STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105572	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observation and interviews the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 3 wings in the facility, [NAME] wing. The findings included: On 05/28/24 at 9:53 AM, an observation was made in Resident #67's room of an offensive urine-like odor noted in the resident's room. On 05/28/24, a side-by-side observation of Resident #67's room bathroom was conducted with the Housekeeping Manager and District Housekeeping Manager. They both acknowledged the offensive odor. The Housekeeping Manager stated that the Certified Nursing Assistants (CNAs) inform them when the room has odors, they do use deodorizers, and clean the room as necessary. The District Housekeeping Manager stated they were aware of other rooms which are in their focus cleaning list and will add Resident #67's room to the list. On 05/30/24 at 1:00 PM, an observation was made of an overwhelming smell of urine in the hallway between rooms 60 to 62. An interview was on 05/28/24, at 9:55 AM with Staff E, CNA, who stated Resident #67 gets out of bed and walks to the bathroom to urinate and that he also urinates on the floor. Staff E stated that when the resident urinates on the floor, she puts a sheet over because his roommate goes to the bathroom also, and she then calls housekeeping to clean the floor. An interview was conducted on 05/30/24 at 1:10 PM with the District Manager of Housekeeping who stated he has worked for the company for [AGE] years. When asked about the strong urine like odor in the hallway between rooms [ROOM NUMBERS], he said the residents in the rooms are incontinent, have behavior issues, and are care planned for their behaviors. He acknowledged there was an odor and housekeeping clean the rooms several times a day with cleaners including enzyme cleaners. An interview was conducted on 05/30/24 at 1:15 PM with the Housekeeping Manager who stated she has worked at the facility for 5 years. When asked about the strong odor in the hallway between rooms [ROOM NUMBERS] she said it is an ongoing issue and they clean those resident rooms at least 3 times a day every day.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to properly document and thoroughly investigate an injury of unknown origin for 1 of 1 sampled resident reviewed for skin discoloration, Resident #120. The findings included: Review of the facility's policy, titled, Abuse Prevention Program, dated August 2022, included, in part, the following: These policies guide the identification, management and reporting of suspected, or alleged, abuse, neglect, mistreatment and exploitation. Injury of Unknown source: An injury should be classified as an injury of unknown source when all of the following criteria are met: No person observed the source of the injury. The resident could not explain the source of the injury. The injury is suspicious because of its extent or location. Procedure: The facility has implemented the following processes: The Administrator is responsible for designating an Abuse Coordinator. The designed shift supervisor is identified as responsible for immediate initiation of the reporting process. The Administrator, DON and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, abuse, neglect, and exploitation and misappropriation. Identification: Events of inquiries of unknown origin/source, such as suspicious bruising occurrences, patterns, and trends or other resident injury that may constitute abuse, neglect, or mistreatment are identified and thoroughly investigated, with appropriate reporting as indicated. Investigation: Investigation may include but may not limited to: Resident statements/interviews; Employee statements/interviews; Visitor statements/interviews; Observation of resident(s), staff, environment; Document review i.e. chart reviews, policy review, education programs, appropriate resource review. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review for Resident #120 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Cerebral Atherosclerosis, Alzheimer's Disease, Generalized Anxiety Disorder, History of Falling, and Chronic Kidney Disease. Review of Section C of the Minimum Data Set (MDS) dated [DATE], revealed Resident #120 had a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. Review of the Physician's Orders showed Resident #120 had an order dated 04/19/24 for admission to Vitas Hospice Healthcare on 03/23/24, with diagnosis of Cerebral Atherosclerosis; Seroquel Oral Tablet 50 mg (Quetiapine Fumarate), give 1 tablet by mouth at bedtime for Psychosis; Tylenol Oral Tablet 325 mg (Acetaminophen), give 2 tablet by mouth every 4 hours as needed for Pain; and Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, give 5 mg by mouth every 4 hours as needed for Pain. Review of the Care Plan dated 05/07/24 documented Resident #120 had Risk for falls or fall-related injury because of Gait/balance problems and a history of falls. The goals were to minimize the risk of falls and have no untreated fall-related injury. Interventions included: Encourage to wear Non-Skid socks / shoes when out of bed; Encourage resident when rising from a lying position, sit on side of bed for a few minutes before transferring / standing; Observe for side effects of drugs including but not limited to gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness and change of mental status; and Report to physician any side effects associated with the residents medication. During an initial tour of the facility conducted on 05/28/24 at 9:23 AM, the surveyor observed Resident #120 in her room in bed. She was awake and alert. Upon further inspection of the resident's face, a blue, purplish-like bruise was noted around her right eye to go to her right forehead and right temple. When this surveyor inquired about the bruise around the eye, Resident #120 appeared confused and stated that she could not recall why she had a bruise. Review of the Nurses Progress Notes dated 04/18/24 to 05/28/24 revealed no documentation of a fall event or report of a bruise for Resident #120. Review of Weekly Skin Assessments dated 04/21/24, 04/28/24, 05/05/24, 05/12/24, 05/19/24, and 05/26/24 documented, No New Areas of Skin Impairment for Resident #120. On 05/30/24 at 2:23 PM, an interview was conducted with Staff N, South Wing Unit Manager and a Registered Nurse (RN), who stated Resident #120 had a fall, but she was not working when the fall happened about a week ago. She acknowledged receiving report from the Vitas Hospice nurse that Resident #120 was doing okay and that the resident reported no pain. She also stated that she had yet to review the report or documentation of the fall event, but this information can be found in the electronic chart. After searching for the event report, Staff N acknowledged that no fall event had been reported and that there were no nurse progress notes for the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 3:35 PM, an interview was conducted with the facility's Director of Nursing (DON). She stated that she contacted Vitas Hospice, and Resident #120 had an incident on 05/17/24. The DON stated that she spoke with the floor nurse on duty that night. The floor nurse stated that she heard a noise coming from Resident #120's room. She went to check on the resident and found her sitting on her bed, and appeared to have bumped her head on the nightstand. She called Vitas Hospice and reported the incident to the Hospice team. The DON stated the floor nurse took Resident #120's vital signs, applied ice to the injury, and assessed the resident. She stated she did not document the incident nor file an incident report. The DON also stated that the Vitas Hospice nurse came in on 05/18/24 to assess Resident #120. An interview was conducted on 05/30/24 at 3:46 PM with Staff J, Licensed Practical Nurse (LPN). Staff J stated that on 05/17/24, she was working the 3-11PM shift, and around 10:00 PM, she was at the nurses' station when she heard a noise coming from Resident #120's room. She entered the room and found the resident sitting in bed, leaning to the right. She noticed the resident had a red spot above her right eye and assumed Resident #120 might have hit her head against the nightstand. She assessed the resident, who appeared okay. She stated that Resident #120 has always been confused but was alert and able to respond to her questions. Staff J stated that at 10:15 PM, she called her supervisor and directed Staff J to contact Vitas Hospice. The supervisor did not inquire about the incident report. Staff J acknowledged not documenting the incident in the nurse progress notes 05/17/24. On 05/30/24 at 4:21 PM, the facility's Assistant Director of Nursing (ADON) was interviewed. She stated that on 05/17/24, she worked the 7-3 PM shift. The ADON stated she was aware Staff J had mentioned that she called her, but she did not recall receiving a phone call. In addition, she stated that she went on vacation after her shift on 05/17/24 and returned to the facility on [DATE]. On 05/30/24 at 5:24 PM, an interview was conducted with Staff P, LPN. He stated that on 05/17/24, he was working the 11 PM-7 AM shift. During rounds, he noticed the bump on Resident #120's head and asked Staff J if she had reported it and if an incident report was filed because he would have to follow up. Staff J stated that she reported it to the supervisor, and Staff P was not concerned. There were no nurse progress notes documented from 05/17/24 to 05/18/24.

