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	12/11/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and a review of facility records, the facility failed to provide evidence of documented grievances submitted by 1 of 1 sampled resident, Resident #75, regarding delays in the call-light response and concerns related to activities of daily living (ADL) care. The findings included: Clinical record review showed that Resident #75 was admitted on [DATE] with diagnoses including shoulder arthroplasty, brain tumor, anemia, left-sided paralysis, and recent right-shoulder surgery. She was alert, oriented, and verbally responsive. Further documentation listed diagnoses of traumatic arthropathy of the right shoulder, primary osteoarthritis, hemiplegia and hemiparesis following cerebral infarction affecting the left side, and coordination deficits.Review of the ADL [Activities of Daily Living] Plan of Care identified significant self-care deficits related to her medical conditions. Interventions included assistance with bathing, dressing, eating, hygiene, mobility, toileting, transfers, skin assessments, and use of a call bell for help. The plan also noted impaired vision and use of glasses.Review of the nursing progress notes dated 11/03/2025 indicated that Resident #75 had been referred for a psychological evaluation due to complaints and adjustment concerns. The psychological assessment documented frequent complaints, general unhappiness, nervousness, and episodes of verbal abusiveness, based on staff reports.On 12/08/2025 at 1:20 PM, Resident #75 stated dissatisfaction with the services and quality of care received. She stated that upon her admission, the care was terrible, and described waiting approximately four hours for assistance after activating her call light, particularly during nighttime hours. She stated these concerns to the head nurse, but no improvements were observed. Resident #75 also stated that Certified Nursing Assistants (CNAs) told her they were responsible for 16 residents and lacked adequate time to provide timely care. She stated that her family reported concerns to the Administrator but perceived the response as indifferent.Resident #75 further stated that when she requested to receive ADL care before other residents due to her functional limitations, staff responded that permanent residents were prioritized over her. She explained that she was unable to use either arm due to left-sided paralysis and recent right-shoulder surgery. She stated that the Administration did not address her complaints. During an interview on 12/11/25 at 11:39 AM, Staff C (Registered Nurse / RN) reported that the resident required complete assistance with all ADLs on admission. Staff C stated Resident #75 had complained of waiting 5-10 minutes for care after activating the call light and expressed frustration about delays in having her sanitary brief changed. Staff C had stated communicating these concerns to the Director of Nursing (DON) and documenting the resident issues in the facility's electronic system (TELL). She stated that although she has filed grievances for other residents, she had not submitted any grievance documentation for Resident #75.During an interview on 12/11/25 at 12:39 PM, Staff D (Certified Nursing Assistant / CNA) stated she had worked at the facility for nearly 40 years. She stated Resident #75 initially required total assistance with all tasks but had since improved. She stated the resident complained about noise and other residents entering her room but indicated she did not consider these issues necessary to report to Administration unless they were dangerous. Staff D stated no knowledge of call-light delays for Resident #75.On 12/11/25 at 1:36 PM, the Social Worker stated that grievance forms are available in boxes near the nurses' station and (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must be addressed within three days. She stated having received no grievance submissions from Resident #75 and no documentation indicating that staff had submitted grievances on her behalf.On 12/11/25 at 2:33 PM, the Director of Nursing / DON stated she had not received complaints from the resident or her family. She described the facility's grievance procedure, which requires documentation of the issue, resolution within three days, and transfer of the resolution to the Social Worker. No documentation existed for Resident #75's grievance.