STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105609	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Tamarac	5901 NW 79th Avenue Tamarac, FL 33321

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews, and record review, the facility failed to provide a wheelchair to a resident for mobility and to allow the resident to attend activities, for 1 of 1 sampled resident, Resident #13. The findings included: Record review revealed Resident #13 was admitted to the facility on [DATE] with the following diagnoses that included COPD (Chronic Obstructive Pulmonary Disease), Chronic Bronchitis, Depression, and Left Below the Knee Amputation (BKA). Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE], Section C revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of Section GG of this MDS revealed Resident #13 was dependent on some functional abilities such as toileting, dressing, transferring from bed to wheelchair (vice-versa), and changing positions from lying down flat on his bed to sitting up. Review of Physician's Orders dated 03/21/24 included notes for Resident#13 to participate in activities of choice 2 times weekly for the next review date, and to modify the daily schedule treatment plan as needed [PRN] to accommodate activity participation as requested by the resident. Review of Physical Therapy Evaluation on 03/21/24 showed the following Treatment Approaches: Therapeutic exercise, Neuromuscular re-education, and Therapeutic activities. The Goal was for Resident # 13 to improve ability to safely and efficiently transfer to and from bed to a chair (wheelchair) with maximal assist, and with ability to achieve maintain balance (Target 04/03/24). Further record review of Therapy Skilled Notes on 03/21/24 showed Resident # 13 received an assessment on Standard Activities of Daily Living (ADL), which indicated he needed assistance in functional activities such as moving out of bed, transferring from bed to wheelchair, toileting, and gait. Review of the Nurses' Notes dated 03/26/24 documented the following: Level of Consciousness (LOC): oriented to person, oriented to place; Mood: Status is pleasant; Behavioral problems are not noted; Oxygen is used via nasal cannula (NC); Physical Therapy/Occupational Therapy (PT/OT): assistance in Activities of Daily Living (ADL); Functional Status noted as generalized weakness. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 06/09/2024 at 11:30 AM, and 4:00 PM, Resident # 13 stated he does not know where his wheelchair is. He stated it has been missing for months now. He stated he had questioned both the morning and evening staff about his wheelchair status, but they did not give him any response. He added staff do not let him do anything especially activities outside his room. There was no wheelchair observed inside the resident's room. During observation on 06/10/2024 at 3:00 PM, Resident #13 was awake and still looking for his wheelchair. There was no wheelchair observed in the room. In an interview with an afternoon Staff B, Licensed Practical Nurse (LPN) at 12:00 noon, this surveyor asked if she knew where Resident #13'swheelchair was. Staff B did not respond. In an interview on 06/10/24 at 9:30 AM and 1:30 PM, Resident# 13 was asked about his wheelchair. He said he asked the staff several times, they gave him 'attitude', but no answer about his wheelchair. He added he wanted to go outside his room. There was no wheelchair observed inside his room. In an interview with Staff W, Certified Nursing Assistant (CNA), on 06/12/2024 at 3:06 PM, she stated that she does not know where Resident #13's wheelchair is. In an interview with the MDS coordinator on 06/11/24 at 4:00 PM, she did not know where the resident's wheelchair was. Review of March 2024 and May 2024 paper, titled, Daily Recreation Activity Participation Documentation, provided by the Director of Activities showed Resident # 13 as Absent (designated by Capital Letter, A), and Independent (designated by Capital Letter, I), in activities which included arts and crafts, singing/music, puzzles, spiritual/religious, etc. In an interview with the Director of Activities on 06/11/224 at 4:42 PM, she stated she has been working in the facility for a year. When asked about Resident # 13's participation in activities, she responded, she invited him every other day, but he refused. She did not provide any documentation of refusal. When asked about Resident # 13's missing wheelchair, she stated she does not know. When asked how Resident # 13 would go to activities if he does not have a wheelchair, she did not respond. A few seconds later, she stated her assistant knows Resident # 13 better. When asked when the assistant would be available for additional interview, she stated she is not available. Review of the resident's Electronic Health Record (EHR) revealed there was no evidence that these orders were followed or documentation of Resident # 13's refusal. Review of the Occupational Therapy (OT) notes dated 03/21/24 for Resident #13, they showed the Plan was for therapeutic activities, self-care management training, and wheelchair management training. When the surveyor asked the OT Director for documentation showing the above plan was followed for Resident # 13, she stated, she would provide them later. On 06/11/2024 at 3:30 PM, the Speech Therapist stated she found Resident #13's wheelchair and will deliver it to him soon. When this surveyor asked where she located the wheelchair, and why was it not with Resident #13, she did not say anything. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of another OT note dated 03/25/2024 revealed Resident # 13 actively participated with skilled interventions with maximal encouragement. The notes did not clarify what skilled interventions Resident #13 participated in specifically regarding to wheelchair management training. When OT Director was asked on 06/11/2024 at 2:30 PM to provide more Interventions, and Outcomes documentations during the months of April, May, and June 2024 for Resident # 13, she responded she would submit them later. No further documentation was provided to the surveyor by the end of the survey. In an interview with Physical Therapist (PT) Director on 06/12/24 at 1:30 PM, the surveyor asked where to locate the OT/PT Interventions and Outcomes during the months of April, May and June 2024, for Resident # 13 in the Electronic Health Records. She stated she would provide paper copies, but she was unable to locate them electronically. No further documentation was provided to the surveyor by the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interiors for residential rooms, community shower rooms, activity rooms, and common areas) located on First Floor West, Second Floor East, and Second Floor West. The findings included: During the resident screenings conducted by the surveyors on 06/09-10/24 and environment observation tour conducted on 06/11/24 at 9:00 AM, and on 06/12/24, accompanied with the Corporate Nurse Consultant and Corporate Director of Maintenance, the following were noted: 1. First Floor [NAME] Unit: a. 1500 Unit Community Shower Room: One of two hand wash sinks did not have running water and soiled gloves located in the sink basin, large rotting piece of wood (2 X 4 ') located on shower floor, three privacy curtains too short to promote privacy during bathing and toileting, shower stall floor soiled and heavily stained, and broken wall tiles (4). b. room [ROOM NUMBER]: Room floor soiled and stained, room privacy curtains (x 2) too short to promote resident privacy, room walls in disrepair and numerous large holes, and room base boards soiled and in disrepair. c. room [ROOM NUMBER]: bathroom floor soiled and black stains throughout, and portable over commode seat rust laden. d. room [ROOM NUMBER]: Privacy curtain (D -bed) too short to promote resident privacy, bathroom toilet requires re-caulking to the floor, bathroom floor soiled and heavily stained, and portable over commode seat rust laden. e. room [ROOM NUMBER]: Privacy curtain (D -bed) too short to promote resident privacy, and bathroom floor heavily soiled and stained. f. room [ROOM NUMBER]: Privacy curtains (D & W-beds) too short to promote resident privacy. g. Nurses Station: Station carpet floor heavily soiled and with numerous large black stains. h. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, 1/3 dresser drawers broken, and room wall room damaged and in disrepair. i. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, bathroom floor soiled and stained j. room [ROOM NUMBER]; Bathroom toilet requires re-caulking to the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. room [ROOM NUMBER]: room [ROOM NUMBER]; Bathroom toilet requires re-caulking to the floor, bathroom floor soiled and stained. l. room [ROOM NUMBER]: Pervasive room odor, bathroom floor soiled and stained, numerous black scuff marks to room walls, bathroom toilet requires re-caulking to the floor. 2. Second Floor East Unit: a. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy. b. room [ROOM NUMBER]: Bathroom walls in disrepair. c. room [ROOM NUMBER]: Room ceiling light not working, and privacy curtains (D & W-beds) were too short to promote resident privacy. d. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, sink requires re-caulking, and bathroom floor soiled and stained. e. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, and closet wall in disrepair. f. Two East Community Shower: Shower stall faucet will not shut off, room and shower stall floor soiled and stained, and emergency call cord wrapped around the wall handrail. g. Two East Nurse's station: There was an accumulation of dust on the air conditioning vents and the ceiling tiles around them. h. room [ROOM NUMBER]: Observed a brown smeared substance on the floor from the entrance to the room that led into the bathroom floor and was noted on the toilet seat as well i. room [ROOM NUMBER]: Room floor soiled and stained, broken dresser drawers (3), and privacy curtains (D & W-beds) were too short to promote resident privacy j. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, two unlabeled urinals on bathroom sink full of urine, and exterior of room chair was heavily worn. k. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy. l. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, dresser drawers broken (3/3), and room floor soiled and stained, corner wall frame protector located close to the bathroom was noted to be in disrepair and separated from the wall m. room [ROOM NUMBER]: Room walls damaged and in disrepair, bathroom floor soiled and stained, and bathroom toilet requires re-caulking to the floor. n. room [ROOM NUMBER]: Numerous holes (10) in room walls. o. room [ROOM NUMBER]: Pervasive room urine odor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Second Floor [NAME] Unit: a. room [ROOM NUMBER]: Bathroom floor numerous black stains, portable over-commode seat was rust laden, and privacy curtain (W-bed) to short to provide visual privacy for the resident. b. room [ROOM NUMBER]: Bathroom floor had numerous areas of black stains, toilet requires re-caulking, bathroom walls in disrepair, room floor and baseboards soiled, stained and in disrepair, and air condition caulking strip was off of the unit. c. room [ROOM NUMBER]: Toilet seat was loose, room walls and base board were soiled, stained and in disrepair, and privacy curtain (D & W - Beds) were too short to promote resident privacy. d. room [ROOM NUMBER]: Bathroom walls torn and in disrepair, room walls and base boards soiled and stained, and privacy curtains (W-bed) were soiled. e. room [ROOM NUMBER]: Bathroom floor in disrepair, soiled and stained, and portable over-commode seat was rust laden. f. room [ROOM NUMBER]: Offensive and pervasive urine odor in room. g. room [ROOM NUMBER]: Bathroom floor in disrepair with large area of buckling, privacy curtain soiled, and privacy curtain (W-bed) was too short to promote resident privacy. h. room [ROOM NUMBER]: Bathroom floor in disrepair with large area of buckling, toilet required caulking to the floor, room wall damage, and wall area around air conditioning unit was damaged. i. room [ROOM NUMBER]: Bathroom walls damaged and in disrepair. j. Two [NAME] Activity Room: Numerous areas of peeling and torn wallpaper, and exteriors of 2 room chairs were heavily worn. k. Two [NAME] Nurses Station: The walls around the station (3) were noted to have numerous large black scuff marks and there was an accumulation of dust on the air conditioning vents and the tils around them. l. Two [NAME] Nourishment Room: Exterior of refrigerator was soiled and worn, the ceiling air condition vent was dust laden, large area of damage to ceiling area, one ceiling light #1 not working, and ceiling light #2 large crack and broken light cover. m. Two [NAME] Community Shower: Three shower stalls (3/3) and 1 toilet (1/) area were not equipped with privacy curtains, and ceiling vent dust laden. n. room [ROOM NUMBER]: Room walls damaged and in disrepair, exterior of room chair was heavily worn, poor TV reception (W-bed), and large screws left in wall. o. room [ROOM NUMBER]: Large area of bathroom floor was buckled, stained and soiled, privacy curtains (D & W - beds) were too short to provide resident privacy, wheelchair arms (D-bed) were damaged and torn. