) value. The documented blood pressure for that administration was 124/59. Review of the December 2024 MAR revealed all three of the above mentioned medications were held on 12/06/24 at 9 AM, 12/07/24 at 9 AM, and 12/09/24 at 9 AM. The corresponding progress notes documented a heart rate of 57 on 12/06/24 but lacked any documented vital signs or rationale for the 12/07/24 and 12/09/24 held medications. Final review of the record lacked any notification to the physician for any of the held medication. During a side-by-side review of the record on 01/30/25 at 12:05 PM, the [NAME] Unit Manager was shown the held medications for Resident #45 and had no response. During an interview on 01/30/25 at 1:17 PM, the Director of Nursing (DON) agreed with the findings and that there were no parameters to hold the medications. 33103 3) Review of Resident #57's medical records revealed he was admitted to the facility on [DATE]. His diagnosis included Essential Hypertension, Encephalopathy, End Stage Renal Disease, Coronary Artery Disease and Type II Diabetes. A review of the resident's physician orders, and the current MAR (Medication Administration Record) revealed that Resident #57 had parameters for two of his medications that were not being followed. Further review of the physician orders dated 07/07/24 documented, Northera Oral Capsule 100 MG (Droxidopa) give 1 capsule by mouth three times a day for hypotension. Hold for SBP (Systolic blood pressure) greater than 120. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following times and dates documented the medication was given when it should have been held: 9:00 AM Dose: 01/09/25 with a B/P (blood pressure) of 132/85 01/13/25 with a B/P of 154/69 01/23/25 with a B/P of 130/70 01/25/25 with a B/P of 139/78 01/27/25 with a B/P of 168/92 01/28/25 with a B/P of 128/67 01/29/25 with a B/P of 121/71 1:00 PM Dose: 01/09/25 with a B/P of 141/52 01/13/25 with a B/P of 124/65 01/25/25 with a B/P of 139/78 01/27/25 with a B/P of 168/92 01/29/25 with a B/P of 124/73 5:00 PM Dose: 01/07/25 with a B/P of 149/88 01/10/25 with a B/P of 139/72 01/17/25 with a B/P of 130/65 01/18/25 with a B/P of 126/69 01/21/25 with a B/P of 144/74 A review of the physician's orders dated 03/29/24 and the MAR (Medication Administration Record) revealed documented medication with parameters including, Clonidine HCl Tablet 0.1 MG, give 1 tablet by mouth every 6 hours as needed for Hypertension for SBP (Systolic blood pressure) over 140, do not give on dialysis days. The following dates the medication was not given when the blood pressure was above 140. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/07/25 B/P 149/88 taken at 1700 01/21/25 B/P 144/74 taken at 1700 01/09/25 B/P 141/52 taken at 1300 During an interview on 01/30/25 at 7:16 AM, Staff F, LPN (Licensed Practical Nurse) stated she has worked at the facility for 3 months. Staff F reviewed the MAR with the Surveyor and was asked about the medication order and the parameters for Northera Oral for Hypotension. She stated that some patients have a fragile side, and their B/P can change rapidly. She was asked about the Clonidine PRN order that documented to give if B/P is over 140. She stated she would not give it if it was above 140. If it was 145, she said she would have the resident watch his salt intake. She stated that Clonidine is not a batch medication, and is usually given PRN (as needed), if the resident asks for it. Clonidine is not a batch medication. The surveyor asked her to elaborate what she meant by that remark; she said Tylenol is always on the MAR as a PRN med. She then said, I don't look for PRN"s unless I think the patient is in Jeopardy. She then said she was not aware he (Resident #57) had PRN medication. During an interview on 01/30/25 at 7:30 AM with the DON and the Regional Nurse Consultant they reviewed the MAR with the Surveyor, and both acknowledged the concerns with the two medications and the parameters. 50895 4) Record review revealed Resident #77 was admitted to the facility on [DATE]. Her diagnoses included Frontal Lobe and Executive Function Deficit following Nontraumatic Intracerebral Hemorrhage, Vascular Dementia, and Major Depressive Disorder. Review of the Minimum Data Set quarterly assessment dated [DATE], documented Resident #77 had one or more unhealed pressure injuries, and she had significant weight loss. Review of the Occupational Therapy Evaluation and Plan of Treatment dated 12/26/24, documented to use a pillow between the resident's knees to prevent knee adduction and lower body contractures. Documentation in Resident #77's medical record, dated 12/30/2024, revealed a doctor's order, that documented: Patient to use pillow between her leg to ensure wheelchair positioning. Calf pads and extenders for lower body position. Record review revealed that there was no care plan in place that corresponded to