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, record review and interview, the facility failed to obtain physician orders for intravenous (IV) midline catheter and care for 1 of 1 sampled resident observed, Resident #111. The findings included: Review of the facility's policy, titled, Midline Catheter Flushing, Locking, Removal, provided by the Director of Nursing (DON), reviewed/revised 11/07/25 documented in the Policy Statement: It is the policy of this facility to ensure that midline catheters are flushed, locked and removed consistent with current standards of practice. Policy Explanation: Midline catheters are longer peripheral catheters that are placed in peripheral veins.Compliance Guidelines: 1. The nurse will obtain and/or verify the physician's order for the type of Intravenous (IV) solution or medication, dose, rate and length of treatment.10. Midline catheter removal will be performed by the practitioner or nurse in accordance with facility policy and your state's nurse practice act. 11. Removal of a midline catheter will occur at the end of therapy, onset of complications or when deemed no longer necessary. Obtain a physician's order for removal.Removal 1. Verify the physician's orders.9. Inspect the site for signs of infection.19. Document the procedure.Record review revealed Resident #111 was re-admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, Gangrene, Chronic Obstructive Pulmonary Disease, Lymphedema, Atherosclerotic Heart Disease and Hypertension. The record indicated a Brief Interview Mental Status (BIM) 13, indicative of intact cognition.On 12/08/25 at 10:11 AM, an observation was conducted of Resident #111's left upper arm IV (intravenous) midline catheter in place, with today's date of 12/08/25, documented as changed by Staff A, Registered (RN). Further observation of the IV Midline catheter site base revealed it appeared to have some brownish discoloration with a small, darkened blood-tinged area noted in the IV midline catheter tubing.During an interview conducted on 12/08/25 at 10:15 AM with Resident #111, she stated she has had this IV midline catheter in place since her date of admission. She said she does not know why she still has this in place since to her knowledge, she said that she had not been receiving any medication in there since being admitted to this facility. Record review of both the physician's discontinued order sheets, as well as of the current order forms, dated for the months of November and December 2025, revealed neither contained orders for the discontinuance, or for the care and maintenance of the resident's current IV midline catheter. Additional record review of the Medication Administration Record (MAR) and of the Treatment Administration Record (TAR) for the months of November and December 2025 did not document any orders for the discontinuance or the care and maintenance of the resident's current IV midline catheter. Review of the 11/28/25 Clinical admission by Staff A, documented that, [the resident's] Peripherally Inserted Central Catheter (PICC) line was patent and that the PICC dressing was intact, with no current antibiotics noted for the resident.An interview was conducted with Staff B, the resident's readmitting and current RN, who when asked about the IV Midline catheter being in place, responded she did not recall whether or not the resident was admitted with the IV midline in place, and she wasn't sure exactly when or how long it had been in place. Staff B indicated the resident had been receiving only oral antibiotics, which subsequently had been discontinued. Staff B also stated she needed to contact the resident's physician to see if she could get an order to discontinue the IV midline catheter. Staff B acknowledged that a physician's order had never been obtained for the care and maintenance of the IV midline catheter.A side-by-side record review was conducted with Staff B, which revealed that, the November 2025 Physician's Orders for Resident # 111 only documented the following two (2) oral antibiotics of: Levofloxacin Oral Tablet 500 mg to give one (1) tablet by mouth one time for infected wound for 16 Days, ordered 11/01/25 through 11/16/2; and for Doxycycline Monohydrate 100 mg capsule to give one (1) capsule by mouth every 12 hours for wound infection for 7 Days, ordered 11/01/25 through 11/07/25. There was no IV antibiotics ordered for this resident during her facility stay.On 12/08/25 at 4:05 PM, a second observation was conducted of the resident's left upper (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	underneath arm of the IV midline catheter, and it was observed still in place. There remained no current physician's order for either the discontinuance, or for the care and maintenance of the IV midline catheter. The IV midline catheter site base still appeared to have brownish discoloration with a small, darkened blood-tinged area noted in the IV midline catheter tubing.On 12/09/25 at 9:47 AM, a third observation was conducted of the resident's left upper arm IV midline catheter, and it was observed still in place, and there was still no current physician's order obtained for the discontinuance or for the care and maintenance of the IV midline catheter. The IV midline catheter site base still appeared to have brownish discoloration with a small, darkened blood-tinged area noted in the IV midline catheter tubing.A telephone interview was conducted on 12/10/25 at 2:07 PM with Staff A, who had initialed changing the resident's IV dressing on 12/08/25. Staff A was asked about the IV midline catheter and acknowledged she had identified the resident's IV as having been present and in place in the resident's left upper arm. Staff A revealed she