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p. room [ROOM NUMBER]: Privacy curtains (D & W -beds) were too short to promote resident privacy. q. room [ROOM NUMBER]: Room walls damaged and in disrepair. r. room [ROOM NUMBER]: Room walls and baseboards damaged and in disrepair. s. room [ROOM NUMBER]: Bathroom floor damaged and in disrepair, exterior seat of room chair was stained, privacy curtains (D & W - beds) were too short to promote resident privacy, privacy curtains stained and soiled, and Geri chair seat was broken (D-bed). t. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, large area of ceiling stains and damage, 2 of 3 dresser drawers of track and would not close. u. room [ROOM NUMBER]: Toilet seat loose. v. room [ROOM NUMBER]: Privacy curtains (D & W-beds) were too short to promote resident privacy, bathroom floor soiled and stained, toilet requires re-caulking to the floor, and portable toilet commode seat was rust laden. w. room [ROOM NUMBER]: Privacy: curtains (D & W-beds) were too short to promote resident privacy, exterior of room chair was heavily worn, privacy curtain (A-bed) missing, and privacy curtains soiled and stained. Following the 06/11/24 environment tour, it was noted that the Corporate Maintenance Director stated that the facility has a computerized TELS that enables staff to document and report housekeeping and maintenance issues. It was further stated that facility staff are failing to utilize the system for the proper reporting of housekeeping and maintenance services. The surveyor requested that all environment concerns from the tours to be reviewed with the Administrator.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, interview and record review, the facility failed to ensure that it provided appropriate personal assistive care and services for 1 of 1 sampled resident observed for Activities of Daily (ADLs), Resident #68. The findings included: Review of the facility policy and procedure on 06/12/24 at 10 AM, titled, Bathing/Showering, provided by the Director of Nursing (DON) revised 09/01/17, documented in the Policy Statement: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference. Procedure .Identify resident. Explain procedure to resident .Escort resident to shower room and assure privacy .Document in the medical record. Record review documented Resident #68 was admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis, Acute Respiratory Failure with Hypoxia, Hypothyroidism and Muscle Weakness. He had a Brief Interview Mental Status (BIM) score of 15, indicating cognition was intact. Review of the Admission MDS Assessment, of 12/21/23, documented in section F, Preferences for Customary Routine & Activities, for Resident #68, that it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #68's care plan, for 12/21/23, documented the resident has limited physical mobility related to his Disease Process referring to his ambulation, locomotion, activities, range of motion and therapy only; and nothing specific to ADL care for this Resident. During an observational tour and interview conducted on 06/09/24 at 11:43 AM, Resident #68 stated to the surveyor that it was very bothersome / troubling to him that his shower days, which were originally on Mondays and Thursdays, were moved to the afternoon on Wednesdays and Saturdays. Resident # 68 stated that he has not had a shower in over a week. Resident #68 also said that no one even came back to ask him about having shower assistance, nor was it offered to him, even after he mentioned it directly to them the first time. Resident #68 said that he needs assistance and prefers his showers on Mondays and Thursdays during the day shift and mentioned one (1) Certified Nursing Assistant (CNA), Staff E, in particular by name, who works on the 7 AM to 3 PM shift every other weekend, according Resident #68. On 06/09/24 at 4:12 PM, an interview was conducted with Staff F, Licensed Practical Nurse (LPN) / Minimum Data Set (MDS) Coordinator, who was asked whether or not Resident #68 had a specific ADL care plan. Staff F reviewed the care plan and indicated that it does not include / pertain specifically to any personal ADL care and services for this resident. Staff F also stated that this care plan had been completed by part-time Staff G, Registered Nurse (RN) / MDS Coordinator, who also acknowledged the fact that Resident #68's care plan dated 12/14/23 primarily involved the resident's limited physical mobility as related to his general Disease Process, but not specifically to any personal ADL care and services for this resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the resident's shower schedule documented he is scheduled for a shower on Wednesday and Saturday evenings. Further record review of Resident #68's Task List shower schedule revealed that the resident's last documented shower had been on the previous week of Saturday 06/01/24 at 1:02 PM, on the day shift on the 7 AM-3:30 PM shift. It was documented that Resident #68 was given a bed bath, instead of a shower as per his evening 3-11:30 PM shift shower schedule, on Wednesday 05/29/24 at 10:59 PM, Wednesday 06/05/24 at 5:38 PM, and again on Saturday 06/08/24 at 6:53 PM. Further record review of the Resident's Task List shower schedule dated for 06/01/24 documented that Resident #68 had a shower at 1:02 PM, on the day shift, but Resident #68 maintained that he had not been showered in this facility since the previous week of Saturday 06/01/24. There is no documentation in the record to indicate that Resident #68 ever refused to have any showers while residing in the facility. On 06/10/24 at 11:03 AM, a subsequent interview was conducted with Resident #68, in which he stated that he has still not had a shower to this day for over 10 days. He reiterated this fact that the last time he had a shower was on Saturday 06/01/24. He said the previous Wednesday and the following past Wednesday was when he did ask one (1) of the CNAs about having a shower, but he indicated that the CNA said to him that it was not his day for a shower. Resident #68 stated again that his showers were originally on Monday and Wednesday mornings, then the schedule was changed to the evenings. Resident #68 stated he was unhappy with this, so the facility changed his showers to Wednesday and Saturday mornings, and Saturday 06/01/24 was the last one. He stated ever since then he only had two (2) showers and no more since then. On 06/11/24 at 9:50 AM, an interview was conducted with Resident #68, who he stated he has still not had a shower to this day for over ten (10) days, and that Staff E, who normally works with him said that she would be in tomorrow, Wednesday, to give him a shower on her normal workday of every other Wednesday. On 06/11/24 at 10 AM, an interview was conducted with the facility's Regional Nurse, regarding the resident's showers, who stated the schedule is set according to the resident's preferences, they pick their own days and times. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/11/24 at 3:14 PM with the assigned Staff H, CNA, who worked Wednesday 05/29/24 evenings 3 PM-11 PM shift and Saturday 06/08/24 evenings 3 PM-11 PM shift, Staff H was asked, according to the resident's (assigned) shower schedule for Wednesday and Saturdays, was he assisted or provided a shower or a bed bath on 05/29/24. Staff H responded, a bed bath. When asked if his preferences for a shower were honored that day, Staff H stated the morning CNA should have been charting when she gave him a shower because she said that the morning CNA tells her when she gives a shower to the Resident. Staff H stated the resident was given a bed bath instead of a shower, as per his schedule because the resident preferred to have a shower in the morning. The CNA stated that when Resident #68 was upstairs on another unit, he had always wanted his showers in the morning because he had more energy, and when he moved downstairs, she said that he wanted to keep this schedule. Staff H noted that Resident #68's shower schedule days were still reflected as Wednesdays and Saturdays in the evenings. Staff H was also asked if it was important for staff members to ask, honor and clarify a resident's preferences and she responded, yes. Staff H acknowledged the last documented shower for this resident was between the dates of Monday 05/27/24 and Saturday 06/08/24 was only one (1) time, when it should have been a total of three (3) times. On 06/11/24 at 3:38 PM, a telephone interview was conducted with Staff E, CNA, who works on the 7 AM to 3 PM shift every other weekend for the past two years, with the DON present. Staff E stated that she did not work on Wednesday June 5th nor on Saturday June 8th. She said that she did work on Saturday 06/01/24 on the day shift. She said that she assisted Resident #68 with a shower on that day, which was the last day that she showered him. Staff E stated Resident #68 was supposed to shower twice a week Wednesday and Saturday. She said that he used to be scheduled on the evening shift, but he told her that he was not getting showers in the evenings, and he wanted to change this schedule to the mornings. She further reiterated and acknowledged that the last documented shower for Resident #68 occurred between Monday 05/27/24 and Sunday 06/09/24, and he only one shower during this time, when it should have been three (3). The documentation and interviews confirmed that the two (2) CNA revealed that the daytime staff indicated that the evening staff were providing Resident #68's showers, while in turn, the evening staff indicated that the daytime staff were providing Resident #68's showers. Resident #68 had only received one (1) shower from Monday 05/27/24 and Sunday 06/09/24 during his facility stay, and per Resident #68's own verbal account. Resident #68 was not provided a shower again in the facility, until after surveyor intervention. The DON further recognized and acknowledged on 06/11/24 at 4:30 PM that Resident #68 was given a bed bath on three (3) different occasions (Wednesday 05/29/24, Wednesday 06/05/24, and again on Saturday 06/08/24) instead of a shower, as per his schedule. The DON acknowledged that it was important for nursing staff members to ask, honor and clarify a resident's preferences and to provide assistance with ADL shower care.