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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** 49060 Based on observations, interviews, and record review, the facility failed to initiate a comprehensive care plan for psychotropic medications with measurable objectives and interventions for 2 of 25 sampled residents, Resident #40 and Resident #63. The findings included: Review of the facility's policy, titled, Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, dated February 2024, included, in part, the following: The facility shall support that 'each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care'. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. 1, Record review for Resident #40 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Intraspinal Abscess and Granuloma, Generalized Anxiety Disorder, Depression, Chronic Pain Syndrome, and Paraplegia. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition was intact. Review of Section N revealed Resident #40 was on antianxiety, antidepressive, and opioid medications. Review of the Physician's Orders showed Resident #40 had an order dated 09/01/23 for Morphine Sulfate ER Oral Tablet Extended Release 60 MG (Morphine Sulfate), Give 60 mg by mouth every 8 hours for Non-Acute Pain; Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG (Duloxetine HCl), Give 60 mg by mouth two times a day for depression; Alprazolam Oral Tablet 0.5 MG (Alprazolam), Give 1 tablet by mouth every 12 hours for Anxiety Hold for sedation (dated 11/10/23); Side Effects Monitoring every shift: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes. Review of the Care Plan dated 04/08/24 noted no measurable objectives and interventions in place for psychotropic medications for Resident #40. Review of the Psych consultation dated 05/06/24 documented the following recommendations: Resident #40 is to continue the Duloxetine 60mg, Alprazolam 0.5mg; and will be monitored for mood or behavioral changes, efficacy, and side effects. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 9:55 AM, an interview was conducted with Staff B, Clinical Record Director (CRD). She stated that if a resident were on psychotropic medications, the care plan would include goals and interventions for behavior monitoring as per physician's order. Staff B also acknowledged that Resident #40 is on psychotropic medications and that his care plan did not include measurable objectives, interventions and timeframes for the psychotropic medications. 40153 2. Record review showed Resident #63 was admitted to the facility on [DATE] with diagnoses to include Dementia, Psychosis, and falls. Review of the physician's orders revealed an order for Olanzapine (an antipsychotic medication) Oral Tablet 5 milligrams at bedtime for Psychosis dated 01/17/24. Review of the care plan, initiated on 11/02/23, showed the following: The resident uses psychotropic medications related to antianxiety to manage anxiety and will have minimal side effects and no side effects of psychotropic medication. It further showed monitoring of side effects of Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes. An interview was conducted on 05/30/24 at 8:30 AM with Staff B and Staff C (care plan coordinators) who stated that when a resident is placed on antipsychotic medication, they will initiate a care plan with the title of Psychotropic Medication. Under that section of the care plan, there are usually interventions to monitor the side effects of any antipsychotic medication as well. They were asked regarding the anxiety under the care plan section of psychotropic medication. According to Staff B and C, they should have also initiated or updated the care plan under the psychotropic medication to reflect the antipsychotic medication that Resident #63 was on. An interview was conducted on 05/30/24 at 8:47 AM with the facility's Director of Nursing (DON) who was informed of the findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observation, record review and interview, the facility failed to ensure that residents receive wound care consistent with professional standards of practice for 1 of 1 sampled resident reviewed for wound care, Resident #48. The findings included: Review of the facility's document provided by the Director of Nursing (DON), titled, Clean Dressing Change Competency Checklist, documented, in part, .wash hands and apply gloves .remove dressing and discard, remove gloves, wash hands, apply gloves .clean wound using circular motion starting from the center toward the outside (clean to dirty) .remove gloves, wash hands, don gloves and apply treatment as ordered . Review of Resident #48's clinical record documented an admission on 06/07/19 and readmission on 04/02/24. The resident's diagnoses included Cachexia, Adult Failure to Thrive, Peripheral Vascular Diseases, Pressure Ulcer of Sacral Region and Chronic Pain Syndrome. Review of Resident #48's Minimum Data Set (MDS) significant change assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 7 indicating the resident had severe cognition impairment. The resident's MDS assessment coded Discharge with an anticipated return to the facility, dated 03/04/24 documented under Functional Abilities and Goals that the resident was dependent on the staff to complete most of the activities of daily living including personal care. Review of Resident #48's care plan titled The resident has an Actual Wound-Sacral pressure ulcer initiated on 08/22/23 and revised on 04/03/24 documented interventions to include: Air loss mattress .Treatment as ordered . Review of Resident #48's physician order dated 05/08/24 documented Cleanse Sacrococcygeal area with wound cleanser, apply Dakin's Full Strength solution to gauze, secure with adhesive daily and PRN (as needed) for dislodgement every night shift and as needed. On 05/30/24 at 11:10 AM, observation revealed Resident #48 in bed with an Air loss Mattress in placed. The mattress machine was turned Off. A side-by-side review of the machine was conducted with Staff K, Certified Nursing Assistant (CNA) and Staff G, Unit Manager (UM). Staff K stated she did not turn it off. Staff G turned on the mattress machine and stated it was supposed to be On. They both stated they did not know for how long the resident's air loss mattress was turned off. On 05/30/24 at 11:14 AM, wound care observation started for Resident #48 performed by Staff J, Licensed Practical Nurse (LPN) assisted by Staff K. Staff G, UM was present in the room for staff support. Staff J proceeded to gather wound care supplies, the bordered dressing, Dakin's solution full strength, and a wad of gauzes. Staff J performed hand washing, donned a gown and a pair of gloves. At 11:25 AM, Staff J stated the resident had a bowel movement, retrieved a few paper towels and cleaned the resident's bottom. Staff J applied wound cleanser to a gauze, cleaned the resident bottom, then removed the sacrum wound soiled dressing. Staff J applied wound cleanser to another gauze and wiped the resident's bottom again. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation revealed Staff J continued to wear the same pair of gloves, applied wound cleanser to a gauze, cleaned the wound surroundings and discarded the gauze, then applied wound cleanser to another gauze, cleaned the wound bed (inside the wound). Further observations revealed Staff J continued to wear the same pair of gloves, soaked another gauze with Dakin's solution and applied it to the wound bed. Staff J wore the same pair of gloves as worn for incontinent care as she did throughout the whole wound care procedure. Staff J, then with the same gloved hand proceeded to repositioned the resident's bed using the bed control. Consequently, an interview was conducted with Staff J, LPN, who stated she was supposed to change gloves before putting the treatment on Resident #48's sacrum wound and she did not. Staff J stated she was nervous having the supervisor in the room. On 05/30/24 at 11:40 AM, in a joint interview with Staff G and the DON, the DON was apprised of Resident #48's wound care observation findings. The DON stated they get nervous.

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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** 36057 Based on record review, observations, and interview, the facility failed to ensure staff followed proper indwelling (foley) catheter care consistent with accepted standards of practice; failed to insert the appropriate catheter size and failed to date the urinary drainage bag as per physician order for 1 of 1 sampled resident reviewed for urinary catheter care review during foley care provided for Resident #48. The findings included: Record review for Resident #48 documented an admission on 06/07/19 and readmission on 04/02/24. The resident's diagnoses included Cachexia, Adult Failure to Thrive, Obstructive and Reflux Uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), Chronic Kidney, Pressure Ulcer of Sacral Region, and Chronic Pain Syndrome. Review of Resident #48's Minimum Data Set (MDS) significant change assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 7 indicating the resident had severe cognition impairment. The resident's MDS assessment-coded Discharge with an anticipated return to the facility, dated 03/04/24 documented under Functional Abilities and Goals that the resident was dependent on the staff to complete most of the activities of daily living including personal care. Review of Resident #48's care plan, titled, Indwelling/Other Catheter: The Resident uses a Urinary catheter with risk for infection and/or complications related to: Obstructive Uropathy initiated on 07/24/20, revised on 04/03/24, documented care plan interventions that included: Catheter size 16 French, Change drainage bag routinely and as needed . Review of Resident #48's physician order dated 04/03/24 documented Urinary Catheter: Urinary catheter to drainage bag for Diagnosis of Obstructive Uropathy. Insert urinary catheter size #16F with 10 cc balloon . Review of Resident #48's physician order dated 04/03/24 documented Urinary Catheter: Change urinary catheter bag as needed. Change catheter bag as needed .Label with date. On 05/28/24 at 1:45 PM, a side-by-side observation of Resident #48's Foley (urinary) catheter was conducted with Staff H, Licensed Practical Nurse (LPN). Observation revealed the Foley tubing was not anchored to the resident's thigh and the tubing was across and underneath the resident's bed, Staff H acknowledged this placement. The urinary drainage bag had cloudy urine in it and the bag was not dated. Attempted to interview the resident and he answered only okay to all questions asked. On 05/30/24 at 8:29 AM, observation revealed Resident #48 in bed with his eyes open. Attempted to interview the resident and he stated okay to every question asked. Further observation revealed a drainage bag with approximately 200 cc (cubic centimeter) of cloudy urine. The bag was on a basin out of the privacy pouch on the right side of the resident's bed. The bag was not labeled with a date. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 10:46 AM, observations for Resident #48's Foley and pericare were performed by Staff K, Certified Nursing Assistant (CNA). Staff K performed handwashing, donned gown, gloves and retrieved two basins of water. Observation revealed Resident #48 assisting with turning to the side, the Foley catheter was a 18 French with 30 cc balloon, was not anchored to the thigh/leg and was observed being pulled from the penile opening as he was turning. Further observation revealed Staff K lifted the basin with the urinary drainage bag from the floor and placed it on top of the bed. Staff K proceeded to do Foley care. During an interview, Staff K stated that she always placed the basin with the urinary drainage bag on top of the bed while doing the care. Staff K was apprised that the resident's urinary bag cannot be above the bladder level to avoid urinary tract infection. The bag had approximately 100 cc of urine in it. Staff K was asked regarding anchoring the resident's catheter to his thigh and stated that the resident pulls the device. On 05/30/24 at 11:11 AM, a side-by-side observation of Resident #48's Foley catheter tubing was conducted with Staff G, Unit Manager. Staff G was apprised of the resident's Foley tubing not being anchored and the urinary drainage bag placed on the top of the bed during Foley care. Staff G stated that sometimes they do anchor the Foley, if the residents are moving around. Staff G was apprised that Resident #48 was able to move around in the bed and the staff reported that he likes to sit on the floor. Staff G was apprised that the catheter tubing was pulling during the care. Staff G stated that Staff K should not put the urinary drainage bag on top of the bed.