the doctor's order, and the goal stated in the Occupational Therapist's evaluation, to place a pillow between the legs to prevent knee adduction and lower body contractures. During an observation on 01/27/25 at 4:03 PM, Resident #77 was observed sitting in a high back wheelchair, in her bedroom. Observation revealed heel protection boots covered the resident's heels, and there were cushions on the resident's arm rests. Resident #77's knees were noted to be pressing against each other. There was no pillow in between her legs. During an observation on 01/29/25 at 5:05 PM, Resident #77 was observed sitting in a high back wheelchair, in her bedroom. Her knees were observed pressed together. There was no pillow in between her legs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/25 at 6:03 PM with Staff G, when asked how she knew when to place a pillow in between Resident #77's knees, she answered that sometimes CNAs (Certified Nursing Assistant) place pillows behind the resident's head and under the resident's arms. Staff G did not mention placing a pillow between the resident's legs or knees. In an interview with the Director of Rehabilitation (DOR) on 01/30/25 at 8:33 AM, she was asked what the process was when she sees someone in a wheelchair with their knees pressed together. The DOR stated that a therapist would evaluate a resident if it was reported to the therapy department. After the surveyor informed the DOR regarding the concerns for Resident #77, the DOR stated that Resident #77 was evaluated for a possible leg contracture. She revealed that the therapist determined the positioning of this resident's legs was mostly behavioral. Her recommendation was to train the staff regarding wheelchair positioning and to use a pillow in between the residents' knees. The DOR explained that the therapists encouraged the CNAs to use the recommended positioning for Resident #77 to keep her knees without touching each other.

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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** 36734 Based on record review and interview, the facility failed to discard narcotics/controlled medications in a timely manner for 2 of 8 sampled residents (Resident #64 and #124); and failed to reconcile narcotics, as evidenced by not documenting the medication administration on the Medication Administration Record (MAR) for 2 of 8 sampled residents (Resident #124 and #263). The findings included: A review of the facility's policy titled, Administration of Medication, last reviewed on 09/16/24, documented: Medication administration should be documented timely following the administration to the resident. 1. Record review revealed Resident #64 was admitted to the facility on [DATE]. A medication storage observation was conducted with Staff A, a Licensed Practical Nurse, of the Northwest medication cart on 01/29/25 at 4:00 PM. The observation revealed 6 medication packs of Lorazepam (anti-anxiety medication) for Resident #64 as follows: a. A medication pack of 3 pills of Lorazepam 0.5 mg. The pack was received on 02/02/24. b. A medication pack of 1 pill of Lorazepam 0.5 mg. The pack was received on 04/17/24. c. A medication pack of 3 pills of Lorazepam 0.5 mg. The pack was received on 05/08/24. d. A medication pack of 1 pill of Lorazepam 0.5 mg. The pack was received on 07/10/24. e. A medication pack of 3 pills of Lorazepam 0.5 mg. The pack was received on 08/03/24. f. A medication pack of 1 pill of Lorazepam 0.5 mg. The pack was received on 11/13/24. During the medication storage observation, Staff A could not explain why the 6 packets of Lorazepam for Resident #64 were in the medication cart. A review of Resident #64's Physician orders revealed an order dated 03/19/23 for Lorazepam 0.5 mg, give 1 tablet one time a day for dental cleaning for one day. Further review of Resident #64's Physician orders revealed an order dated 08/04/24 for Lorazepam 0.5 mg, give 3 tablets one time only for 1 hour prior dental procedure for one day. No other orders for Lorazepam were found. An interview was conducted with the Director of Nursing (DON) on 01/30/25 at 12:00 PM. The DON stated it appeared that the pharmacy kept sending packets of Lorazepam for Resident #64. The DON further stated the unused medication should have been returned to pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review Resident #124 was admitted to the facility on [DATE]. A medication storage observation was conducted with Staff A, a Licensed Practical Nurse, on northwest medication cart on 01/29/25 at 4:10 PM. The observation revealed a medication pack for Resident #124 of Lorazepam (anti-anxiety medication) 0.5 mg ,containing 16 pills. A side by side review with Staff A of Resident #124's Controlled Medication Utilization Record revealed Lorazepam 0.5 mg was removed for administration on 12/11/24 at 9:00 PM and 12/22/24 at 4:05 PM. A side by side review of Resident #124's Medication Administration Record (MAR) revealed no evidence of Lorazepam administered to the resident on 12/11/24 at 9:00 PM and 12/22/24 at 4:05 PM. Staff C acknowledged the above. A review of Resident #124's Physician orders revealed an order dated 07/22/24 to discontinue the Ativan (Lorazepam) 0.5 mg order. An interview was conducted with the Director of Nursing (DON) on 01/30/25 at 12:00 PM. The DON stated the unused medication should have been returned to pharmacy. 