had not notified the on-coming nurse, the DON, and had not contacted the resident's physician, in order to obtain orders for either the removal of or the care and maintenance of the IV midline catheter. She stated she, forgot to do so.There was no evidence documented in the facility's nursing admission progress notes, the facility's subsequent on-going nursing progress, the facility's baseline care plan, or in the facility's current comprehensive care plan, of the identification or existence of Resident #111's left upper arm IV midline catheter. There was no current physician's order obtained for the discontinuance or for the care and maintenance of the IV midline catheter. The IV line remained in place and not in use in the resident's left upper arm for eleven (11) days.There was no physician's order obtained to remove Resident #111's midline IV catheter until after surveyor inquisition.The Director of Nursing (DON) recognized and acknowledged on 12/10/25 at 3:10 PM that the nurse should have contacted the resident's physician to obtain an order to either discontinue or to provide for the care and maintenance of the resident's midline IV catheter.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their menu for 2 sampled residents on a therapeutic diet, Residents #1 and #45. The census at the time of survey was 121, with 31 residents designated as being on a mechanical soft diet and 7 residents designated as on a CHO (Carbohydrate) Controlled diet. The findings included: 1. Review of the Menu Spread Sheets provided by the Certified Dietary Manager (CDM) specified that the Mechanical Soft Diet was to provide Grd (ground) meats every day for Breakfast, Lunch, and Dinner. Record review revealed Resident #45 was readmitted on [DATE] with diagnoses which included Dysphagia, Type 2 Diabetes Mellitus, Dementia, and Hypertension (HTN). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], section C, documented Resident #45 had a Brief Interview for Mental Status (BIMS) score of 10, on a scale of 0 to 15, indicating the resident's cognition was moderately impaired. On 12/09/25 at 12:16 PM, during a dining room observation on the second floor, Resident #45 was observed consuming her lunch meal. Per the resident's meal ticket, the resident was prescribed a Mechanical Soft Diet. The meal included roast beef which was cut into pieces or chunks that were about 0.5 inches in size. Photographic Evidence Obtained. During a Tray Line observation on 12/10/25 at 11:28 AM, the CDM called the Mechanical Soft chicken, diced chicken while taking its temperature. There was no ground meat noted on the tray line. On 12/10/25 at 12:07 PM, a dining room observation was conducted on the second floor. Resident #45 was observed with diced or chopped chicken. Photographic Evidence Obtained. An interview with the facility's CDM in the front conference room was conducted on 12/10/25 at 1:05 PM. The CDM has been employed with the facility for about 1 year. The CDM stated that Sysco provides the menus and their breakdown. These menus are approved by a corporate Registered Dietitian (RD). When asked, the CDM stated that the current Diet Consistency Orders available were: Regular, Mechanical Soft, and Pureed. He further stated that the menu and breakdowns which he provided were new and had just started about three weeks ago. The CDM was then shown the Diet Spreadsheet with the breakdown of the different diets. He stated that the Soft diet on the spread sheet was the Mechanical Soft diet in the system. It was pointed out to the CDM that the Soft Diet specified ground meat. His response was, We don't have any ground diets. During an interview on 12/10/25 at approximately 1:30 PM in the front conference room, both the Director of the Therapy Department, who is a Speech Language Pathologist (SLP), and the facility SLP, were interviewed. The SLP stated that the facility offered the following consistencies: Pureed, Mechanical Soft or Soft Bite Sized, and Regular. Both the Director of Therapy and the SLP were aware of the new menus and stated that they were reviewed with the Registered Dietitian, but they had not seen the menu breakdown. When shown the spread sheet they agreed that bite sized or chopped meats were not there, and it instead read grd which meant ground. The Director stated they use the International Dysphagia Diet Standardization Initiative (IDDSI) guidelines for their mechanically altered diets and that in the building Mechanical Soft is considered bite sized, not ground. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #1 was re-admitted to the facility on [DATE] with an initial admission of 08/27/24. Resident #1 had diagnoses that included Type 2 Diabetes Mellitus, End Stage Renal Disease and Acquired Absence of Left Leg Above Knee. He received Hemodialysis three times a week. The documented resident's BIMS score was 15 on the PPS (Prospective Payment System) Part A Discharge Minimum Data Set with an Assessment Reference Date of 11/14/25, indicating he was cognitively intact. On 12/10/25, a record review was conducted of Resident #1's orders. Review of the diet order revealed an order for 'CHO (Carbohydrate) Controlled, Hi Pro Renal Diet, Regular texture, thin consistency'. An observation was conducted on 12/10/25 at 10:34 AM of Resident #1's breakfast meal. The food on the resident's tray included 2 slices of wheat bread, a serving of scrambled eggs with peppers, a cup of oatmeal, 2 strips of bacon, 4 ounces on apple juice and 4 ounces of 2% milk. The items on the meal tray were confirmed to be for Resident #1 with Staff J, Certified Nursing Assistant (CNA). The surveyor asked the resident if this was a typical breakfast he received and stated that he gets what everyone else does and he was not aware that was on a special diet. On 12/10/25 at 12:20 PM, the lunch meal was served to Resident #1. The lunch meal included 2 rolls, chicken cacciatore with penne, frozen strawberries with whip cream and 4 ounces of cranberry juice. Review of the resident's lunch meal ticket revealed a Regular, CCHO (Controlled Carbohydrate Diet), Hi Pro Renal diet. Review of the Food Service Supplier's [Name provided] Traditional Menu for Week 3 Day 18 revealed the House diet for breakfast would be bacon 1 slice and whole wheat toast 1 slice. The House diet for lunch would be 1/2 cup frozen parslied cauliflower and 1 breadstick. An interview was conducted with the CDM (Certified Dietary Manager) on 12/10/25 at 1:07 PM. He stated he had been working in the facility for one year. He was asked what he serves a resident on a CHO Controlled, Hi- Pro Renal Diet. He stated they do not have a renal diet on the spreadsheet, so he uses a Hi -Pro diet. For a CHO Controlled diet, the resident would have received for breakfast 1 slice of bacon and 1 slice of whole wheat bread. For lunch it would be 1/2 a breadstick and that would be the only difference. The surveyor asked the CDM who would get a CKD5 (Chronic Kidney Disease stage 5) menu. He stated he does not use that and uses a Hi-Pro diet for someone with a renal diet order. According to the Nutritional Care Manual, salty processed meats (such as bacon, bologna, salami and other lunch meats), ham, hot dogs, sausage, breakfast sausage, and pre-seasoned meats) are not on the CKD5 diet. The surveyor revealed to the CDM that observation of Resident #1's breakfast meal revealed he received 2 slices of whole wheat bread and 2 slices of bacon; and for lunch he received 2 rolls and no cauliflower. The CDM stated that was a mistake, that was too many carbohydrates for that resident, and he should have had only 1 slice of bread for breakfast and 1 roll for lunch. He stated he did not have breadsticks, so he substituted rolls. An interview was conducted with the Dietetic Technician (DTR) on 12/10/25 at 1:45 PM. Review of the Sysco spreadsheet was conducted along with the diet order for Resident #1. She stated the diet order in the Electronic Health Record (EHR) did not match the spreadsheet. She stated she would use (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Hi-Pro diet for the renal diet. She also stated that she had not seen this spreadsheet before and the dietician works with it. An interview was conducted with the facility's Dietician over the phone on 12/10/25 at 2:00 PM. She stated she was aware that the diets in the EHR do not match the Food Service Supplier's [Name provided] diet spreadsheets. She stated this has happened in the past and she had to customize the diets. It was discussed with the Dietician that Resident #1 was given bacon for breakfast because he was on a Hi-Pro diet and the CKD5 diet does not allow bacon. When asked how we can be sure he is receiving the proper diet, she stated she agreed with the surveyor that they should match and there should be no guessing on what they are giving the resident. She stated she goes over the labs once a month with the dialysis dietician. The Dialysis Center keeps the labs there, if there are any changes with his diet, the dietician there would let her know. An additional interview was conducted with the CDM on 12/11/25 at 3:00 PM. He stated the Food Service Supplier's [Name provided] diet is in the 4th week, so they have been used for 3 weeks. He stated no one went over the diets with him. He decided that the Hi-Pro diet matched the renal diet order in the EHR. He stated he had a limited discussion with the facility's Dietician that the diets did not match the EHR.