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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** 40153 Based on observations, interviews, and record reviews, the facility failed to provide nutritional interventions in a timely manner for 1 of 3 sampled residents reviewed for nutrition, Resident #63. The findings included: Review of the facility's policy, titled, Nutrition Assessment and Progress Note, dated January 2023, revealed, in part, the following: Initial nutrition assessment will be completed within 14 days of admission, and reassessment is completed quarterly, annually, and with significant change or readmission as needed. Record review showed Resident #63 was admitted to the facility on [DATE] with diagnoses to include Dementia, Psychosis, and falls. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #63 has a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive impairment. In an observation conducted on 05/30/24 at 9:03 AM, Resident #63 received her breakfast tray. The tray was filled with crispy bacon, cereal, fortified oatmeal, juice, and coffee. Review of Resident #63's recorded weights showed the following: 11/2/23, a weight of 128.4 pounds; 01/02/24, a weight of 124.6 pounds; 03/04/24, a weight of 126.4 pounds; 04/01/24, a weight of 124.2 pounds; and 05/07/24, a weight of 119 pounds. The Nutrition Evaluation Quarterly dated 01/30/24 showed the following: average meal intake above 50%, weight trending down, and Body Mass Index (BMI) at 20.7, which is lower than optimal. On this note, the facility's clinical dietitian recommended fortified cereal for breakfast and Mighty Shake (nutritional supplements) twice a day to stabilize weight and promote weight gain. Further review did not show that a follow-up nutrition quarterly assessment was completed after 01/30/24. A new weight was observed taken using a Hoyer lift on 05/30/24 at 10:50 AM which showed Resident #63 was at 117 pounds. This showed about 5.8% weight loss in a little over a month. No follow up notes or nutritional assessment were noted addressing the weight loss as above. The care plan dated 04/30/24 revealed Resident #63 has a nutritional or potential problem. It showed how to maintain nutritional intake and monitor weight for significant changes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Nursing Assistants' (CNAs) documentation of the percentage of meals consumed showed that from 05/16/24 to 05/29/24, Resident #63 ate the following: 4 meals between 25% to 50%, 9 meals between 50% to 75%, and 7 meals between 75% to 100%. An interview was conducted on 05/30/24 at 9:27 AM with the facility's clinical dietitian, who said she reviews all the weights for any weight changes daily. The residents not at high nutritional risk will be monitored quarterly, yearly, and as needed. She further said that a quarterly evaluation for Resident #63 was completed on 01/31/24, and the next one should have been done on 04/28/24 but for some reason, it was not triggered by the MDS to be seen Quarterly. The clinical dietitian stated that she recommended fortified cereal and nutritional supplements twice a day for breakfast and added them to the meal tracker. She should have followed up on Resident #63, looking at her weights and any significant changes, whether she drinks her supplements, and if she had any further decline in nutrition. Another interview was conducted on 05/30/24 at 12:00 PM with the clinical dietitian, who reported the quarterly follow-up on Resident #63 never triggered in the electronic system, which was why it was missed. She then said, I will go ahead and do a quarterly assessment on Resident #63.

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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** 36057 Based on observation, interviews and record review, the facility failed to ensure controlled substance medication reconciliations were accurate for 4 of 6 sampled residents reviewed during the controlled substance record review at the facility's west and south wings, for Residents #48, #82, #93 and #117; failed to obtain a physician's order for a psychotropic medication for Resident #93, reviewed for controlled substance use; failed to properly dispose of a controlled substance medication for Resident #117; failed to provide and document a scheduled medication as ordered for sampled Resident #83, as evidenced by it not being available; and failed to administer a scheduled medication to 1 of 3 residents observed for medicaiton administration, Resident #6. The findings included: Review of the facility's policy, titled, Medication Administration General Guidelines, with no revision date, provided by the Director of Nursing (DON) documented under documentation .the resident's MAR (Medication Administration Record) .is initialed by the person administering the medication .when PRN (as needed) medications are administered, the following documentation is provided: date and time of administration, dose, route .signature or initials of person recording the administration . Review of the facility's policy, titled, Medication Orders Controlled Substance Medication Orders, with no revision date, provided by the DON documented .each controlled substance medication order is documented in the resident's medical record with the date, time and signature of the person receiving the prescription 1. Review of Resident #48, clinical record documented an admission on [DATE] and readmission on [DATE], and had diagnoses that included Cachexia, Adult Failure To Thrive, Dementia and Chronic Pain Syndrome. Review of Resident #48's clinical record documented a physician order dated [DATE] for Ativan (Lorazepam) oral tablet 1 mg (milligram) *Controlled Drug* give 1 tablet by mouth every 6 hours as needed for Anxiety. Review of Resident #48's [DATE]'s Medication Administration Record (MAR) documented the resident received Ativan 1 mg on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review revealed the lack of a renewed physician order for Ativan 1 mg every 6 hours as needed for anxiety, as the medication order had expired 14 days after the original order of [DATE]. On [DATE] at 12:58 PM, a side-by-side review of Resident #48's Controlled Drug Declining Inventory Sheet was conducted with Staff J, Licensed Practical Nurse (LPN). The review revealed the resident's Controlled Drug Declining Inventory Sheet for Lorazepam 1 mg every 6 hours as needed for agitation was received from the pharmacy on [DATE] and there were 20 tablets left in the controlled substance box. Further review revealed the controlled substance was last removed from the box on [DATE]. During an interview, Staff J stated that any controlled substance removed from the box and administered to the resident, would be documented on the resident's MAR. (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 #48's Controlled Drug Declining Inventory Sheet received from the pharmacy by the facility on [DATE] for Lorazepam 1 mg (30 tablets), give one tablet every 6 hours as needed tablet was conducted. The sheet documented that one tablet of lorazepam 1 mg was removed from the controlled substances box on [DATE], [DATE] and [DATE], (the time of removal was unable to be read). Further review revealed that Lorazepam tablet was not initialed as administered on the resident's MAR on [DATE], [DATE] and [DATE]. The resident's controlled substance was not reconciled as required. On [DATE] at 9:31 AM, a side-by-side review of Resident #48's MAR's documentation and Lorazepam 1 mg Controlled Drug Declining Inventory Sheet for [DATE] was conducted with the DON. The DON acknowledged the lack of the reconciliation for the controlled substance medication for [DATE], [DATE] and [DATE]. 2. Review of Resident #82, clinical record documented an admission on [DATE] with no readmissions, and had diagnoses that included Alzheimer's, Adult Failure To Thrive, Generalized Anxiety and Chronic Pain Syndrome. Review of Resident #82's Minimum Data Set (MDS) admission assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS score of 0, indicating severe cognitive impairment. Review of Resident #82's clinical record documented a physician order dated [DATE] for Ativan (Lorazepam) oral tablet give 1 mg via G-tube every 4 hours as needed for Anxiety. On [DATE] at 2:18 PM, a side-by-side review of Resident #82's Controlled Drug Declining Inventory Sheet was conducted with Staff L, LPN. The review revealed the resident's Controlled Drug Declining Inventory Sheet for Lorazepam 1 mg every 4 hours as needed for anxiety was received from the pharmacy on [DATE]. During an interview, Staff L stated that any controlled substance removed from the box and administered to the resident, would be documented on the resident's MAR. Review of Resident #82's [DATE]'s MAR for Lorazepam 1 mg every 4 hours as needed revealed that one tablet was removed from the controlled substances box on [DATE] and was not initialed as administered on the resident April MAR's on [DATE]. The resident's controlled substance medication was not reconciled as required. On [DATE] at 10:18 AM, a side-by-side review of Resident #82's physician orders for Ativan (Lorazepam) 1 mg was conducted with the DON. The DON acknowledged that lorazepam 1 mg removed from the controlled box on [DATE] was not initialed as administered on the resident's MAR as required. The DON stated the controlled substance are to be documented in both places, the controlled sheet and the MAR. 3. Review of Resident #93's clinical record documented an admission on [DATE] with a readmission on [DATE], and had diagnoses that included Cerebral Infarction, Restlessness and Agitation, Anxiety and Bipolar Disorder. Review of Resident #93's MDS quarterly assessment dated [DATE] documented a BIMS score of 14 indicating no cognitive impairment. (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 #93's Controlled Drug Declining Inventory Sheet received by the facility from the pharmacy on [DATE] for Alprazolam 0.25 mg (26 tablets), give one tablet twice a day as needed for agitation, was conducted. The inventory sheet documented that one tablet of Alprazolam 0.25 mg was removed from the controlled substances box on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and on [DATE]. Further review revealed that Lorazepam tablet was not initialed as administered on the resident's June, July, August, September, October, [DATE] and [DATE]'s MAR on the above mentioned dates. The resident's controlled substances was not reconciled. The resident's [DATE]'s MAR documented Alprazolam 0.25 mg was initiated as administered on [DATE] at 1437 hours (2:37 PM). The medication was not documented on the resident's controlled drug declining inventory sheet as removed from the box. On [DATE] at 10:26 AM, a side-by-side review of Resident #93's Controlled Drug Declining Inventory Sheet dated [DATE] for Alprazolam was conducted with the DON. The DON stated that they