3. Record review revealed Resident #263 was admitted to the facility on [DATE]. Record review revealed an order dated 01/13/25 for Lorazepam 0.5 mg every 6 hours as needed for anxiety for 14 days. A medication storage observation was conducted with Staff D, a Licensed Practical Nurse, of Southwest med cart on 01/29/25 at 4:30 PM. A side by side review with Staff D of Resident #263's Controlled Medication Utilization Record revealed Lorazepam 0.5 mg was removed for administration on 01/19/25 at 5:20 PM and 11:00 PM, 01/20/25 at 9:00 AM, 01/21/25 at 9:00 AM and 9:00 PM, 01/22/25 at 9:00 AM and 5:10 PM, 01/23/25 at 9:00 AM and 4:46 PM, 01/24/25 at 9:10 AM and 5:15 PM, 01/25/25 at 9:00 AM and 4:17 PM, 01/26/25 at 9:00 AM and 4:41 PM, 01/27/25 at 9:42 AM and 4:37 PM. A side by side review with Staff D of Resident #263's Medication Administration Record (MAR), revealed no evidence of Lorazepam administered to the resident from 01/13/25 -01/27/25. Staff D acknowledged the findings.

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	105516	A. Building B. Wing	01/30/2025

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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. 25404 Based on observation and interview, the facility failed to ensure safe medication storage for 1 of 8 medications carts (D Unit) and 1 of 3 treatment carts (West Unit), as evidenced by these carts being left unlocked and unattended, with independently ambulatory residents noted. The findings included: 1) On 01/27/25 at 9:54 AM, the medication cart on the D Unit was observed unattended and the push in lock was not engaged. The lock was easily pulled out and the medication cart drawers were easily opened. The medication cart was filled with medications for the 22 residents residing on the D Unit along with the generic stock medications. While awaiting the arrival of a staff member, Resident #100 was observed independently ambulating in the hallway in front of the medication cart. There were no staff observed in the hallway of the D Unit. A few minutes later the Assistant Director of Nursing (ADON) came to the medication cart and agreed with the concern of the unlocked medication cart. On 01/27/25 at 9:58 AM, Staff A, Licensed Practical Nurse (LPN), returned to the medication cart and immediately tried to pull open the lock without using her key. When asked if there was a reason she did not lock the cart, the nurse stated, I swear I pushed the lock in. The LPN was questioned about the partially engaged lock previously observed and again stated she thought she had pushed in the lock all the way. At the time of the survey there were 14 independently ambulatory residents residing on the A, B, C, and D Units, all of which had access to the D unit medication cart. 2) On 01/27/24 at 1:34 PM, an unattended and unlocked treatment cart was observed in the hallway of the [NAME] Unit, which was the locked memory care unit (Photographic Evidence Obtained). Upon opening the treatment cart, numerous wound care supplies and medicated wound ointments were noted to include Santyl (an ointment used to debride wounds), Clobetasol (an ointment to treat itching and or psoriasis), Aspercreme (a lotion with Lidocaine for pain), Hibiclense (an antiseptic skin cleanser), Triamcinolone cream (a corticosteroid cream), and collagen powder. The cart also contained a box of curettes (sharp instruments used to mechanically debride a wound). There was no staff noted in the area of the treatment cart. Throughout the survey multiple cognitively impaired residents were observed ambulating or wheeling themselves up and down the hallway of the [NAME] Unit. The surveyor went to the [NAME] Unit nurses' station and reported the open treatment cart to Staff B, Registered Nurse (RN). The RN went to the treatment cart and acknowledged the findings. There were 19 cognitively impaired independently ambulatory residents on the [NAME] Unit, where the unlocked and unattended treatment cart was located.