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the prescribed therapeutic diet for 1 of 2 sampled residents reviewed for therapeutic diets, Resident #1.The findings included:Record review revealed Resident #1 was re-admitted to the facility on [DATE] with an initial admission of 08/27/24. Resident #1 had diagnoses that included Type 2 Diabetes Mellitus, End Stage Renal Disease and Acquired Absence of Left Leg Above Knee. He received Hemodialysis three times a week. The resident's Brief Interview for Mental Status (BIMS) score was 15 on the PPS (Prospective Payment System) Part A Discharge Minimum Data Set with an Assessment Reference Date of 11/14/25. This indicated he was cognitively intact.On 12/10/25, a record review was conducted of Resident #1's orders. A review of the diet order revealed an order for CHO (Carbohydrate) Controlled, Hi Pro Renal Diet, Regular texture, thin consistency. An observation was conducted on 12/10/25 at 10:34 AM of Resident #1's breakfast meal. The food on the resident's tray included 2 slices of wheat bread, a serving of scrambled eggs with peppers, a cup of oatmeal, 2 strips of bacon, 4 ounces on apple juice and 4 ounces of 2% milk. The items on the meal tray were confirmed to be for Resident #1 with Staff J, Certified Nursing Assistant (CNA). The surveyor asked the resident if this was a typical breakfast he received. He stated that he gets what everyone else does and he was not aware that he was on a special diet.On 12/10/25 at 12:20 PM, the lunch meal was served to Resident #1. The lunch meal included 2 rolls, chicken cacciatore with penne, frozen strawberries with whip cream and 4 ounces of cranberry juice. A review of the resident's lunch meal ticket revealed a Regular, CCHO (Controlled Carbohydrate Diet), Hi Pro Renal diet.Review of the Food Supply Company's (Name provided) Traditional Menu for Week 3 Day 18 revealed the House diet for breakfast would be bacon 1 slice and whole wheat toast 1 slice. The House diet for lunch would be 1/2 cup frozen parslied cauliflower and 1 breadstick.An interview was conducted with the CDM (Certified Dietary Manager) on 12/10/25 at 1:07 PM. He stated he had been working in the facility for one year. He was asked what he serves a resident on a CHO Controlled, Hi-Pro Renal Diet. He stated they do not have a renal diet on the spreadsheet, so he uses a Hi -Pro diet. For a CHO Controlled diet, the resident would have received for breakfast 1 slice of bacon and 1 slice of whole wheat bread. For lunch it would be 1/2 a breadstick and that would be the only difference. The surveyor asked the CDM who would get a CKD5 (Chronic Kidney Disease stage 5) menu. He stated he does not use that and uses a Hi-Pro diet for someone with a renal diet order. According to the Nutritional Care Manual, salty processed meats (such as bacon, bologna, salami and other lunch meats), ham, hot dogs, sausage, breakfast sausage, and pre-seasoned meats are not on the CKD5 diet.The surveyor revealed to the CDM that observation of Resident #1's breakfast meal revealed he received 2 slices of whole wheat bread and 2 slices of bacon. For lunch he received 2 rolls and no cauliflower. The CDM stated that was a mistake. That was too many carbohydrates for that resident. He should have had only 1 slice of bread for breakfast and 1 roll for lunch. He stated he did not have breadsticks, so he substituted rolls.An additional interview was conducted with the CDM on 12/11/25 at 3:00 PM. He stated the Food Supply Company (Name provided) diet is in the 4th week, so they have been used for 3 weeks. He stated no one went over the diets with him. He decided that the Hi-Pro diet matched the renal diet order in the EHR. He stated he had a limited discussion with the facility's Dietician that the diets did not match the EHR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and staff interviews, the facility failed to ensure that meat prepared and ready to be served to residents was maintained at the proper hot-holding temperature on the steam table. This deficiency had the potential to affect all 12 of 12 sampled residents who received the alternate lunch meal, which included chicken on 12/08/25. The census at the time of survey was 121. The findings included: On 12/08/25 at 11:45 AM, during an observation of food service operations and temperature checks conducted with Food Service Assistant, Employee F, the surveyor observed the temperature of cooked chicken on the steam table. Staff F prepared two plates and placed them on the food cart for distribution to residents. Immediately following this, the surveyor measured the temperature of the chicken in the steamtable pan. The pieces located on the top measured 107 F, while the pieces at the bottom measured 127 F (Fahrenheit). At the request of the surveyor, the chicken was immediately reheated to the proper temperature of 165 degrees before serving it to the residents. Review of the facility's Prepared Food Temperature record on 12/11/25 at 12:18 PM revealed that the recorded temperature for the chicken did not match the temperatures observed on 12/08/25. The log showed a temperature of 162 F, which the Food Service Director confirmed reflected the temperature of the meat when removed from the oven, not the temperature while being held on the steam table. The temperature recorded by the surveyor (107 F and 127 F) was below the required minimum hot-holding temperature of 165 F.During an interview on 12/11/25 at 12:22 PM, the Food Service Director acknowledged the discrepancy, stating that the logged temperature represented the initial post-oven reading and confirming that the temperature may have dropped while the chicken was on the steam table. He agreed with the findings and had no further information to provide.