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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 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** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to follow appropriate care and services for 1 of 1 sampled resident observed during a Foley catheter and peri care observation, Resident #8. The findings included: Review of the facility policy and procedure on 06/11/24 at 1:02 PM, titled, Perineal Care, provided by the Director of Nursing (DON), revised 09/05/17, documented, in part, in the Policy Statement: .provide privacy . Perform hand hygiene . Review of the facility policy and procedure on 06/11/24 at 1:26 PM, titled, Urinary Catheter Care, provided by the Director of Nursing (DON), revised 09/05/17, documented, in part, in the Policy Statement: .Provide privacy .Perform hand hygiene .Put on gloves. Remove catheter securement device while maintaining connection with drainage tube .Reattach catheter securement device .Perform hand hygiene. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included Neuromuscular Dysfunction of Bladder, Peripheral Vascular Disease, Hypertension, Multiple Sclerosis, Major Depressive Disorder, Seizures, Polyneuropathy and Muscle Weakness. She had a Brief Interview Mental Status (BIM) score of 15, indicating cognition was intact. Record review for 05/08/24 revealed Resident #8's care plan had a documented Focus for: The resident has a Foley catheter: Neurogenic Bladder. Interventions / Tasks: .Check tubing for kinks each shift .Monitor / document for pain / discomfort due to catheter .Position catheter bag and tubing below the level of the bladder . On 06/11/24 at 10:50 AM, Peri-care and Foley catheter care observation was conducted by Staff I, Certified Nursing Assistant (CNA). Staff I was observed gathering her pre-bagged supplies. She had initially dropped the bagged towels and supplies in the garbage can next to Resident #8's bed. Staff I closed the privacy curtain, but she left the door to the resident's room wide open. Staff I then began to perform Resident #8's pericare without first donning a gown. Staff I was observed placing Resident #8's Foley catheter on top of her bed above the level of her chest and left the Foley bag in that position throughout the entire observation. Staff I proceeded to take the resident's basin and fill it water from the sink. During the observation, Resident #8 was not observed with a Foley catheter strap and anchor in place to secure her Foley catheter. There ws no physician's order for a anchor or strap. Photographic Evidence Obtained. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff I was observed using a washcloth folded in four parts to which she added soap and washed Resident #8's peri-area, using different sections of the cloth to wash the outer and inner peri-area. Staff I turned Resident #8 over and washed the bottom area using different sections of another washcloth while motioning as if she was done. Staff I was reminded that Foley care was also requested to be observed. Staff I asked the two surveyors to provide her with some towels. She was told that we were only there to observe what she usually does all the time. Staff I was then observed using the same pair dirty gloves that she cleaned Resident #8's perineal area. She then proceeded to touch the bedside dresser, Resident #8's table and dresser across from the resident's bed without first removing those gloves, and without washing her hands and applying a new pair while she searched for additional towels and supplies. Staff I then asked the two surveyors if she could leave the room to get additional supplies, but she was again told that we were only there to observe what she usually does and that we could not tell her what to do. Staff I then left Resident #8's bedside to go out into the hallway. At this time, she was again observed touching all the following surfaces, without any type of hand sanitation and no protective gloves: the clean linen cart and the inside of her red blouse, in an effort to fix her bra. During this time, Staff I was observed leaving Resident #8's bed in high position while leaving the resident unattended on the far-right corner edge of her bed to obtain additional supplies outside of Resident #8's room. After returning to Resident #8's room, Staff I began to do Foley catheter care, without first donning a gown. Staff I then took Resident #8's basin into the bathroom to change the water, without protective gloves and she touched the faucet to wash the basin in the sink. The CNA was observed putting on a clean pair of gloves, without first sanitizing or washing her hands, to take the basin back to Resident #8's bed. Staff I was observed using a washcloth folded in four parts, added soap to the washcloth and performed Foley care for the resident. She was observed wiping the area with different parts of the washcloth and holding the Foley catheter tubing in place while she cleaned from the base out. Staff I was observed wearing the same dirty gloves that she cleaned Resident #8's peri-area and then she proceeded again to touch multiple surfaces in Resident #8's room, cross-contaminating them all. Staff I then removed those dirty gloves and sanitized her hands. Following the Peri-care and Foley care procedure, Staff I was asked to check in the resident's room for Resident #8's Foley catheter leg strap and anchor. There was no Foley catheter leg strap and anchor noted anywhere at Resident #8's bedside or in her room, to use as an anchor her Foley catheter that was in place. During a brief interview conducted on 06/11/24 at 11:10 AM with Resident #8, shortly after the peri-care and Foley care observation, Resident #8 was asked if she ever had or wore a Foley catheter strap and anchor for her Foley. She responded, no, she had not. On 06/11/24 at 11:18 AM, an interview was conducted with both Staff A, RN and with Staff I, CNA, in which they were informed of the peri-care and Foley care observation concerns and they both acknowledged that during Peri-care and Foley care that Staff I was not well prepared, and she should have followed appropriate procedures including wearing a gown, changing gloves and hand hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 12:10 PM, in an interview with the Director Of Nursing (DON), the DON recognized and acknowledged the CNA should have been better prepared, and she should have utilized appropriate infection control techniques throughout the procedure and this was not done.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on record review and interview, the facility failed to ensure residents received ongoing communication and collaboration with the dialysis center, for 1 of 1 sampled resident, Resident #106, reviewed for dialysis, regarding dialysis observation, care and services. The findings included: Record review of Resident #106 on 06/11/24, noted a re-admitted [DATE] to the facility with diagnoses that included Chronic Kidney Disease and Altered Mental Status. It was also noted that the resident receives in-house dialysis three times per week (M/W/F) (Monday, Wednesday, Friday). Review of the current MDS dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, and is independent in Activities of Daily Living (ADLs). Review of the Hemodialysis Communication Record noted that the assessment forms did not have the proper documentation on them by the facility (prior to leaving and on return to the facility) and by the dialysis center. The findings for the dialysis visits' documentation forms included the following: a. 6/10/24: *Facility Prior: Failure to document time of transfer to the dialysis center. *Dialysis Center: Failure to document pre and post dialysis weights, no lab values, and no finish time documented. *Facility Post: Failure to document time of return from the dialysis center, and no documentation of return shunt site observation. b. 06/05/24: *Facility Prior: Failure to document time of transfer to dialysis center. *Dialysis Center: failure to document pre and post dialysis weights, shunt site observation, dialysis center information, no lab values, and dialysis finish time. *Facility Post: Failure to document shunt site observation and time of return from dialysis. c. 06/03/24: *Facility Prior; Failure to document medications administered prior to dialysis, and time of transfer to the dialysis center. *Dialysis Center: Failure to document per and post dialysis weights, shunt site observation, dialysis center information, and dialysis finish time. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Post: Failure to document shunt site observation, and time of return from the dialysis center. d. 05/31/24: *No documented completion of the Hemodialysis Communication Record. e. 05/29/24: *No documented completion of the Hemodialysis Communication Record. f. 05/27/24: *No documented completion of the Hemodialysis Communication Record. g. 05/24/24: *No documented completion of the Hemodialysis Communication Record. h. 05/22/24: *No documented completion of the Hemodialysis Communication Record. i. 05/20/24: *Facility Prior: No documentation of medications administered prior to dialysis, no shunt cite observation, no time of transfer to dialysis. *Dialysis Center: No documentation of pre and post dialysis weights, no shunt site observation, no dialysis center information, no lab values, and no and time of dialysis finish time. *Facility Post: No documentation of shunt site observation, and no time of return from dialysis. j. 05/17/24: *Facility Prior: No documentation of medications administered prior to dialysis, no shunt site observation, and no time of transfer to the dialysis center. *Dialysis Center; No documentation of shunt site observation, pertinent observations, dialysis center information. *Facility Post: No documentation of shunt site observation, and no time of return from the dialysis center. k. 05/15/24: *Facility Prior: No documentation of medications administered prior to dialysis, and shunt site observation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Dialysis Center: No documentation of pre and post dialysis weight, no shunt site observation, no dialysis center information, and no time of dialysis finish time. *Facility Post: No documentation of shunt site observation, and no time of return from dialysis. Following the review of the Hemodialysis Communication Records for Resident #106, they were reviewed with the Corporate Nurse Consultant. The consultant confirmed the surveyor's findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not 5 percent (%) or greater. The medication error rate was 14.70 percent (%), five (5) medication errors were identified while observing a total of 34 opportunities, affecting Resident #499 and Resident #8. The findings included: 1. Record review documented Resident #499 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Colon, Type 2 Diabetes Mellitus, Hypertension, Depression, End Stage Renal Disease, Dependence of Renal Dialysis, and Presence of Cardiac Pacemaker. A medication administration observation was conducted on 06/10/24 8:16 AM with Staff A, Registered Nurse (RN), for Resident #499. Staff A was observed preparing 6 medications for Resident #499, including Methocarbamol tablet 500mg used for Muscle Spasm. Review of the Methocarbamol Blister card revealed it was labeled with a different resident's name, Resident #498. After preparing the medications, Staff A locked the computer and the medication cart. She was about to enter Resident #499's room when the surveyor stopped her and questioned the medications in the cup. Staff A returned to the cart and reviewed the medications for Resident #499 and stated that she would restart the medication preparation for Resident #499. Staff A was again observed preparing the medications for Resident #499 to include 5 medications. Staff A administered the 5 medications to Resident #499. The above medications administered to Resident #499 were reconciled to the Medication Administration Record (MAR) of the documented physician orders. Resident #499 was scheduled to receive 7 medications in the morning that included the 5 medications already administered. Staff A omitted to adminsiter Cyanocobalamin (Vitamin B12) tablet 250mcg (give 0.5 tablet daily for vitamin deficiency) and Pantoprazole Sodium tablet delayed release 40mg (daily for Gastroesophageal Reflux Disease (GERD)). An interview was conducted on 06/10/24 at 10:04 AM with Staff A. She acknowledged not administering the Pantoprazole Sodium tablet to Resident #499 because the pharmacy had not delivered it, and she has not contacted the pharmacy to inquire about delivery time for the medication. When questioned about the Vitamin B12 omission, she stated that Resident #499 is a new admission and she is not familiar with his medication's regimen, but she did not recall administering the medication. 2. Record review documented Resident #8 was admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis (MS), Iron Deficiency Anemia, Sarcopenia, Muscle Weakness, and Polyneuropathy. A medication administration observation was conducted on 06/10/24 at 8:40 AM with Staff A for Resident #8. Staff A was observed preparing 6 medications for Resident #8. Staff A administered the 6 medications to Resident #8. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medications that were administered to Resident #8 were reconciled to the MAR of the documented physician orders. Resident #8 was to receive 8 medications in the morning but only 6 medications were administered. Staff A omitted to administer Ferrous Sulfate tablet 325 (65 Fe) mg daily for anemia and Magnesium Oxide tablet 400mg daily for muscle. An interview was conducted on 06/10/24 at 10:43 AM with Resident #8. She acknowledged feeling tired all the time and her legs being weak, but she is aware that it is all part of her disease. An interview was conducted on 06/10/24 at 10:48 AM with Staff A. She does not recall administering Ferrous Sulfate or Magnesium Oxide to Resident #8. She acknowledged that she was very nervous this morning because the surveyor was observing her. An interview was conducted on 06/10/27 at 11:30 AM with the Director of Nurses (DON) apprising her of the medication administration observation and the reconciliation of the medications administered by Staff A. The DON verbalized understanding.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 properly remove and dispose of controlled medications for 2 of 3 discharged residents reviewed during medication storage observation, affecting Residents #497 and #496; failed to secure and properly lock 3 of 3 emergency crash carts observed during the initial tour; failed to safely secure prescription and over-the-counter (OTC) medications; failed to properly date stamp an opened insulin bottle observed during medication storage opportunities in the 1-East unit; and failed to discard expired topical medication stored in the wound treatment cart observed during medication storage tour. The findings included: Review of the facility's policy, titled, Storage of Medications, dated [DATE], included, in part, the following: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or standards of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal. Review of the facility's policy, titled, Controlled Drug Disposal, dated [DATE], included, in part, the following: To ensure controlled drugs are disposed of and records maintained to Federal and State Laws and regulations by the Director of Nursing and Consultant Pharmacist. Discontinued Controlled Drugs are controlled drugs that have been discontinued or the resident has been discharged : Nurse to remove the controlled drugs from medication cart along with the Controlled Drug Declining Inventory sheet. Controlled drug to be given to Director of Nursing. 1. Record review for Resident #497 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Seizure, and Hypertension. Review of the Physician's orders showed Resident #497 had an order dated [DATE] for Lacosamide tablet 200mg two times daily for Seizure. Record review revealed Resident #497 was discharged from the facility on [DATE] to an Assisted Living Facility (ALF). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A medication cart storage observation was conducted on [DATE] at 1:52 PM with Staff A, Registered Nurse (RN). Random inspection of the Controlled Drug Inventory binder revealed a pharmacy labeled sheet for Resident #497 for Lacosamide. Staff A removed the blister card from the controlled substance locked drawer. Further observation revealed the blister card was for Resident #497's Lacosamide. The Controlled Drug Declining Inventory sheet documented Resident #497 received Lacosamide until [DATE]. An interview was conducted on [DATE] at 4:03 PM with Staff C, Supervisor/RN of 2-West unit. She stated Resident #497 no longer resides at the facility. She acknowledged the resident was discharged on [DATE] and that his medications should have been removed from the controlled medications box and given to the Director of Nursing (DON) for disposal. 2. Record review revealed that Resident #496 was admitted to the facility on [DATE] and was discharged on [DATE]. A medication storage room observation located at the 2-East unit was conducted on [DATE] at 2:28 PM, with Staff B, Licensed Practical Nurse (LPN). Inspection of the refrigerator revealed a locked box containing controlled medications which included Lorazepam Intensol oral concentrate 2mg. Upon closer examination, the medication was labeled with Resident #496's information. An interview was conducted with Staff B, who revealed Resident #496 no longer resides at the facility. Staff B stated she could not recall when the resident was discharged . Staff B confirmed that controlled medications for discharge residents are removed from the refrigerator by the floor nurses and given to the DON for disposal. On [DATE] at 9:08 AM, an interview was conducted with the DON. She acknowledged that controlled medications are to be removed from the medication carts and refrigerator by the floor nurses and brought to her to be turned in to pharmacy for disposal. 38349 3. During an observational tour conducted on [DATE] at 11:17 AM near the one (1) East Nurses' station, an observation was made of the fifth (5th) drawer of the 1st floor Emergency Crash cart noted to be partially open and unsecured with no lock securely in place. The Emergency Crash cart contained both sterile and non-sterile emergency supplies. The third drawer of the Emergency Crash cart contained several syringes of normal saline dated [DATE] x 2 and [DATE], one (1) syringe with a capped needle, and two (2) bottles of Normal saline with expiration dates of [DATE] and [DATE]. The first (1st) floor Emergency Crash cart was unlocked, unattended, unsecured and accessible to residents, employees and visitors. On [DATE], the Emergency Cart Checklist documented that the Emergency Crash Cart was last checked by Staff J, Registered Nurse (RN), working on the previous 7 PM to 7 AM night shift. On [DATE] at 11:22 AM, an interview was conducted with Staff K, RN, who acknowledged the Emergency Crash cart was unlocked, unattended and unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:00 PM, a telephone interview was conducted, with the DON present, with Staff J, RN, who worked the previous 7 PM to 7 AM shift. Staff J was asked if he had locked and properly secured the one (1) East Emergency Crash cart on the early morning of [DATE]. Staff J responded he was not sure if the lock was placed on the Emergency Crash cart that morning, and he could not remember if he put it on or not. 4. During a Medication Storage Observation conducted on [DATE] at 2:13 PM of the one (1) East medication cart with Staff L, RN, along with the DON, it was noted that there was one (1) loose, unidentified tan pill located in the bottom of the second (2nd) drawer of the medication cart, and one (1) small loose, unidentified orange pill located in the bottom of the third (3rd) drawer of the medication cart. Photographic Evidence Obtained. 5. On [DATE] at 2:42 PM, a Medication Storage Observation was conducted with the RN Wound Care Nurse, who noted that there were two (2) tubes of over-the-counter (OTC) Zinc Oxide 20% Ointment with expiration dates ,d+[DATE] Both were located in the top drawer of the one (1) East Wound Care Cart. Photographic Evidence Obtained. 6. While exiting a resident's room in which a Foley care and pericare observation was conducted on [DATE] at 11:35 AM, the surveyor, accompanied by Staff A, RN, both observed there were two (2) boxes each of fifteen (15) OTC 4% Lidocaine Pain Relief Gel Patches with an expiration date of [DATE]. The two (2) boxes were sitting atop the north-side Medication cart of the two (2) [NAME] facility floor. These medications were unattended, unsecured and accessible to residents, employees and visitors. During an interview with Staff A on [DATE] at 11:35 AM, she stated that the Central Supply office staff had just left the two boxes of 4% Lidocaine Pain Relief Gel Patches for her for Resident #482. Staff A acknowledged that the OTC medications should not have been left there unattended, and should have been secured. On [DATE] at 4:07 PM, in review with the DON, the DON recognized and acknowledged the Emergency Crash carts and residents' medications must be kept secured at all times, and the expired wound care ointments must be promptly discarded. 38893 7. During an observation of the emergency crash cart at the 2-East Nurse's station on [DATE] at 11:39 AM, it was noted that the crash cart was not secured. The cart opened easily with no resistance and minimal effort. During an interview at the time of the observation, Staff R, LPN, stated the crash cart had not been used recently. During an observation of the emergency crash cart at the 2-West Nurse's station, on [DATE] at approximately 11:45 AM, it was noted that the cart was not secured and opened with no resistance and minimal effort. During an interview at the time of the observation, Staff N, RN, stated the crash cart had not been used this day.