do psychotropic meeting every third Wednesday with the Social Worker, the Psychiatrist and all the Unit Manager. She added she did not know how Resident #93's psychotropic medications got missed. The DON stated the physician order dated [DATE] read Alprazolam 0.25 mg every 12 hours as needed for agitation for 14 days - hold for sedation. The DON acknowledged that the resident received Alprazolam 0.25 mg during the month of June, July, August, September, October, [DATE] and on February and [DATE] without a physician order. During the review, the DON acknowledged that Resident #93's Alprazolam 0.25 mg removed from the controlled box on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE],[DATE], and [DATE] were not initialed as administered on the resident's respective MARs. 4. Review of Resident #117's clinical record documented an admission on [DATE] with no readmissions and had diagnoses that included Traumatic Subarachnoid Hemorrhage, Multiple Fractures and Gastrostomy tube. Review of Resident #117's MDS comprehensive assessment dated [DATE] documented a BIMS score of 9 indicating moderate cognitive impairment. Review of Resident #117's physician order dated [DATE] documented Ativan oral tablet 0.5 mg (Lorazepam) give 0.5 mg via PEG every 12 hours as needed for Anxiety for 14 days. On [DATE] at 1:03 PM, a side-by-side review of Resident #117's Controlled Drug Declining Inventory Sheet was conducted with Staff J, LPN. The review revealed the resident's Controlled Drug Declining Inventory Sheet for Lorazepam 0.5 mg by mouth every 12 hours as needed hold for sedation, was received on [DATE]. Review of Resident #117's Controlled Drug Declining Inventory Sheet received from the pharmacy by the facility on [DATE] for Lorazepam 0.5 mg give one tablet every 12 hours as needed documented that one tablet of lorazepam 0.5 mg was removed from the controlled substances box on [DATE], [DATE], [DATE], and [DATE]. Further review revealed that Lorazepam tablet was not initialed as administered on the resident's March and April's 2024 MARs respectively. The resident's controlled substances was not reconciled. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:51 AM, a side-by-side review of Resident #117's March, April and [DATE] MARs documentation and Controlled Drug Declining Inventory Sheet received by the facility on [DATE] for Ativan (Lorazepam) was conducted with the DON. The DON stated the resident had a physician order dated [DATE] for Ativan 0.5 mg via PEG every 12 hours as needed for Anxiety for 14 days. The DON stated she did not see any more order for lorazepam beside the one for [DATE]. The DON acknowledged that Lorazepam 0.5 mg tablets removed from the controlled substances box on [DATE], [DATE], [DATE], and [DATE] were not initialed on the resident's MAR. The DON stated the nurses were supposed to document on the MAR as well as in the controlled sheet. 5. Review of Resident #117's clinical record documented an admission on [DATE] with no readmissions, and had diagnoses that included Traumatic Subarachnoid Hemorrhage, Multiple Fractures and Gastrostomy tube. Review of Resident #117's physician order dated [DATE] documented Ativan oral tablet 0.5 mg (Lorazepam) give 0.5 mg via PEG every 12 hours as needed for Anxiety for 14 days. On [DATE] at 10:07 AM, a side-by-side review of Resident #117's Controlled Drug Declining Inventory Sheet dated [DATE] for Ativan (Lorazepam) 0.5 mg as needed for Anxiety was conducted with the DON. The DON stated that on [DATE] and [DATE], respectively, the nurses wrote on the sheet that a pill fell (unable to read the writing). The DON stated that they need two nurse signature for the controlled substance wasted tablets and that the controlled sheet did not have the two nurses signatures for the [DATE] and [DATE] tablets wasted as required. The disposal of two Lorazepam tablets, a controlled substance medication, was not completed as per the DON. 41837 6. Record review for Resident #83 revealed the resident was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses that included: Cerebral Infarction Unspecified, Malignant Neoplasm of Esophagus, Morbid (Severe) Obesity, Chronic Pain, Nausea with Vomiting, and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of the Minimum Data Set for Resident #83 dated [DATE] revealed in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #83 revealed an order dated [DATE] for Zofran Oral Tablet 8 MG (Ondansetron HCl) give 8 mg by mouth every 8 hours as needed for Nausea and Vomiting. Review of the Physician's Orders for Resident #83 revealed an order dated [DATE] for Zofran Oral Tablet (Ondansetron HCl) give 8 mg by mouth every 6 hours for Nausea and Vomiting. Review of the Medication Administration Record for Resident #83 for Zofran Oral Tablet give 8 mg by mouth every 6 hours for Nausea and Vomiting from [DATE] to [DATE] documented the following: On [DATE] at 12:00 PM, code 9 was documented indicating Other/See Nurse Notes On [DATE] at 6:00 PM, code 9 was documented indicating Other/See Nurse Notes On [DATE] at 12:00 PM, there was no documentation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:00 PM, code 9 was documented indicating Other/See Nurse Notes Review of the Medication Administration Record for Resident #83 for Zofran Oral Tablet 8 MG give 8 mg by mouth every 8 hours as needed for Nausea and Vomiting from [DATE] to [DATE] documented the following: [DATE], the medication was documented as given at 7:50 AM [DATE], the medication was documented as given at 10:30 PM [DATE], the medication was documented as given at 8:17 AM [DATE], the medication was documented as given at 10:44 AM Review of the Care Plan for Resident #83 dated [DATE] with a focus on the resident has a potential, current, or history of alteration in gastro-intestinal status related to GERD (Gastroesophageal Reflux Disease) and Epigastric Pain. The goals included: Manage Symptoms. Minimize risk of fall. Will have no untreated signs/symptoms (s/sx) of dehydration. The interventions included: Treat per Gastrointestinal symptom protocol. Observe/document/report to MD PRN for but not limited to: Nausea, Diarrhea, Vomiting, Abdominal Cramps, Rash, Fever, Swelling, Pruritus, tolerance to diet, tolerance to fluids, decreased urine output, hypotension, increased heart rate (Tachycardia), abnormal electrolyte levels. Diet as tolerated. (Refer to orders for current orders). Administer medication as ordered (Refer to orders for current orders)and observe for effectiveness. Observe/document for any precipitating factors. Minimize factors which increase the risk of episodes. Review of the Care Plan for Resident #83 dated [DATE] with a focus on the resident receiving Radiation related to Esophagus Cancer. The goal was for the resident to have no untreated s/sx of complications related to radiation therapy side effects through review date. The interventions included: Give medications and treatments as ordered. Observe/document for side effects and effectiveness. Observe nutritional status and intervene as indicated. Increase calories, protein PRN. Provide diet as ordered and encourage the resident to consume meal. Observe/document/report to MD PRN radiation therapy complications or side effects, including Anemia, Anorexia, Bleeding, Abnormal blood counts, Chills, Constipation, Diarrhea, Fatigue, Nausea/vomiting, Flu-like symptoms, Malaise, Hair loss, Stomatitis, Heartburn, Infection Lips dry, cracked, Mood problems, Muscle soreness, weakness, Peripheral neuropathy, Pain, Skin changes, Swallowing problems, Sore throat, Weight changes. Review of the Care Plan for Resident #83 dated [DATE] with a focus on the resident receiving radiation therapy r/t Cancer: Esophageal Cancer. The goals were for the resident's symptoms related to side effects will be improved or resolved by review date. The resident will have no untreated s/sx of complications related to radiation treatment side effects through review date. The interventions included: Give medications and treatments as ordered and observe for side effects, effectiveness. Observe nutritional status and intervene as indicated. Increase calories, protein PRN. Provide diet as ordered and encourage the resident to consume meal. Observe/document/ report to MD PRN radiation treatment complications or side effects, including Anorexia, Chills, Constipation, Diarrhea, Fatigue, Nausea/vomiting, Flu-like symptoms, Malaise, Hair loss, Stomatitis, Heartburn, Infection, Lips dry, cracked, Mood problems, Muscle soreness, weakness, Peripheral neuropathy, Pain , Skin changes (burns, irritation, rashes, redness, itching), Swallowing problems, Sore throat, Weight changes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 10:43 AM with Resident #83 who stated he is not getting his nausea medication, he got it today, but they often run out of the medication. He said he was without it for a couple of days before today. He said he gets nausea medications 4 times a day and really needs it since he had chemo and every time he eats he feels nauseous. An interview was conducted on [DATE] at 8:35 AM with Staff H, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 9.5 years. When asked if they ran out of medication, what the process was, Staff H LPN stated they would check if it were in the E-kit, they would get the medication from the e-kit, call pharmacy to reorder the medication. If the resident misses the medication for more than a day, they would notify the physician. When asked how they would document that the resident was not receiving the medication due to it not being available, she said they would 'document it to see notes and document what happened in the nurse progress notes'. An interview was conducted on [DATE] at 8:45 AM with the Staff Development Coordinator (SDC) who stated he has been working at the facility for 10 months. When asked, if they ran out of medication what the process was, the SDC stated they would call pharmacy for an emergency order to obtain med from E-kit or have it delivered to facility and call the MD (Medical Doctor). When asked how they would document the resident was not receiving the medication due to it not being available, the SDC said they would document what happened in the nursing progress notes. When asked if Zofran is in the E-kit, the SDC said it should be. 49060 7. Record review for Resident #6 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD), Morbid (Severe) Obesity with Alveolar Hypoventilation, Chronic Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia, Type 2 Diabetes Mellitus (DM), and Hypertensive Heart Disease with Heart Failure. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #6 had a Brief Interview for Mental Status of 15, indicating cognition was intact. Review of the Physician's Orders showed that Resident #6 had a physician order dated [DATE] that included Bupropion HBr ER Oral Tablet Extended Release 24 Hour Give 150 mg by mouth one time a day for Depression. Observation on [DATE] at 8:16 AM revealed Staff 1 prepared medications for Resident #6 but did not include the Bupropion HBr ER Oral Tablet Extended Release 24 Hour 150 mg medication. Review of the Medication Administration Record (MAR) for Resident #6 revealed that although Staff I did not administer the Bupropion HBr ER 150 mg Tablet medication to Resident #6, Staff I had signed the medication had been administered on [DATE]. Photographic Evidence Obtained.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record review, the facility failed to adequately monitor residents' behaviors for those residents receiving psychotropic medications for 4 of 25 sampled residents, Residents #63, #40, #99 and #113. The findings included: Review of the facility's policy, titled, Behavior Monitoring Record, dated October 2021, included in part, the following: Procedure 1. Enter the following information into electronic medical record. 2. Describe the specific behavior to be monitored. 3. Code the interventions determined to address the specific behavior. 4. Enter the frequency of the behavior on each shift. 5. Enter the letter code (or # code) of the intervention(s) chosen to address the behavior. 6. Enter the outcome code of the intervention(s). 1. Record review for Resident #63 revealed the resident was admitted to the facility on [DATE] with a readmission on 03/12/24 with diagnoses that included: Fracture of Unspecified Part of Neck of Left Femur, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance, Unspecified Psychosis Not Due to a Substance or Known Physiological Condition and Generalized Anxiety Disorder. Review of the Minimum Data Set (MDS) for Resident #63 dated 04/28/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 0 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #63 revealed an order dated 10/23/23 for Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V (Nausea and vomiting), Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes every shift Do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. Report changes to practitioner if needed. Review of the Physician's Orders for Resident #63 revealed an order dated 01/17/24 for Olanzapine Oral Tablet 5 MG give 5 mg by mouth at bedtime for Psychosis. Review of Medication Administration Record (MAR) for Resident #63 from 05/21/24 to 05/27/24 for side effect monitoring revealed the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24, NS (No Symptoms) were documented for the day and evening shift; a check mark was documented for the night shift. On 05/22/24, a check mark was documented for the day and night shift and NS was documented for the evening shift. On 05/23/24, a check mark was documented for the day and night shift and NS was documented for the evening shift. On 05/24/24, NS was documented for the day shift and a check mark was documented for the evening and night shift. On 05/25/24 to 05/27/24, all days had a check mark documented for the day, evening, and night shift. Review of Progress notes and E-MAR (Electronic Medication Administration Record) notes for Resident #63 from 05/21/24 to 05/27/24 revealed no side effects, behaviors, interventions, or outcomes documented. Review of the Task titled: Behavior Monitoring & Interventions for Resident #63 from 05/21/24 to 05/27/24 revealed the following: On 05/21/24, no documentation. On 05/22/24, no documentation. On 05/23/24 at 12:35 PM, documented hitting others, cursing at others, and scratching self with no intervention(s) documented. At 8:32 PM, documented resident not available, and at 11:58 PM documented no behaviors observed. On 05/24/24 at 12:24 PM, documented hitting others and accusing of others with no intervention(s) documented, at 8:39 PM documented resident not available, and at 11:31 PM documented no behaviors observed. On 05/25/24 at 1:03 PM, documented hitting others and accusing of others with no intervention(s) documented, at 10:59 PM documented no behaviors observed. On 05/26/24 at 1:30 PM and 2:59 PM, documented no behaviors observed. At 10:59 PM documented not applicable. On 05/27/24 at 12:04 AM and 11:50 PM, documented no behaviors observed, at 11:55 PM documented hitting others, accusing of others with no intervention(s) documented, and at 9:46 PM documented resident not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105572	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #63 dated 11/02/23 with a focus on the resident uses psychotropic medications r/t [related to] Antipsychotic medication to manage: Psychosis related to Dementia with behavioral disturbance and Anxiety Disorder. The goals were for the resident to have minimal side effects and to have no side effects of psychotropic medication. The interventions included: Psychotropic Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes. Administer medications as ordered. Observe/document for side effects and effectiveness. 2. Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Cerebrovascular Disease, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance, Schizoaffective Disorder, and Anxiety Disorder. Review of the MDS assessment for Resident #99 dated 04/22/24 revealed in Section C a BIMS score of 2 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #99 revealed an order dated 04/28/23 for Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes every shift Do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. Report changes to practitioner if needed. Review of the Physician's Order for Resident #99 revealed an order dated 01/04/24 for End of Life Care Hospice services for diagnosis of: Declining function. Review of the Physician's Orders for Resident #99 revealed an order dated 8/30/23 for Celexa Oral Tablet 20 MG give 20 mg by mouth one time a day for Depression Review of the Physician's Orders for Resident #99 revealed an order dated 01/18/24 for Lorazepam Injection Solution 2 MG/ML use 0.5 mg intravenously every 4 hours as needed for Anxiety Inject 0.5mg (0.25ml) Intravenously q4hrs PRN (use Subcutaneously if IV site not available) [every 4 hours as needed]. Review of the Physician's Orders for Resident #99 revealed an order dated 01/25/24 for Lorazepam Oral Tablet 0.5 MG give 0.5 mg by mouth every 4 hours as needed for Anxiety/agitation. Review of the Physician's Orders for Resident #99 revealed an order dated 01/25/24 for Quetiapine Fumarate Oral Tablet 25 MG give 25 mg by mouth two times a day for Anxiety/Agitation. Review of the Medication Administration Record (MAR) for Resident #99 from 05/21/24 to 05/27/24 for side effect monitoring revealed the following: On 05/21/24, NS was documented for the day shift; a check mark was documented for the evening and night shift. (continued on next page)

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Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24, NS was documented for the day shift, a check mark was documented for the evening and night shift. On 05/23/24, NS was documented for the day and evening shift and a check mark was documented for the night shift. On 05/24/24, NS was documented for the day and evening shift and a check mark was documented for the night shift. On 05/25/24, NS was documented for the day and evening shift and a check mark was documented for the night shift. On 05/26/24, NS was documented for the day and evening shift and a check mark was documented for the night shift. On 05/27/24, NS was documented for the day and evening shift and a check mark was documented for the night shift. Review of the Task titled: Behavior Monitoring & Interventions for Resident #99 from 05/21/24 to 05/27/24 included the following: On 05/21/24, no documentation. On 05/22/24 at 2:47 PM, documented not applicable. On 05/23/24 at 2:59 PM and 10:35PM, no behaviors observed. On 05/24/24 at 12:22 AM and 9:08 PM, documented no behaviors observed and at 2:43 PM documented not applicable. On 05/25/24 at 2:59 PM, documented no behaviors observed. ON 05/26/24 at 12:04 AM, 2:59 PM, and 10:28 PM, documented no behaviors observed On 05/27/24 at 6:47 AM, 2:21 PM, and 11:39 PM, documented no behaviors observed and at 9:52 PM documented not applicable. Review of the Care Plan for Resident #99 dated 10/17/23 with a focus on the resident is at Risk for falls or fall related injury because of: Cognitive impairment, Psychoactive drug use, frequent wondering, dx with Dementia, Anxiety Disorder, Depression and Schizoaffective Disorder. The goals were for the resident to participate in activities of choice and to minimize the risk of fall. The interventions included: Observe for side effects of drugs including but not limited to; gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness and change of mental status. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #99 dated 02/08/24 with a focus on the resident has a mood problem r/t Schizoaffective Disorder, Dementia, Anxiety, and Depression. The goals were to not harm others and to not harm self. The interventions included: Administer psychotropic medications as ordered Report missed or refused medication to physician (Missed doses can lead to an acute event & should be reported to the physician). Speak softly & clearly when communicating. Discuss procedures & mediations prior to administration. Psychiatry Services as needed. Psychological Services An interview was conducted on 05/31/24 at 8:35 AM with Staff H Licensed Practical Nurse (LPN) who stated she has worked at the facility for 9.5 years. When asked about residents receiving psychotropic medications, whether they monitor behaviors, side effects, and interventions, Staff H LPN said yes, they document the side effects on the MAR by indicating a NS for no symptoms and a check mark if the resident is having symptoms. And they would document the side effect, behavior, and any interventions in the progress notes. An interview was conducted on 05/31/24 at 8:45 AM with the Staff Development Coordinator (SDC) who stated he has been working at the facility for 10 months. When asked about residents receiving psychotropic medications, whether they monitor behaviors, side effects, and interventions, the SDC said of course. When asked where these are documented, he said on the MAR and also in the nursing progress notes. A telephone interview was conducted on 05/31/24 at 9:30 AM with the Consultant Pharmacist (CP) who stated that she has been working with the facility since May 2020. When asked if she reviews the medications for residents monthly, she said yes and that includes monitoring side effects and behaviors. The CP said she runs a report for behavior monitoring and none of the residents have behaviors. 