STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105622	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Beach Health and Rehabilitation Center	401 East Sample Road Pompano Beach, FL 33064

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41837 Based on observations, interviews and record review the facility failed to ensure all areas and equipment are clean and in good repair in 11 of 95 resident rooms and in 1 of 1 laundry rooms; and ensure functioning call lights for 2 of 188 resident occupied beds (Resident #290 and #287). The findings included: Review of the facility's policy titled, Physical Environment with an effective date of August 2024 included, in part, the following: A safe, clean, comfortable, and home-like environment is provided for each resident, allowing the use of personal belongings to the greatest extent possible. All essential mechanical, electrical, and resident care equipment is maintained in a safe operating condition through the facility's Preventive Maintenance Program. Assure an applicable working system is in place and within reach for the resident to summon assistance, including, but not limited to: Typical call light with cord. 1) During the initial tour completed on 03/03/25 from 9:30 AM to 11:00 AM, the following observations were noted: room [ROOM NUMBER], the air conditioning vents had a black substance. room [ROOM NUMBER], the air conditioning filter was covered with thick amount of dust/debris. room [ROOM NUMBER], Bed B, the privacy curtain had multiple reddish-brown stains. room [ROOM NUMBER], there were broken drawers at the bottom of 2 wardrobe closets. room [ROOM NUMBER], the air conditioning vents had a black substance. room [ROOM NUMBER], Bed B, there were pieces of laminate flooring that were dislodged. room [ROOM NUMBER], the air conditioning vents had a black substance; the air conditioning filter was covered with thick dust/debris; a hole was in the wall with crumbling plaster at the baseboard next to the bathroom door. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER], the wall around the sink area at the baseboard had a hole in the wall and crumbling plaster. room [ROOM NUMBER], the air conditioning unit had a gap around the unit; and there were dark marks on the wall next to the air conditioning unit. room [ROOM NUMBER], there was missing paint on the bathroom wall; the air conditioning vents with black substance, and gap around the air conditioning unit, missing paint on wall nest to air conditioning unit. room [ROOM NUMBER], Bed B, there was missing paint on the wall behind the head of bed. room [ROOM NUMBER], bathroom had a overwhelming smell of urine. room [ROOM NUMBER], Bed A, the privacy curtain had multiple reddish-brown stains, and there was an overwhelming smell of urine. On 03/06/25 at 11:36 AM, a tour of the facility was conducted with the Administrator who acknowledged the areas of concern. She stated they have been working on air conditioning vent cleanings. 40153 2) A record review showed that Resident #287 was admitted to the on 02/27/25 with diagnoses of Type 2 Diabetes, Altered Mental Status, and Anorexia. The Admission Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 13, indicating the resident is cognitively intact. In an interview conducted on 03/03/25 at 10:55 AM, Resident #287 stated that she verbally asked a staff member 20 minutes ago for assistance to get out of bed to her wheelchair and is still waiting. This Surveyor then asked her if she could use the call light on her bed to call for assistance. Resident #287 pressed the round call light on her bed, but no light was noted outside her room. Continued observation in the nurse's station did not show any light or noise on the call light box for Resident #287's room. In an interview conducted on 03/03/25 at 11:30 AM, Resident #287 stated that she was still waiting to get out of bed and could not get any of the staff's attention. She then attempted to press the call light button again, but no light was noted outside her room or in the nurse's station. Record review showed that Resident #290 was admitted to the facility on [DATE] with diagnosis of a history of falling and Muscle Weakness. The Admission Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. In an interview conducted on 03/03/25 at 11:35 AM with Resident #290, she stated that the call light is not working sometimes, and she has to wait over an hour for staff to come into the room. She often calls the front desk nurse's station to ask for help when the call light does not work. In this interview, Resident #290 used the call light in front of the Surveyor, but no light was noted outside the room. About 3 minutes later, Resident #290 used the call light again, and a light was noted outside the room and in the nurse's station. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/25 at 8:35 AM, an observation was made of Resident #287 in bed with the call bell in reach, call bell pushed and no light outside of resident door and no sound at nursing station. On 03/05/25 at 8:40 AM, an observation was made of Resident #290 in bed with the call bell within reach. The call bell was pushed three times before the light outside the resident's door came on, and a sound was heard at the nursing station. During an interview conducted on 03/05/25 at 8:45 AM with Staff D, Certified Nursing Assistant who acknowledged that the call bell for Resident #287 did not work. She stated there should have been a light outside of the resident's door and a ring at the nursing station. During an interview conducted on 03/05/25 at 8:50 AM with Staff E, a Registered Nurse (RN) who stated she has worked at the facility for 2 years, she said that when a call bell is activated by a resident, it should light up outside of the resident's door and also ring at the nursing station. 