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 01948 Based on observation, interview, and record review, the facility failed to provide residents with a nourishing, palatable, well-balanced diet and to meet the preferences of potentially 117 facility residents. The findings included: During routine interview conducted with the Administrator and Certified Dietary Manager (CDM) on 06/10/24 and 06/11/24, it was noted the facility's Walk-in Refrigerator had stopped working on 05/31/24 and Reach-in Refrigerator had stopped working on 06/04/24. They stated a refrigeration contractor evaluated the issues and parts were ordered to repair the units. They further stated the contractor was contacted for days when the repairs were to be completed but the facility was informed the shipped parts have not been received to complete the repairs. They stated there was not proper refrigerator space (walk-in and reach-in refrigerators) to store and thus prepare and serve foods that require refrigeration. They stated a decision was made by the facility's administration to put into place the Emergency Menu (non-perishable food that require no refrigeration) beginning on 06/08/24 and was to continue until the refrigeration units were repaired and functioning properly. Review of the facility's Emergency Food Menu was submitted to the surveyors for review. The review noted the following: 1) Breakfast Meal: *Only dry cereal served. *Only Peanut Butter served as a protein serving, *No cottage cheese, yogurts etc. served. *No toast, muffins, fresh breads, etc. served. *No hot breakfast foods served (eggs, sausage, bacon, etc.) *Only [NAME] Crackers served. 2) Lunch: *Only canned entrees heated and served (7/7 lunch meals). *Instant Mashed Potatoes served 7 /7 lunch meals. *Only canned vegetables served 7/7 lunch meals. *Desserts included on canned fruits or canned puddings. (continued on next page)

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	105609	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Tamarac	5901 NW 79th Avenue Tamarac, FL 33321

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*No fresh breads served. 3) Dinner: *Only canned entrees served for 7/7 dinner meals. *Instant Mashed potatoes served for 5/7 meals. *Saltine Crackers served for 2/7 Dinner meals. *No fresh breads served. *canned pudding served for dessert 5/7 meals. *Canned fruit served for 2/7 dinner meal. During resident screening and interviews performed by the surveyor and 06/9-10/24, it was noted that numerous alert and oriented residents complained concerning no hot foods for breakfast and horrible tasting canned foods for the lunch and dinner meals. The residents further stated they were aware of the dietary refrigeration units but stated there was ample time for repairs and the restart of preparing and serving of fresh made foods for all meals. Specific interview conducted with Resident #54 on 06/11/24 noted to state that the situation of being forced to eat horrible, canned foods and no hot foods for the breakfast meals were terrible. During multiple interviews conducted with Resident #32 on 06/11/24, it was noted the resident was alert, orientated and able to make own decisions and has been residing at the facility for over ten years. The resident stated the issues with the food, specifically the issues with broken refrigeration units, that the refrigeration units (2) have been broken since 05/31/24 and have not been repaired, and that due to the this, the emergency menu of mostly canned and non-perishable foods were served for all 3 meals since this date. Resident #32 further stated that staff have meals catered in daily and staff eat these meals in view of the residents, they smell the staff's fresh food when residents are forced to be served and eating terrible canned food for days now. On 06/11/24 at 1:30 PM, interview with the Administrator and CDM, by the survey team, revealed the current status of resident meals, to include the following: *The walk-in refrigeration unit stopped working on 05/31/24, and the reach in refrigeration unit stopped working on 06/04/24. *The administration has made numerous attempts to have the refrigeration units repaired without success. *The facility failed to utilize refrigerators (4) located within the facility to refrigerate perishable foods that include: fresh eggs, breakfast meats, cheeses, yogurts, fresh fruits and vegetables. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The failed to contact their grocery vendor to have a refrigerated truck to be located at the facility for storage of perishable foods to be able to continue with the approved cycle menu and avoid the implementation of the emergency food menu. Following the meeting it was noted that the administrator contacted their grocery vendor and arrangements were made to have a refrigerated truck delivered to the facility. *The facility was able to prepare fresh hot foods and other menu items without the use of refrigeration units which included: hot cereals, use of frozen pasteurized eggs, preparation serving of fresh entree and preparation and serving of frozen vegetables. preparation and serving of fresh beards and desserts. Following the 06/11/24 meeting, it was concluded the facility failed to investigate the options of utilizing refrigeration units in the facility and contact grocery vendor for use of a refrigerated truck. The facility still had the use of the freezer unit as well as use of all major cooking equipment to be able to follow the approved menu and avoid the implementation of the emergency food menu. It was also revealed that the administration was not aware of the following: a. Resident's complaints concerning the implementation of the canned, non-perishable emergency food menu and poor quality and acceptance of the meals being served. b. Unaware of the residents' knowledge that the facility's refrigeration units had stopped working for weeks and failure of the administration to correct the issues and develop alterative refrigeration options. c. Unaware that residents were viewing and could smell the catered meals being served to staff for days while they were being served canned/non-perishable foods. d. The facility acknowledged that the refrigeration issues could and should have been handled in a more positive manner for the facility residents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38893 Based on observation, interview and record review, the facility failed to prepare foods in a manner to maintain the nutritional value of the foods, for potentially 117 residents. The findings included: During the initial kitchen tour, on 06/09/24 at 9:25 AM, accompanied by Staff R, [NAME] and the Dietary Manager, it was noted that the hot holding unit was already set up for the lunch meal that included: chicken and mechanically altered chicken, chicken and dumplings, mashed potatoes, rice, pureed chicken, pureed peas, mechanical soft peas, gravy and carrots. Staff R confirmed that the food was for the lunch meal on this day. When asked when the items that were being 'hot held' for lunch were cooked stated, we finished breakfast at about 8:30 AM and then started cooking for lunch. Staff R further stated that the carrots were canned and took approximately 20 minutes to prepare. When asked about the facility's policy for preparing foods prior to meal being served, Staff R did not provide a response. The Dietary Director acknowledged concerns related to preparing and hot holding vegetables for extended amount of time, over 2 hours from being cooked, hot held and then served. The facility's recipe for the canned carrots and canned peas did not address hot holding for extended periods of time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observations, interviews and record reviews, the facility failed to prepare, store and serve foods in a sanitary manner in accordance with professional standards for food safety. The findings included: 1. During the initial kitchen tour, on 06/09/24 at 9:25 AM, accompanied by Staff S, cook, and the Dietary Director / Certified Dietary Manager (CDM), the following were noted: a. The internal temperature of a full-sized 4-inch deep pan of canned carrots that was being 'hot held' in the steamer was 93 degrees Fahrenheit (F). b. The concentration of the quaternary ammonia based sanitizer in a bucket on the assembly line less than 200 Parts per Million (PPM). c. In the walk in freezer, there was a canned beverage and a bottle of water placed directly on top of a case of milk shakes. The Dietary Director confirmed that the beverages were employees' drinks. d. On the top shelf of the walk in freezer, there was a box of dough that was uncovered and the uncooked dough that was exposed to contamination. e. There was an accumulation of dust on the fan guards in the walk in freezer. f. There was an accumulation of dust on the air conditioning vents throughout the kitchen and food preparation areas. g. There was an accumulation of food residue on the blade of the table mounted can opener. h. There were several serving utensils (scoops, spoodles) that the handles were worn and created a surface that could not be cleaned and sanitized. 2. The facility's policy, titled, Thawing Meat, effective date 01/0/11 with a revision date of 03/19/12, documented, in part, the following: Policy - meat or other food items which should be thawed prior to cooking will be thawed according to current FDA (Food and Drug Administration) Food Code regulations. Meat may be thawed under running water which is 70 degrees Fahrenheit or less. The product must be placed in a pan which allows water to drain away from the item. The meat item may not sit in standing water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a return visit to the kitchen, on 06/10/24 at 6:53 AM, accompanied by the Dietary Director/CDM , there was a 5-gallon bucket of raw chicken drumsticks observed in a prep sink. It was noted that there was no water running into the bucket to aid in thawing and to slack any food and ice particles from them. Staff D, Cook, stated the chicken was in the process of thawing. Staff D stated she had left the water running because the chicken was frozen and somebody else 'must have turned it off.' Staff D then turned the water on over the container of chicken. It was noted the chicken was in the bottom approximately one third of the container and the water was not running onto the product to slack any loose particles and ice from the chicken. b. During observation and interview regarding the thawing process for the chicken, after turning the water back on to aid in the process of thawing the chicken, Staff D was observed donning a pair of clean single use gloves without performing hand hygiene. 3. During the follow up kitchen tour, on 06/11/24 at 11:45 AM, accompanied by the Dietary Director/CDM, the following was noted: a. While plating the meal for lunch, Staff T, cook, was observed reaching over a full-sized six-inch deep pan of mashed potatoes. During the observation, Staff R was noted to be dragging the sleeve of a loose fitting sweatshirt across the top of the mashed potatoes. b. Staff T, cook, was observed changing single use and disposable gloves without performing hand hygiene. c. Staff T , cook, was observed making mashed potatoes. During the process, Staff T used a spatula to stir the ingredients together and then placed the spatula in the prep sink at the food prep table. After continuing to mix the ingredients, Staff T took another spatula from over the food prep table and stirred the ingredients more. After stirring the ingredients with the spatula, Staff T then rinsed one of the spatulas and then hung it back over the food preparation table with other cleaned and sanitized utensils. e. After mixing the potatoes, Staff T placed the potatoes in the steamer and then went to the convection oven and the steamer and then donned single use gloves without performing hand hygiene. f. There was a waste receptacle in the processing area that was nearly full that did not have a cover. 