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 The facility failed to provide food in a puree form to meet the individual needs of residents for 3 of 17sampled residents (Resident #48, Resident #46, Resident #65) on a medically ordered pureed diet. The findings include: Review of the facility's Life Care Centers of America Policy, reviewed on 5/01/2024, documented the Pureed diet consists of foods that are easy to swallow because they are blended, whipped, or mashed until they are pudding-like texture. All foods on this diet should be smooth and free of lumps. (National Dysphagia Definition). The purpose of the pureed diet is designed to minimize the amount of chewing required and to facilitate the ease of swallowing food. This diet is designed for residents who have moderate to severe dysphagia, with poor oral phase abilities and reduced ability to protect their airway. 1). Record review revealed Resident #46's active diagnoses included Alzheimer's disease, and Dementia. A review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE], documented the resident's Brief Interview for Mental Status score was 99. This indicated that the resident was unable to complete the assessment. In addition, the MDS assessment noted that Resident #46 was rarely/never able to make herself understood. The diet was coded therapeutic and mechanically altered. A pureed diet is a mechanically altered diet. According to the Diet Type Report dated 01/27/25, Resident #46's Diet Order was a Regular diet, with Puree texture, and Nectar/ Mildly consistency fluids. During an observation in the small dining room on 01/27/25 at 11:48 AM, Resident #46 was provided with assistance with feeding. Review of the menu ticket documented the resident was to receive a pureed diet. The lunch listed on the menu for the pureed diet was pureed pepper steak, pureed rice, pureed cabbage, and pureed stir fry vegetables. Further observation of the meal revealed the pureed cabbage and rice was lumpy. 2). Record review revealed that Resident #48 was admitted to the facility on [DATE]. Resident #48's diagnoses included Alzheimer's disease and Oropharyngeal Dysphagia. The Minimum Data Set Annual assessment documented Resident #48 was on a mechanically altered diet. The Brief Interview for Mental Status was 99. This indicated that the resident was unable to complete the assessment. The diet order dated 12/04/2023 documented the resident was on a Regular diet, Puree texture, and Nectar/ Mildly consistency. The care plan dated 01/14/2019 documented Resident #48's nutritional risk was related to Alzheimer's disease, and dysphagia. An observation on 1/27/25 at 12:16 PM revealed Resident #48 in the [NAME] Unit Dining Room eating lunch. Review of the menu ticket documented the resident was to receive a pureed diet with nectar thick liquids. Resident #48 took a bite of the mashed potatoes served on her plate. The mashed potatoes were not smooth, and a large lump was noted in the serving. Further observation revealed the resident bit the lump of mashed potatoes in half, and spit half of the lump back onto her spoon. The resident then took a second attempt at eating the spoonful of mashed potatoes. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3). Record review of Resident #65's Minimum Data Set (MDS) Annual assessment dated [DATE], revealed the resident's active diagnoses included Cerebrovascular Accident, Transient Ischemic Attack, or Stroke, Dementia, Hemiplegia or Hemiparesis, and Aphasia. The score of the Brief Interview for Mental Status was 04. This indicated that the resident had severe cognitive impairment. In addition, the MDS assessment noted that Resident #65 was sometimes able to make herself understood. The diet was coded therapeutic and mechanically altered. A pureed diet is a mechanically altered diet. According to the MDS annual assessment, Resident #65 was dependent on assistance with feeding. According to the Diet Type Report dated 01/27/25, Resident #65's Diet Order was a Regular diet, with Puree texture, and Nectar/ Mildly consistency fluids. An observation on 01/27/25 at 1:03 PM revealed that Resident #65 was served lunch at the tray table in her room. Review of the menu ticket documented the resident was to receive a pureed diet. Observation revealed the meal plate contained pureed pepper steak, pureed rice, pureed cabbage, and pureed stir fry vegetables. Further observation of the meal revealed the pureed cabbage and rice was lumpy. During an interview with the Food Service Director (FSD) on 01/27/25 at 1:15 PM, the surveyor expressed concern that the pureed foods were not smooth. The surveyor requested a sample of the pureed lunch plate, which included pureed beef, pureed rice, pureed stir fry vegetables, and mashed potatoes were on the plate. When the surveyor informed the FSD that the pureed rice was not smooth, the FSD said, yes I see the bumps, they look like little pearls. When the surveyor tasted the pureed rice, it was not smooth and contained solid particles. The surveyor then tasted the pureed stir fry vegetables. Visible strands in the vegetables were observed. When asked why there were strands in the stir fry vegetables, the FSD answered, because they are vegetables. Photographic evidence obtained.