3. Record review for Resident #113 revealed the resident was admitted to the facility on [DATE] with diagnosis that included Nontraumatic Compartment Syndrome of Left Lower Extremity, Schizoaffective Disorder, Major Depressive Disorder, Major Depressive Disorder Single Episode In Full Remission, Anxiety Disorder Due to Known Physiological Condition, and Insomnia Due to Other Mental Disorder. Review of the MDS for Resident #113 dated 04/08/24 revealed in Section C a BIMS score of 13 indicating a cognitive response. Review of the Physician's Orders for Resident #113 revealed an order dated 12/15/23 for Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes every shift Do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. Report changes to practitioner if needed. Review of the Medication Administration Record (MAR) from 05/21/24 to 05/27/24 to monitor side effects revealed the following: On 05/21/24, NS was documented for the day shift; a check mark was documented for the evening and night shift. On 05/22/24, NS was documented for the day shift; a check mark was documented for the evening and night shift. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/23/24, NS was documented for the day and evening shift, and a check mark was documented for the night shift. On 05/24/24, NS was documented for the day and night shift and a check mark was documented for the evening shift. On 05/25/24, NS was documented for the day shift and a check mark was documented for the evening and night shift. On 05/26/24, a check mark was documented for all 3 shifts (Day, evening, and night). On 05/27/24, a check mark was documented for all 3 shifts (Day, evening, and night). Review of the Task Behavior Monitoring and Intervention for Resident #113 reviewed from 05/21/24 to 05/28/24 included the following: On 05/21/24, no documentation On 05/22/24 at 6:59 AM, 2:59 PM and 11:32 PM, documented no behaviors observed On 05/23/24 at 1:21 PM, documented not applicable, at 10:49 PM and 11:40 PM, documented no behaviors observed On 05/24/24 at 10:11 PM, documented no behaviors observed On 05/25/24 at 6:59 AM, 10:59 PM and 11:35 PM, documented no behaviors, observed at 1:13 PM documented hitting others with no intervention(s) documented. On 05/26/24 at 2:59 PM and 11:59 PM, documented not applicable On 05/27/24 at 1:35 PM, documented hitting others with no intervention(s) documented and at 11:45 PM, no behaviors observed. Review of the progress notes and EMAR progress notes for Resident #113 for the month of May 2024 revealed no side effects or interventions for behaviors or side effects of psychotropic medications were documented for the physician ordered medications administered, as follows: a. 04/15/24, for Quetiapine Fumarate Oral Tablet 100 MG give 100 mg by mouth at bedtime for Schizoaffective Disorder. b. 04/15/24, for Quetiapine Fumarate Oral Tablet 100 MG give 1 tablet by mouth one time a day for psychosis. c. 04/15/24, for Citalopram Hydrobromide Oral Tablet 40 MG give 40 mg by mouth one time a day for Depression. d. 04/15/24, for Trazodone HCl Oral Tablet 100 MG give 2 tablet by mouth at bedtime for insomnia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. 04/17/24, for Alprazolam Oral Tablet 0.25 MG give 1 tablet by mouth two times a day for Anxiety. f. 05/22/24, for Hydroxyzine HCl Oral Tablet 50 MG give 1 tablet by mouth four times a day for Anxiety. Review of the Care Plan for Resident #113 dated 01/04/24 with a focus on the resident is noted with the following disorders that effect behavior: General Anxiety Disorder, Nicotine Dependence, Insomnia, Schizoaffective Disorder, Altered Mental Status, Psychoactive Substance Abuse and Depression. Behaviors include screaming at staff, verbally aggressive and yelling profanities at staff. The goal was for the resident to be informed of the risk/outcomes associated with preference of choice. The interventions included: Administer psychotropic medications as ordered. Report missed or refused medication to physician (Missed doses can lead to an acute event & should be reported to the physician). Allow time to communicate effectively. Discuss procedures & mediations prior to administration. Give clear explanation of all care activities prior to and as they occur during each contact. Document episodes of behavior & review to determine the effectiveness of intervention. 49060 4. Record review for Resident #40 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Intraspinal Abscess and Granuloma, Generalized Anxiety Disorder, Depression, Chronic Pain Syndrome, and Paraplegia. Review of Section C of the MDS dated [DATE] revealed that Resident #40 had a BIMS score of 15 indicating the resident was cognitively intact. Review of Section N revealed Resident #40 was on antianxiety, antidepressive, and opioid medications. Review of the Physician's Orders showed that Resident #40 had an order dated 09/01/23 for: Morphine Sulfate ER Oral Tablet Extended Release 60 mg, give 60 mg by mouth every 8 hours for Non-Acute Pain; Duloxetine HCl Oral Capsule Delayed Release Particles 60 mg, give 60 mg by mouth two times a day for depression; Alprazolam Oral Tablet 0.5 mg, give 1 tablet by mouth every 12 hours for Anxiety Hold for sedation (dated 11/10/23); Side Effects Monitoring every shift: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, Nausea & Vomiting, Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes. Review of the Psychiatry consultation dated 05/06/24 documented the following recommendations: Resident #40 is to continue the Duloxetine 60mg, Alprazolam 0.5mg, and will be monitored for mood or behavioral changes, efficacy, and side effects. Review of Tasks, titled, Behavior Monitoring and Interventions from 05/21/24 through 05/27/24, the following was noted: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/21/24 at 14:59 and 21:30: no behaviors observed. 05/22/24 at 11:45, 14:21, and 21:59: no behaviors observed. 05/23/24 at 4:41 and 22:52: no behaviors observed. 05/24/24 at 00:12 and 22:35: no behaviors observed. 05/25/24 at 15:03, 22:20, and 23:56: no behaviors observed. 05/26/24 at 14:37 and 23:17: no behaviors observed. 05/27/24 at 14:50 and 21:50: no behaviors observed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record review, the facility failed to address physician ordered 'As Needed' (PRN) psychotropic medications that had 'no stop date' in a timely manner for 3 of 25 sampled residents, Residents #48, #82, and #99. The findings included: Review of the facility's policy, titled, Use of Anti-Psychotic Medication, dated [DATE], included, in part, the following: To assess, monitor and manage a resident receiving an antipsychotic medication. PRN antipsychotic medications will be discontinued after the 14th day post the initial order. If the prescriber wishes to continue the medication: A face to face evaluation Documentation to include the reason the prn medication is required The benefit to the resident and ways in which the residents condition improved as a result of the prn This documentation must be in the medical record. 1. Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Cerebrovascular Disease, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance, Schizoaffective Disorder, and Anxiety Disorder. Review of the Minimum Data Set (MDS) assessment for Resident #99 dated [DATE] revealed in Section C a Brief Interview of Mental Status (BIMS) score of 2 indicating severe cognitive impairment. Physician order for Resident #99 dated [DATE] dcouemtned for Side Effects Monitoring: Agitation, Blurred Vision, Cardiac or Blood Abnormalities, Confusion, Constipation, Dry Mouth, Difficulty Urinating, Disturbed Gait, Drooling, Drowsiness, Headache, Hypotension, Involuntary movement of mouth, tongue, trunk or extremities, N&V (Nausea and Vomiting), Pacing, Seizure Activity, Stiffness of Neck, Sore Throat, Tremors, Rashes every shift Do not use if any side effects are present or resident appears to be lethargic, drowsy, or sedated. Report changes to practitioner if needed. Review of the Physician's Order for Resident #99 revealed an order dated [DATE] for End of Life Care Hospice services for diagnosis of :Declining function. Review of the Physician's Orders for Resident #99 revealed an order dated [DATE] Lorazepam Injection Solution 2 MG/ML use 0.5 mg intravenously every 4 hours as needed for Anxiety Inject 0.5mg (0.25ml) Intravenously q4hrs PRN (use Subcutaneously if IV site not available (ordered by the Attending Physician). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #99 revealed an order dated [DATE] for Lorazepam Oral Tablet 0.5 MG give 0.5 mg by mouth every 4 hours as needed for Anxiety/agitation (ordered by the Attending Physician). Review of Medication Administration Record (MAR) for Resident #99 from [DATE] to [DATE] documented Lorazepam 0.5mg tablet was administered as follows: On [DATE] at 8:20 AM On [DATE] at 9:00 AM and 4:39 PM On [DATE] at 5:00 PM On [DATE] at 4:28 PM On [DATE] at 8:10 AM Review of the 'Note To Attending Physician / Prescriber (Pharmacy Recommendations)' for Resident #99 from [DATE] to [DATE] revealed the following: a. On [DATE] - documented this resident is currently on PRN lorazepam 2mg/ml. Please evaluate current diagnoses, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the resident's medical record and indicate the duration for the PRN order. The Physician / Prescriber Response documented Pt (Patient/Resident) under hospice. Meds are managed by hospice. and was signed [DATE] by the PMHNP (Psychiatric-Mental Health Nurse Practitioner). b. On [DATE] - documented this resident is currently on PRN lorazepam 0.5mg. Please evaluate current diagnoses, behaviors and usage patterns and evaluate continued need. PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the resident's medical record and indicate the duration for the PRN order. The Physician / Prescriber Response documented Pt [Patient/Resident] under hospice. Meds are managed by hospice. and was signed [DATE] by the PMHNP. c. From [DATE] to [DATE], there were no recommendations or Notes To Attending Physician / Prescriber. Review of the Care Plan for Resident #99 dated [DATE] with a focus on the resident is at Risk for falls or fall related injury because of: Cognitive impairment, Psychoactive drug use, frequent wondering, dx with Dementia, Anxiety Disorder, Depression and Schizoaffective Disorder. The goals were for the resident to participate in activities of choice and to minimize the risk of fall. The interventions included: Observe for side effects of drugs including but not limited to; gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness and change of mental status. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #99 dated [DATE] with a focus on the resident has a mood problem r/t [related to] Schizoaffective Disorder, Dementia, Anxiety, and Depression. The goals were to not harm others and to not harm self. The interventions included: Administer psychotropic medications as ordered Report missed or refused medication to physician (Missed doses can lead to an acute event & should be reported to the physician). Speak softly & clearly when communicating. Discuss procedures & mediations prior to administration. Psychiatry Services as needed. Psychological Services A telephone interview was conducted on [DATE] at 9:30 AM with the Consultant Pharmacist (CP) who stated that she has been working with the facility since [DATE]. When asked about psychotropic medications if they can be ordered PRN (as needed), she said yes it needs to have a stop date and a rationale document for the need for PRN. The CP stated psychotropic medications as needed can only be ordered for 14 days then would have to be reordered. When asked if she reviews the medications for residents monthly, she said yes. When asked when she makes a recommendation to the physician as to the timeframe, she stated she would expect the physician to respond. She did not answer the question asked and said if she does not get a response from the physician, they would make the same recommendation the following month. An interview was conducted on [DATE] at 1:00 PM with the Director of Nursing (DON) who was asked regarding psychotropic medications ordered prn with no stop day, she said she was under the impression if the resident was on hospice services they did not need a stop date. 36057 2. Review of Resident #48's clinical record documented an admission on [DATE] and readmission on [DATE] with diagnoses that included Cachexia, Adult Failure To Thrive, Dementia and Chronic Pain Syndrome. Review of Resident #48's MDS significant change assessment dated [DATE] documented a BIMS score of 7 indicating the resident had severe cognition impairment. The resident's MDS assessment coded Discharge with an anticipated return to the facility, dated [DATE] documented under Functional Abilities and Goals that the resident was dependent on the staff to complete most of the activities of daily living including personal care. Review of Resident #48's clinical record documented a physician order dated [DATE] for Ativan (Lorazepam) oral tablet 1 mg (milligram) *Controlled Drug* give 1 tablet by mouth every 6 hours as needed for Anxiety. The physician order did not have a stop date as required for as needed psychotropics. Review of Resident #48's [DATE]'s Medication Administration Record (MAR) documented the resident received Ativan 1 mg on [DATE], [DATE], [DATE], [DATE] and [DATE]. The physician written prescription of [DATE] for Ativan 1 mg every 6 hours as needed for anxiety expired on [DATE], 14 days after it was ordered. Review of Resident #48's [DATE]'s Medication Administration Record (MAR) documented the resident received Ativan 1 mg on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review revealed the lack of a renemal physician order for Ativan 1 mg every 6 hours as needed for anxiety. The physician written prescription had expired on [DATE]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:28 AM, a side-by-side review of Resident #48's physician orders for Ativan (Lorazepam) 1 mg was conducted with the Director of Nursing (DON). The DON stated the last physician order for Lorazepam was written on [DATE]. The DON added that normally the medication would be discontinued because it was as needed, but because the resident was on hospice care, they do not discontinue as needed medication for the residents on hospice care. 3. Review of Resident #82, clinical record documented an admission on [DATE] with no readmissions, with diagnoses that included Alzheimer's, Adult Failure To Thrive, Generalized Anxiety and Chronic Pain Syndrome. Review of Resident #82's MDS admission assessment dated [DATE] documented a BIMS score of 0 indicating severe cognitive impairment. Review of Resident #82's clinical record documented a physician order dated [DATE] for Ativan (Lorazepam) oral tablet give 1 mg via G-tube every 4 hours as needed for Anxiety. The physician order did not have a stop date as required for as needed psychotropics. Review of Resident #82's [DATE]'s MAR documented the resident received Ativan 1 mg on [DATE], [DATE], and [DATE]. Further review revealed the lack of a renewed physician order for Ativan 1 mg every 4 hours as needed for anxiety. The physician written prescription had expired on [DATE]. On [DATE] at 2:18 PM, an interview was conducted with Staff L, LPN, who stated that she was not aware of having a physician order every 14 days for lorazepam as needed and added that when they were down to , d+[DATE] pills, they will call hospice for a new prescription. On [DATE] at 10:18 AM, a side-by-side review of Resident #82's physician orders for Ativan (Lorazepam) 1 mg was conducted with the DON. The DON stated the last physician order for Lorazepam was written on [DATE]. The DON added that normally the medication would be discontinued because it was ordered as needed, but because the resident was on hospice care, they do not discontinue 'as needed' medication for the residents on hospice care.

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Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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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** 49060 Based on observations, interviews, and record review, the facility failed to maintain medications and medication carts in a secure and sanitary manner for 2 of 3 medication carts observed during facility tours and medication administration opportunities; and failed to dispose of expired eyedrops as observed during medication storage tours. The findings included: Review of the facility's policy, titled, Storage of Medication, dated ,d+[DATE], included in part the following: Medications and biologicals are stored properly, following manufacturer or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: 1. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including requirements of good manufacturing practices established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock. Review of the facility's policy, titled, Medication Administration, General Guidelines, dated ,d+[DATE], included in part the following: Medication Preparation: 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Medication Administration: 17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A medication administration observation was conducted on [DATE] at 8:16 AM with Staff I for Resident #6. While preparing the prescribed medications, Staff I noted she did not have one of the scheduled medication for Resident #6. She stated that she had ordered the medication from the pharmacy, but it had yet to be delivered. Staff I then proceeded to place the prepared medications in the top drawer and went to the end of the hallway to speak to Staff G, Unit Manager (UM). Staff I left the medication cart unlocked. There were two residents within 5 meters from the medication cart and staff members were observed passing by. During this observation, Staff I was away from the unlocked medication cart for approximately 7 minutes. Upon returning to the medication cart, Staff I realized that she left the cart unlocked, did not address it with the surveyor, and continued to dispense the medications. 41837 2. On [DATE] at 9:50 AM, an observation was made of a medication (med) cart left unattended and unlocked outside of room [ROOM NUMBER]. An interview was conducted on [DATE] at 9:51 AM with the Development Coordinator (SDC) who was asked to check and see if the med cart was unlocked, he opened the top drawer full of medications and acknowledged the med cart was unattended and unlocked. The SDC stated it should not be left unlocked when the nurse steps away. An interview was conducted on [DATE] at 9:53 AM with Staff O, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 2 years. When asked if the med cart in the hallway in front of room [ROOM NUMBER] was assigned to her today, she said yes. She acknowledged she left the med cart unlocked and unattended. She stated she said she did not know how that happened. 36057 3. On [DATE] at 1:33 PM, a side-by-side review of the facility's South wing medication cart was conducted with the Staff Development Coordinator (SDC). The review revealed an over-the-counter Eye drop bottle with an expiration date on ,d+[DATE]. During the review, Staff N, Unit Manager (UM) interjected and stated that the staff found the eye drop bottle in the resident's room and it was removed from her, was not sure when it was removed, and was placed in the medication cart. Staff N stated the resident was using it while she had in the room. The expired bottle was given to the SDC for disposal. 4. On [DATE] at 1:40 PM, further side-by-side review of the facility's South wing medication cart with the SDC revealed one loose red round pill in the top drawer of the cart. Consequently, an interview was conducted with the SDC who stated there was not supposed to be any loose pills in the cart and added that he just checked the cart for that and did not see any loose pill prior to the review. 5. On [DATE] at 2:18 PM, a side-by-side review of the facility's South wing-medication cart #2 was conducted with Staff L, LPN. The review revealed one loose white oblong capsule in the second drawer. Staff L stated they should not have any loose pills in the cart. On [DATE] at 10:20 AM, during an interview, the Director of Nursing stated she was informed of the findings.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40153 Based on observations, interviews and record review, the facility failed to follow their menus to meet the nutritional needs of the residents for 1 of 2 observations completed in the main kitchen. This has the potential to affect 40 residents on a regular diet. The cnesus at the time of survey was 124 residents. The findings included: Review of the facility's menu cycle, week 2, 2024 diet menu, showed the following food items on the regular diet: 3 ounces of corn beef, 1/2 of braised cabbage, 1/2 cups of boiled new potatoes, dinner roll, and pudding parfait. In an observation conducted on 05/30/24 at 11:30 AM, Staff A, Cook, was observed plating a piece of corn beef on a regular diet plate during the lunch tray line. The surveyor proceeded to request the weight of the corned beef on the plate be taken. Continued observation showed the Food Service Manager (FSD) taking the weight of the corned beef using a facility's food scale. The corned beef measured 1 ounce, which was plated earlier by Staff A on the regular diet. Another piece of corn beef was taken and placed on the food scale, which measured 1 ounce as well. This revealed that the corn beef pieces were not meeting the 3 ounce serving size noted on the menu. During the observation, the Food Service Manager was heard instructing Staff A, You will need to put two pieces of corned beef on each plate for the regular diet. Two pieces of corned beef would have provided 2 ounces of corned beef, which would still not meet the 3 ounces of serving as per the facility's menu. On 05/31/24 at 2:00 PM, in an interview was conducted with the Food Service Manager, and he was infomred of the findings.