4. During a tour of the unit pantry on the 1-East Unit, on 06/12/24 at 10:48 AM, the following was noted: a. There was an accumulation of a black mold type substance in the chute of the ice dispenser. b. In the reach in cooler compartment of an upright refrigerator / freezer unit, there was no working thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. a. During an observation of lunch served to the residents in their rooms, on 06/09/24 at 12:30 PM, Staff D, Cook, and the Activity Director were observed serving the meals to the residents' rooms. It was noted there was no hand hygiene performed by either staff members, but continued lunch tray distribution. After distribution of 3-4 residents, Staff X, Registered Nurse (RN), placed a bottle of hand sanitizer on top of the tray cart. Staff D and the Activity Directors started to pick up a tray without using hand sanitizer and the RN intervened and offered the hand sanitizer bottle. b. On 06/12/24 at 1:10 PM, an interview was conducted with the Activity Director. She stated that she has participated in infection control and hand washing in-service education during meetings as well as in the computer. She acknowledged that she performs hand sanitizing prior to activities and sanitizes the Bingo chips and cards. In addition, she acknowledged that recently she was made aware that she needs to perform hand hygiene via hand sanitizer when passing meal trays and in between each meal tray.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 38893 Based on observations, interviews and record reviews, the facility failed to ensure it developed and implemented an effective Quality and Performance Improvement Plan (QAPI) that addressed residents' food concern needs, failed to ensure kitchen euipement was repaired timely and failed to make effective efforts to provide meals that were palatable, appealing and at appropriate temperatures. The findings included: Review of the QAPI Committee activities revealed the facility had not addressed and made an effective effort to address, rectify, even temporarily, and develop a plan to address residents' food concerns and repairs for kitchen equipment since August 2023, and, most recently, regarding the broken walk-in cooler that has not been working since May 31, 2024. The facility resorted to serving the emergency food menu unnecessarily. The facility made no other efforts to ensure that the food was palatable (e.g. changes in procedures for hot holding, other means to ensure that the food was an appropriate temperature {per residents}, interview with residents for quality concerns,or to monitor how long the food sits in carts before being delivered. 1. During the initial kitchen tour, on 06/09/24 at 9:25 AM, accompanied by the Dietary Manager (DM) / Certified Dietary Manager (CDM), it was noted that the walk-in cooler was out of order with a sign on the door. During an interview, the Dietary Manager/CDM stated that the walk in cooler had not been working since Wednesday of previous week and that the facility was using the disaster emergency menu and products. The Dietary Manager stated that the facility expected to have parts repaired near the end of the week. During a follow up interview, on 06/11/24 at 6:32 AM, with the DM/CDM, the Dietary Manager/CDM stated that the walk-in cooler had been down since 05/31/24 and was hoping to be repaired by 06/12/24. During an interview, on 06/09/24 at 11:38 AM, with Resident #10, with a Brief Interview for Mental Status (BIMS) score of 15, Resident stated that he was served peanut butter and white toast grape Jelly and Corn flakes with Milk yesterday breakfast and today. He said that it was ok, but not substantial and varied as breakfast. Resident #10 stated that he did speak with someone yesterday morning from the Kitchen that he was not happy with his breakfast. He said that they did not offer him anything else for Breakfast. Resident was offered alternative today for lunch of a cheese sandwich. During an interview, on 06/09/24 at 1:36 PM, with Resident #109 with a BIMS score of 15, when asked about the food served to the residents, Resident #109 stated that she was served peanut butter and Jelly with either bread or graham crackers and some dry cereal and milk the previous day, yesterday breakfast and today. When asked if the food served was her preference, Resident #109 stated, no, I would prefer some eggs, grits, bacon. Resident #108 stated that she told the Dietician about this some months ago. Resident #109 stated, Everything was ok, up until a few days ago. Resident #109 stated that she was not given any explanation. And, she added that she believes that all of the residents got this as well. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview, on 06/10/24 at 10:14 AM, Resident #10 stated that for dinner the previous evening, he had Chicken Tenders again, more often and Rice and Ravioli. Corn Flakes with Milk, Peanut Butter [NAME] crackers for Breakfast, today. Resident #10 stated that they used to give him a menu, but he does not get a menu in order to select his own food preferences, on a regular basis. Resident #10 stated that he would prefer some eggs and cheese/Omelet/Scrambled with Bacon and some white toast, or a bagel with cream cheese. During an interview, on 06/10/24 at 10:28 AM, with Resident #32, with a BIMS score of 15, Resident #32 stated, It's their fault that the cooler is not working. A year ago, they had a repair guy working on it when it broke last year. He put a band aid on it and didn't fix it and now it doesn't work, and they can't serve what they are supposed to on the menu. The food here is crap so I have to order out. During an interview, on 06/10/24 at 3:32 PM, the Dietary Director/CDM stated that the decision to serve meals from the emergency food menu was explained to the residents during a Resident Council Meeting on 06/06/24 During an interview, on 06/11/24 at 7:51 AM, with the Director of Maintenance, when asked about the walk in cooler and the reach in cooler being repaired, the Director of Maintenance stated, Direct Supply Sales is coming to make repairs, Direct Supply will be bring the part with them between 12-2 or earlier, he was supposed to be here yesterday. I put in the request on 05/31/24. Usually I would rent one (referring to renting a cooler). They (referring to facility administration) were on the way between that week and now to rent one from Sysco or Direct Supply. On 06/11/24 at 1:30 PM the survey team (Registered Dietitian and Health Facility Evaluator) requested a meeting with the Administrator and CDM to discuss the current status of resident meals. The meeting revealed the following: * The walk-in refrigeration unit stopped working on 05/31/24, and the reach in refrigeration unit stopped working on 06/04/24. * The administration has made numerous attempts to have the refrigeration units repaired without success. * The facility failed to utilize refrigerators (4) located within the facility to refrigerate perishable foods that include: fresh eggs, breakfast meats, cheeses, yogurts, fresh fruits and vegetables. * The failed to contact their grocery vendor to have a refrigerated truck to be located at the facility for storage of perishable foods to be able to continue with the approved cycle menu and avoid the implementation of the emergency food menu. Following the meeting it was noted that the administrator contacted their grocery vendor and arrangements were made to have a refrigerated truck delivered to the facility. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* The facility was able to prepare fresh hot foods and other menu items without the use of refrigeration units which included: hot cereals, use of frozen pasteurized eggs, preparation serving of fresh entree and preparation and serving of frozen vegetables. preparation and serving of fresh beards and desserts. Following the 06/11/24 meeting it was concluded that the facility failed to investigate the options of utilizing refrigeration units in the facility and contact grocery vendor for use of a refrigerated truck. The facility still had the use of the freezer unit as well as use of all major cooking equipment to be able to follow the approved menu and avoid the implementation of the emergency food menu. It was also revealed that the administration was not aware of the following: * Resident's complaints concerning the implementation of the canned/non-perishable emergency food menu and poor quality and acceptance of the meals being served. * Unaware the resident's knowledge that the facility's refrigeration units had stopped working for weeks and failure of the administration to correct the issues and develop alterative refrigeration options. * Unaware that residents were viewing and could smell the catered meals being served to staff for days while they were being served canned/non-perishable foods. * The facility acknowledged that the refrigeration issues could and should have been handled in a more positive manner for the facility residents. 2. During the follow up kitchen tour, on 06/11/24 at 11:45 AM, it was noted that the kitchen staff were not using the pellet warmer while plating the lunch meal. The pellet warmer was unplugged on a shelf by the assembly line. During an interview, on 06/12/24 at 9:51 AM, with the Long Term Care Ombudsman, the Ombudsman stated that she was at the facility in May with the Executive Director and came back last week. The Ombudsman stated, The residents were complaining that the eggs are cold, all of the warm food is cold when it gets to the resident's rooms, because the warmer plates don't work. They ordered the warmer that wasn't compatible with the plates that they had. They were ordering one that was compatible with the plates that they have, they were ordering it, but it's very expensive. In March she said that they are being ordered. In April, she said that they are still waiting for it. In May, I came back and they were still waiting for the heating element to come in. She said 'each unit has a microwave and if the residents request it, staff can use the microwave to reheat the food'. Last week when I was here, she said 'we are still waiting on it.' I have been discussing this with her since February. There was no evidence provided that they have ordered. The CEO in May said that she will light a fire under her supplier. She said that she would call the distributor and light a fire. 3. During the follow up kitchen tour, on 06/11/24 at 11:45 AM, it was noted that the kitchen staff were not using the pellet warmer while plating the lunch meal. The pellet warmer was unplugged on a shelf by the assembly line. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of lunch being served to the residents in their rooms on the 2-East Unit, on 06/09/24 at 12:56 PM, it was noted that the meals were delivered to the units in metal carts that did not have any additional heat source. The plates that the meals were served on were noted to be at an ambient temperature to the touch. During an interview, on 06/12/24 at 9:51 AM, with another Agency, the Agency staff stated that she was at the facility in May with the Executive Director and came back last week. The other Agnecy stated, The residents were complaining that the eggs are cold, all of the warm food is cold when it gets to the resident's rooms, because the warmer plates don't work. They ordered the warmer that wasn't compatible with the plates that they had. They were ordering one that was compatible with the plates that they have, they were ordering it, but it's very expensive. In March she said that they are being ordered. In April, she said that they are still waiting for it. In May, I came back, and they were still waiting for the heating element to come in. She said, 'each unit has a microwave and if the residents request it, staff can use the microwave to reheat the food'. Last week when I was here, she said 'we are still waiting on it.' I have been discussing this with her since February. There was no evidence provided that they have ordered. The CEO in May said that she will light a fire under her supplier. She said that she would call the distributor and light a fire. The other Agency provided documentation of visits to the facility that reflected the concerns related to the temperature of the food upon arriving to the residents' rooms on 02/16/24, 03/21/24, 04/25/24, 05/23/24, and 06/05/24, as well as documentation of the facility being made aware of the concerns during the visits. During an interview, on 06/12/24 at 10:20 AM, with Resident #32, with a BIMS score of 15, Resident #32 stated, this morning's breakfast was the first time for a hot meal and has been an issue for months. The facility provided documentation in the form of invoices that revealed that the warmer had not worked as of 09/07/23. During an interview, on 06/12/24 at approximately 1:00 PM, with the Registered Dietitian, when asked if there was any documentation that the facility made any other efforts to remedy the concerns in lieu of not having a working pellet warmer, the Registered Dietitian stated that she was not aware of any efforts. On 06/12/24 at approximately 1:30 PM, the Registered Dietitian stated that she had reached out to the Dietary Director/CDM, who was off site at the time, stated that there had been no additional efforts made. There was no evidence the facility implemented an effective plan to address the foods, the kitchen equipment timely and residents' food concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews, review of policy and procedures, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) per Centers for Disease Control (CDC) guidelines and facility policies and procedures for 24 of 24 sampled residents on Enhanced Barrier Precautions, Residents #478, 86, 494, 23, 475, 106, 489, 482, 491, 29, 15, 98, 495, 474, 40, 70, 72, 17, 498, 8, 49, 81, 30, and 124. The facility failed to follow procedures for donning appropriate PPE (Personal Protective Equipment) during Foley catheter care for 1 of 1 sampled residents observed during catheter care, Resident #8. The facility failed to follow procedures for donning appropriate PPE for 1 of 1 sampled resident observed while initiating enteral feeding to Resident #41. The findings included: Review of the Center for Disease Control (CDC) guidelines documented, in part, that for residents on EBPs that PPE (gowns and gloves) are to be located at the residents' doors. The CDC website is: CDC_Implementation_Of_Personal_Protective_Equipment_(PPE)_Use_In_Nursing_Homes_To_Prevent_Spread_Of_Multidrug-resistant_Organisims_(MDROs). The facility's policy for Enhance Barrier Precautions, with a reference date of August 2022, documented: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs). 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing b. bathing/showering c. transferring (continued on next page)

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	105609	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Tamarac	5901 NW 79th Avenue Tamarac, FL 33321

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Providing hygiene e. changing linens f. changing briefs or assisting with toileting g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) h. wound care (any skin opening requiring a dressing 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling mediation devices regardless of MDRO colonization. 11. PPE is available outside of the resident rooms. During a unit by unit tour of the facility, beginning on 06/09/24 at 8:00 AM, the following was noted: On the 1500 unit, there were two residents on Enhanced Barrier Precautions (EBP) with a sign at the door that indicated the precautions at Rooms #1504 and #1510. Further observation revealed that there was no PPE at the entrance to the rooms. On the 1600 unit, there was one resident on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at Room#1602. Further observation revealed that there was no PPE at the entrance to the room. On the 2100 unit, there were 5 residents on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at Rooms #2101, 2102, 2103, and 2104. Further observation revealed that there was no PPE at the entrance to the room. On the 2200 unit, there was one resident on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at room [ROOM NUMBER]. Further observation revealed that there was no PPE at the entrance to the room, and no PPE available on the unit. On the 2300 unit, there were 5 residents on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at Rooms #2300, 2305, 2307, and 2310. Further observation revealed that there was no PPE at the entrance to the rooms. On the 2400 unit, there were 3 residents on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at Rooms #2400, 2402, and 2406. Further observation revealed that there was no PPE at the entrance to the rooms. On the 2500 unit, there were 3 residents on Enhance Barrier Precautions with a sign at the door that indicated the precautions at Rooms #2503, 2509, and 2512. Further observation revealed that there was no PPE at the entrance to the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the 2600 unit, there were 5 residents on Enhanced Barrier Precautions with a sign at the door that indicated the precautions at Rooms #2602, 2608, and 2607. Further observation revealed that there was no PPE at the entrance to the rooms. During an interview, on 06/09/24 at 11:14 AM, with Staff C, Registered Nurse (RN) Supervisor, and Staff V, RN, when asked about the policy for Enhanced Barrier Precautions, Staff V replied, Residents with Foleys, wounds, residents on antibiotics, we don't have anybody on actual precautions. There is one box for each wing (referring to the availability of PPE). During an interview, on 06/09/24 at 11:20 AM, with Staff R, Licensed Practical Nurse (LPN), when asked about residents on EBP, Staff R replied, the sign means that when we are handling a catheter to make sure we wear gowns and wash hands and everything and that is why the sign is there (referring to the signage at the residents' room doors that indicated the precautions). During an interview, on 06/10/24 at 8:08 AM, with Staff B, LPN, when asked about residents being on EBP, Staff B replied, they are for anyone with an open wound, catheter, tube feeding, any opening on the body. Staff B stated that the PPE should be at the entrance to the residents' rooms. During an interview, on 06/10/24 at 8:17 AM, with Staff U, RN, when asked about the facility's policy for placing PPE for residents on EBP, Staff U replied, it should be on the door. During an interview, on 06/12/24 at 7:05 AM, with the Director of Nursing / Infection Preventionist (DON/IP), the DON/IP acknowledged understanding of the EBP concerns. The DON/IP stated that the facility's policy for PPE for residents on EBPs was based on recommendations made by CMS. The DON/IP was made aware of the concerns based on observations during Foley catheter care and tube feeding care by other members of the survey team. The DON/IP stated, Each hallway has one(referring to carts that contained PPE). 38349 2. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses that included Neuromuscular Dysfunction of Bladder, Peripheral Vascular Disease, Hypertension, Multiple Sclerosis, Major Depressive Disorder, Seizures, Polyneuropathy and Muscle Weakness. Resident #8 had a Brief Interview Mental Status (BIMS) score of 15 (cognitively intact). During a Peri-care and Foley catheter care observation conducted on 06/11/24 at 10:50 AM by Staff I, Certified Nursing Assistant (CNA), Staff I was observed doing the following: a. while gathering her pre-bagged supplies, she initially dropped the bagged towels and supplies in the garbage can next to Resident #8's bed b. Staff I began to perform Resident #8's pericare, in her same uniform, without first donning a gown. c. Staff I was observed placing Resident #8's Foley catheter on top of her bed above the level of her chest, and she left the Foley bag in that position throughout the entire observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Staff I was then observed using the same pair of dirty gloves that she cleaned Resident #8's perineal area and proceeded to touch the bedside dresser, Resident #8's table and dresser across from the resident's bed without first removing those gloves, washing her hands and applying a new pair, in search of additional towels and supplies. e. Staff I left Resident #8's bedside to go out into the hallway, and at that time she was again, observed touching the following surfaces (without any type of hand sanitation and no protective gloves): the clean linen cart and the inside of her red blouse, in an effort to fix her bra. f. Staff I was observed taking Resident #8's basin into to bathroom to change the water, without protective gloves in which she touched the faucet to wash the basin in the sink. g. Staff I was observed wearing the same dirty gloves that she cleaned Resident #8's peri-area and then she proceeded again to touch multiple surfaces in Resident #8's room, cross-contaminating them all. On 06/11/24 at 11:18 AM, an interview was conducted with both Staff A, RN and with Staff I, who were informed of the Infection Control concerns observed during Resident #8's peri-care and Foley care observation. They both acknowledged that during peri-care and Foley care that Staff I should have followed appropriate Infection Control procedures. On 06/11/24 at 12:10 PM, the Director of Nursing (DON) recognized and acknowledged that Staff I should have implemented appropriate Infection Control Techniques throughout the procedure; this was not done. 49060 3. A tour of the in-house Dialysis suite was conducted on 06/11/24 at 9:20 AM. It was revealed that 4 residents receiving dialysis treatment. Upon observation of the room, the following concerns were noted: a. Uncovered trash cans near the treatment chairs containing gowns and soiled gloves. b. The cover of the infectious waste cans was broken revealing the contents (syringes, bloody tubes). c. The infectious waste cans were stored on the floor and unlocked. d. Five Citrapure 4-gallon bottles (an essential component in the preparation of Dialysis fluid) were stored on the floor and then placed on the clean equipment for use. e. A personal soiled coffee metal cup stored in the unlocked medicine cabinet.