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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** 50895 Based on observation, interview and record review, the facility failed to accommodate a resident's food preferences and offer an alternative food option after the resident refused a meal, for 1 of 8 sampled residents reviewed for nutrition (Resident #18). The findings include: Record review revealed Resident #18 was admitted to the facility on [DATE]. Her diagnoses included Protein Calorie Malnutrition, Malignant Neoplasm of Breast and Anxiety Disorder. Review of Resident #18's Minimum Data Set quarterly assessment dated [DATE], documented the resident's Brief Interview of Mental Status score was 99, which indicated the resident was unable to complete the interview. She was noted to rarely/never understand, and rarely/never be understood. A nutrition intervention listed on Resident #18's care plan last revised on 01/23/25, was to provide and serve the diet as ordered. Record review of the Resident's Nutrition Care Plan dated 1/23/25, documented Resident #18 had increased needs for nutrition due to her diagnosis of Malignant Neoplasm of Breast. Her most recent weight on 01/22/25 was 119.2 lbs. Her weight decreased 11.6 lbs., 8.8%, since 12/24/24. A review of Resident #18's diet and food preferences listed on her meal ticket documented that she was on a mechanically altered diet, and her dislikes included mayonnaise, rice, and red meat. A review of the facility's recipe for turkey salad included mayonnaise. The Food Service Director provided the recipe to the surveyor upon request. An observation in Resident #18's room on 01/27/25 at 2:35 PM, revealed that her lunch plate contained a scoop of ground pepper steak, cut up stir fried vegetables, pureed rice, and mashed potatoes. The dislikes listed on her meal ticket showed no red meat and she disliked rice. During an observation on 01/27/25 at 5:39 PM, Resident #18 was observed sitting in her wheelchair near the tray table in her room. Her dinner plate had a scoop of turkey salad, sliced beets, and a scoop of bread puree. The resident consumed approximately 5% of her meal tray. A review of the facility's recipe for turkey salad, provided by the Food Service Director, revealed the recipe included mayonnaise, which was listed as a dislike on her meal ticket. During an observation on 01/28/25 at 5:20 PM, Resident #18's dinner was served. The meal plate contained ground Kielbasa (pork) with gravy, roasted potatoes, broccoli and carrots. A bowl of sliced peaches, coffee, milk, and diet soda were on her tray. The surveyor observed the resident pick up her bowl of sliced peaches and she slammed it down on the table. A Certified Nursing Assistant (CNA) observed the surveyor speaking to Resident #18 about food preferences. The CNA called for Staff I, a Registered Nurse, to attend to the issue. Staff I then entered Resident #18's room at 5:24 PM. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff I on 01/28/25 at 5:24 PM, when asked why she thought Resident #18 wasn't eating the dinner meal, Staff I answered, sometimes they say they don't want to eat and then they change their minds. Staff I stated that she will give the resident a Glucerna (nutrition supplement) to replace the meal. Staff I retrieved a carton of Glucerna and offered Resident #18 a sip of the supplement. During an interview with the resident's family member on 01/29/25 at 10:29 AM, the family member stated that [Resident #18] didn't like beef too much and that she was raised eating pasta, not rice. The family member stated she had previously communicated [Resident #18's] food preferences to the Registered Dietitian in the past. Photographic evidence obtained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50895 Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, sanitary conditions, and the prevention of foodborne illnesses. This had the potential to affect approximately 158 of 165 residents. The findings included: During the initial tour of the Main Kitchen on 01/27/25 at 10:13 AM, accompanied by the Food Service Director (FSD), the following was observed: 1. A personal backpack was observed on a shelf below the food preparation area. The backpack was resting on dishware. 2. In the dry storage room, a gray plastic bin was observed with dark colored sediment on the handle of the container, on the inside of the bottom of the container, and on the handles of at least four of the scoop serving utensils. 3. The Cleveland steamer had brown/red wet residue around the perimeter of the upper steamer and the upper exterior of the lower steamer. During a subsequent interview during the tour, the FSD acknowledged the findings. A tour of the nourishment room in the [NAME] Wing was conducted on 01/28/25 at 5:06 PM. The surveyor was accompanied by the DON. The following was observed and noted: 4. An opened plastic container of Med Plus 2.0 Nutritional Drink was on a shelf inside the refrigerator. There was no date written on the container to indicate the date that it was opened. The recommended storage and handling of this item, per the manufacturer's instructions, are to refrigerate the product after it is opened and to consume the drink within 4 days, if properly refrigerated. 5. An unlabeled styrofoam cup with liquid was on a shelf in the refrigerator. This had no product name, no resident's name, and no date. During a subsequent interview during the tour, the DON acknowledged the findings.