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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 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** 40153 Based on observations, interviews, and record review, the facility failed to provide food choices and preferences for 3 of 25 sampled residents during dining observations, Resident #28, Resident #64, and Resident #110. The findings included: 1. Record review showed that Resident #28 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a Brief Interview of Mental Status (BIMS) score of 15, indicating cognition was intact. In an interview conducted on 05/28/24 at 10:10 AM with Resident #28, she stated that they often make mistakes on her meal trays and do not give her the correct food items she requested. In an observation conducted on 05/29/24 at 9:00 AM, Resident #28 was in her room with the breakfast tray. The meal ticket on the tray showed the following food items: Two individual hard-boiled eggs Home fried potatoes Bagel with cream cheese A fruit plate. The continued observation showed a breakfast plate with a bagel and cream cheese, a fruit plate, and potatoes but no eggs. In this observation, Resident #28 stated that she did not get any protein served for her breakfast meal and that they could have provided her with other protein choices that she liked. 2. Record review showed that Resident #64 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], revealed Resident #64 had a BIMS score of 15, indicating cognition is intact. In an observation conducted on 05/29/24 at 12:35 PM, Resident #64 was noted with her lunch meal, which consisted of grilled chicken salad, Italian pasta salad, green salad with no dressing, iced tea, and a fruit cup. The meal ticket was noted with a green salad and dressing that needed to be provided. In this observation, Resident #64 stated that she did not eat her green salad because the dressing was not provided with it. 3. Record review revealed Resident #110 was admitted on [DATE]. The Quarterly MDS, dated [DATE], revealed Resident #64 had a BIMS score of 15 indicating cognition is intact. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 05/29/24 at 12:36 PM, Resident #110 was noted in her room with the lunch tray. Closer observation showed a meal ticket with the following: Regular diet, no pork, grilled chicken sandwich, Italian pasta salad, 4 ounces of ice cream, mighty shake of choice, and fortified pudding. Closer observation of the lunch tray showed that Resident #110 did not receive her fortified pudding or a mighty shake on the tray. In an interview conducted on 05/31/24 at 1:17 PM, the facility's Registered Dietitian (RD) stated that she periodically does tray audits to ensure the meal ticket matches the food items on the meal trays, but she is not in the facility every day. In an interview conducted on 05/31/24 at 1:20 PM with the Food Service Manager (FSM), he stated there is an end person at the end of the tray line who oversees that the food items match the printed meal ticket on the trays. He will also check the meal tickets to ensure the accuracy of the food items. In an interview conducted on 05/31/24 at 1:20 PM with the FSM, he was informed of the findings.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to provide the correct fluid restriction for 1 of 1 sampled resident reviewed for dialysis, Resident #58. The findings included: Record review revealed Resident #58 was admitted on [DATE] with diagnoses of End-Stage Renal Disease (ESRD) and dependence on dialysis. Review of the physician's orders revealed an order for 1200 milliliters (ml) of fluid restriction with a diet of 260 ml at breakfast, 240 ml at lunch, and 120 ml at dinner for a total of 720 ml a day, dated 01/18/24. Further review of orders revealed no water was to be left at the bedside, which was also dated 01/08/24. In an observation conducted on 05/29/24 at 12:58 PM, Resident #58 was in her room with her lunch tray that consisted of the following: 8 ounces of tea and 16 ounces of water noted in a white Styrofoam cup near the lunch tray. The meal ticket for Resident #58 stated the following: Renal diet, with fluid restriction of 720 ml a day and 8 ounces of tea for lunch. In this observation, Resident #58 was provided with 24 ounces of fluids instead of the correct 8 ounces of fluids for the lunch meal. In an observation conducted on 05/29/24 at 3:00 PM, Resident #58 was noted in bed with 16 ounces of water in a white Styrofoam cup on the side table. The surveyor asked Resident #58 if she drank from the cup, and she said, I do not remember. The surveyor asked if she was on a fluid restriction and she did not know. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #58 had a Brief Interview of Metal Status (BIMS) score of 09, indicating moderate cognitive impairment. The care plan dated 04/10/24 revealed fluid restriction and no water at the bedside. In an interview conducted on 05/31/24 at 7:28 AM with Staff G, Registered Nurse, she stated the Certified Nursing Assistants (CNAs) oversee providing water to all residents. They are supposed to look at the electronic system to make sure the resident is not under any fluid restriction. The nurse assigned to the resident will also tell the CNAs if the resident is on any fluid restriction to be on the safe side. Most CNAs who work in the unit are familiar with residents who are under any fluid restriction. In an interview conducted on 05/31/24 at 11:00 PM with Staff M, Certified Nursing Assistant, she stated that she was aware Resident #58 was on fluid restriction and she was not the one who gave Resident #58 extra water at the bedside.

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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. 40153 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 2 observations conducted in the central kitchen. The findings included: The first initial visit to the main kitchen was conducted on 05/28/24 at 7:25 AM. The following concerns were observed: 1. A round garbage can with an opened lid was noted in the food production area. 2. The floor around the food production area and behind the stove was noted with debris and dirt. 3. Another round garbage can with an opened circle created on top of the lid was noted in the food production area. 4. The reach-in refrigerator was noted with a large plastic container with a green lid that was not dated or labeled with the type of food inside. 5. The reach-in refrigerator had an internal thermometer located near the reach-in refrigerator indoors, which had an internal temperature of 51 degrees Fahrenheit (F) and not the recommended 40 degrees and below Fahrenheit for cold food items. 6. The reach-in refrigerator had an internal thermometer located near the back of the refrigerator indoors. Its internal temperature was 55 degrees Fahrenheit, not the recommended 40 degrees and below Fahrenheit for cold food items. 7. The reach-in refrigerator was noted with a metal container that needed to be dated or labeled with the type of food inside. 8. The walk-in refrigerator contained ravioli with a preparation date of 05/18/24 and a used-by date of 05/21/24. 9. The walk-in refrigerator contained a 10-pound package of ground beef that was very soft to the touch. Closer observation revealed that it was placed in the refrigerator on 05/23/24 and used by date on 05/27/24. 10. The walk-in refrigerator was noted with a plastic container labeled beef. Continued observation showed a preparation date of 05/27/24 and a used-by date of 05/27/24. 11. The dry storage area was noted with a box of instant food thickener, graham crackers, and sugar packets located on the floor near the back of the storage room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Continued observation revealed that Staff D, Dietary Aide, was working on the breakfast tray line and plating different food items with his bare hands. He then stopped the work on the tray line and adjusted the glass on his face. He continued plating food on the breakfast trays without washing his hands first. He was told of the findings in an interview conducted on 05/31/24 at 2:00 PM with the Food Service Manager.