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 38893 Based on observations, interviews and record reviews, the facility failed to make prompt efforts to repair and replace necessary kitchen equipment in order to provide wholesome and palatable food at the appropriate temperatures. The findings included: 1. During the initial kitchen tour, on 06/09/24 at 9:25 AM, accompanied by the Dietary Manager (DM) / Certified Dietary Manager (CDM), it was noted that the walk-in cooler was out of order with a sign on the door. During an interview, the Dietary Manager/CDM stated that the walk-in cooler had not been working since Wednesday of previous week and that the facility was using the disaster emergency menu and products. The Dietary Manager stated that the facility expected to have parts repaired near the end of the week. During a follow up interview, on 06/11/24 at 6:32 AM, with the Dietary Manager/CDM, the Dietary Manager/CDM stated that the walk-in cooler had been down since 05/31/24 and was hoping to be repaired by 06/12/24. 2. During the follow up kitchen tour, on 06/11/24 at 11:45 AM, it was noted that the kitchen staff were not using the pellet warmer while plating the lunch meal. The pellet warmer was unplugged on a shelf by the assembly line. During an interview, on 06/12/24 at 9:51 AM, with another Agency, the Agency staff stated that she was at the facility in May 2024 with the Executive Director and retruned last week. The Agency staff stated, The residents were complaining that the eggs are cold, all of the warm food is cold when it gets to the resident's rooms, because the warmer plates don't work. They ordered the warmer that wasn't compatible with the plates that they had. They were ordering one that was compatible with the plates that they have, they were ordering it, but it's very expensive. In March 2024, she said that they are being ordered. In April 2024, she said that they are still waiting for it. In May 2024, I came back and they were still waiting for the heating element to come in. She said, 'each unit has a microwave and if the residents request it, staff can use the microwave to reheat the food'. Last week when I was here, she said 'we are still waiting on it.' She state she has been discussing this with them since February 2024. There was no evidence provided that they have ordered. She stated the CEO [Administrator] in May 2024 said that she would light a fire under her supplier. She said that she would call the distributor and light a fire. The other Agency provided documentation of visits to the facility that reflected the concerns related to the temperature of the food upon arriving to the residents' rooms on 02/16/24, 03/21/24, 04/25/24, 05/23/24, and 06/05/24. The facility provided documentation in the form of invoices that revealed that the warmer had not worked as of 09/07/23.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to maintain call lights within reach of residents for 3 of 3 sampled residents reviewed, Residents #23, 481 and 13, as evidenced by call lights being out of the residents' reach. The findings included: The facility's policy, titeled, Call Bell System - Inoperable, effective date 11/30/14, with a revision date of 08/22/17, documented, in part, Resident must have, at all times, a system to notify staff when assistance is needed . The facility did not provide a policy for call light placement after being asked for ti. 1. Record review documented Resident #23 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, an Annual Minimum Data Set (MDS) assessment, dated 03/08/24, documented Resident #23 had a Brief Interview for Mental Status (BIMS) score of 09, indicating a moderate cognitive impairment. The MDS documented the resident required Partial to moderate assist for activities of daily living (ADLs), except for eating and was frequently incontinent of urine and always incontinent of bowel. Resident #23's diagnoses at the time of the MDS included: Anemia, Coronary Artery Disease (CAD), Hypertension, Peripheral Vascular Disease (PVD), Gastro-esophageal reflux disease (GERD), Diabetes Mellitus (DM), Hyperlipidemia, Thyroid disorder, Non-Alzheimer's Dementia, presence of artificial left leg, Muscle weakness, Unsteadiness on feet, Abnormalities of gait and mobility, repeated falls, and Cognitive Communication Deficit. Review of Resident #23s care plan for ADLs, dated 05/31/22 with a revision date of 09/20/22, documented, The resident has an ADL self-care performance deficit related to Fatigue, Hemiplegia, Limited mobility, pain, left lower prosthesis. Intervention to the care plan included: Encourage the resident to use call bell for assistance. Review of Resident #23's care plan for falls, dated 05/31/22, documented, The resident is at Hight risk or falls related to Gait/balance problems, Incontinence, Paralysis. Intervention to the care plan included, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On 06/09/24 at 12:42 PM, Resident #23's was observed in bed. It was observed that the call light was clipped to the cord that extends from the wall between the beds and out of reach of the resident. When asked, Resident #23 stated that he would not be able to reach the call light should he need to the way that it was placed. On 06/10/24 at 7:18 AM, Resident #23 was observed in bed sleeping with the call light on the floor to the resident's left side of the bed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 06/11/24 at 2:14 PM, with Staff W, Certified Nursing Assistant (CNA), when the concern was brought to her attention, Staff W stated that she didn't notice the call light on the floor. 49060 2. During the facility tour, an interview was conducted on 06/09/24 at 10:28 AM with Resident #481. The resident stated she needed assistance this morning, but she could not find the call light. Observation of Resident #481's room revealed the end of the call light cable, where the call light button is located, was observed inside the nightstand (unable to be reached by the resident). Photographic Evidence Obtained. Another interview was conducted on 06/10/24 at 4:06 PM with Resident #481. She acknowledged not having the call light and was unsure where it was. Upon observation of the room, it was noted the call light was on the floor. Photographic Evidence Obtained. 50370 3. Record review revealed Resident # 13 was admitted to the facility on [DATE] with the diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, Chronic Bronchitis, Depression. Review of the most recent Quarterly MDS dated [DATE], Section C revealed Resident #13 had a BIMS score of 11, indicating moderate cognitive impairment. Review of Section GG of the MDS revealed Resident #13 was dependent on some functional abilities such as toileting, dressing, transferring from bed to wheelchair, and/or changing position from lying down flat on his bed to sitting up. Record review of the Nursing Progress Notes on 06/10/24 at 3:50 PM performed by Staff RN on 03/26/24 showed the following: Level of Consciousness (LOC) as oriented to person, oriented to place; Mood status is pleasant; Behavioral problems are not noted; Oxygen is used via nasal cannula (NC); Activities of Daily Living (ADL) is assisted; Functional status noted as generalized weakness. In an interview and observation on 06/09/24 at 11:35 AM, it was observed that the call light was stuck underneath the bed of Resident #13, making it impossible to call staff for assistance. The metal and rubber parts supporting the top part of the bed were pressing the call light cord. The resident stated he is is blind in one (left) eye. He stated he could not turn on the overhead light because the string was too short for him to reach (about 2-3 cm in length), versus the distance from the resident's right hand to the overhead light string (approximately more than 3 feet). He added the staff do not let him do what he wants, and he is unable to find his call light several times a day. In an interview with Staff B, LPN, conducted at the front desk on 06/09/24 at 3:36 PM, she stated Resident #13 calls the staff all the time. When asked if Resident #13 has access to the call light button, she stated, All residents have access. When asked how the facility residents would call staff when they needed help, she stated, They must use the call lights. When asked how the residents would call staff if call lights were unreachable, she stated, Staff makes rounds. A few minutes later, Staff B stated Resident # 13's call light was stuck under the bed and she needed to call Maintenance since she does not know how to unstick the call light from Resident #13's bed. The Maintenance staff arrived after 20 minutes. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview with Resident #13 on 06/09/24 at 4:05 PM, he stated he cannot call staff to inform them his undergarment was wet, his overhead string light was short, when there was no overhead light, he was unable to locate his call light button, and the call light button was under his bed. During observation on 06/10/24 at 10:00 AM, Resident #13's call light was still under his bed, his overhead string light was still short, and when asked him if he had seen his call light button, he stated I do not know where my call light button is. During observation on 06/10/24 at 3:05 PM, Resident # 13's call light was still under his bed. There was a housecleaning staff who noticed the call light was under the bed. When Resident #13 asked her where his call light button was, she replied, I am not allowed to give you the call light. When Resident #13 asked her to call a staff member to help him find his call light, she kept cleaning the floor. In an interview with the Senior Facilities Director on 06/10/24 at 4:01 PM, he stated the staff should be able to move the bed pinching on Resident #13's call light cord. He said he would check Resident #13's bed today to make sure staff can move his bed to prevent his call light cord from being stucked underneath again. During observation on 06/11/24 at 3:00 PM, Resident #13's call light was within reach, but when Resident #13 pressed the call light button, the light bulb above his door did not turn on and a beeping sound was not heard outside his room. A few minutes later, Maintenance staff appeared and stated he needed to fix Resident #13's call light. After few minutes, it was observed that both the rectangular-shaped bulb above Resident #13's door blinked with a yellowish colored light, and a faintly beeping sound was heard while the Maintenance staff was inside Resident #13's room.