50370 3) A review of documents provided by the NHA (Nursing Home Administrator) on 03/06/25 11:52 AM revealed :a dryer lint repair estimate dated 03/05/25 Another document stated the facility approved the estimate on 03/05/25 at 4:38 PM. There was no new repair estimate submitted for the air conditioner specific to the Laundry Clean Linen room [ROOM NUMBER]. There were no documents submitted for the repair of the Washer #3, Dyer #1 in the Clean Linen Room, and Washer #2 in the Dirty Linen Room. During a tour of the Laundry Room on 03/05/25 9:50 AM , Staff V, Housekeeping , who has been working in the facility for [AGE] years stated that the air conditioner (AC) unit in the Laundry Clean Linen room [ROOM NUMBER] has not been working for weeks. She did not remember when it stopped working, but stated she has a fan to keep herself cool and kept the room closed at all times. Observations revealed the lint box under Dryer #1 had few black lint materials stacked on the filter box. Staff V, Housekeeping added Dryer #1 was not working. Further observations revealed Dryer #2 had a few lint materials at the bottom, showing the filter cartridge was broken and not keeping the clothes lint attached to the filter, although the dryer was running and working. When asked regarding the cleanliness of the room, Staff V, Housekeeping stated it was done by Maintenance. When asked if she had informed the Facility Administration regarding the inoperable AC, Dryer #1, and Washer #3, she responded, The Housekeeping Manager knows. During a tour of the dirty linen room where they receive dirty linen from the facility, Washer #2 was not working. Dried rust was observed around the broken washer. Washer #1 was leaking water both in front of the machine and at the back. There was a bucket of brownish liquid behind Washer #1. Washer #1 also had rusty areas all around the machine and with an open area at the right back side of it. When the Housekeeping Manager was asked about the status of repair of the broken ac unit, washers and dryer, he stated he submitted them. When asked who maintained the washing machines, he responded, The Maintenance Staff. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Staff V, Housekeeping, she stated she uses gown and gloves when putting resident's clothes inside the washer and when taking them out of the washer. She added she is not responsible for the linen because another Housekeeping Staff does the resident's linen. A further observation of the ceiling vent on top of the dryer revealed dirt and blackish color. The Housekeeping Manager was asked regarding the Maintenance schedule record for the laundry rooms cleaning and maintenance. Until the end of the day 03/05/25 5:15 PM, no record was submitted. The NHA was informed that the record for cleaning and maintaining of Laundry Rooms were asked from Housekeeping Manager since morning and still was not received at 5:10 PM. In an interview with another Housekeeping Staff who only speaks a different language (Housekeeping Manager was the interpreter), she stated she does not use gloves when handling clothes from the dryer. She uses a gown all the time when she puts on clothes inside the dryer and when taking them out of the dryer. During a tour of this room, the door had a collection of dried-up lint on the metal hinge of the door. In an interview with the Housekeeping Manager on 03/05/25 10:00 AM, he stated that the request for repair for all the machines, and the ac unit had been submitted to the NH Administrator.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to address a grievance in a timely manner, regarding personal belongings for 1 of 1 sampled resident (Resident #90) reviewed for grievances. The findings included: Review of the facility's policy titled, Grievance/Concern Management, dated November 2024, included the following: Policy: These rights also include the right to prompt efforts by the facility to resolve resident concerns, including concerns/grievances with respect to the behavior of other residents. Procedure: 4. The NHA (Administrator) is responsible for oversight of the concern process. 5. Social Services will monitor and document resident/representative satisfaction upon completion of the investigation and the summary of findings/conclusion. 6. Social Service Director in collaboration with the NHA will be the Grievance Official at the facility. 7. The facility leadership team will review and discuss concerns and the progress of an investigation(s) and resolution(s). 8. The department involved will document the concern and record the resident/resident representative's satisfaction with the resolution to the concern. 11. Concerns are tracked, trended, and reported in the monthly Quality Assessment, assurance and Compliance Committee Meeting. 13. Complete a concern report investigation with summary and conclusion. 14. Social services staff will provide information regarding compliance line information for unresolved concerns. Record review revealed Resident #90 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Dependence on Renal Dialysis, Hereditary and Idiopathic Neuropathy, Atherosclerosis of other Coronary Artery Bypass Graft(S) With other Forms of Angina Pectoris, Muscle Weakness (Generalized), and Encounter for other Specified Surgical Aftercare. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #90 had a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated that he was cognitively intact. During an interview conducted on 03/03/25 at 10:57 AM with Resident #90, who reported he had to go to the hospital two and a half months ago because of a heart attack. He further reported when he returned to the facility, all his personal belongings were gone, which included his iPad, pictures of his family, and clothing. He stated he has asked the Unit Manager, Social Services, and the Administrator for updates on his belongings, and he has not received a response. Resident #90 stated he felt horrible because when he returned, he had to wear someone else's clothes to his Dialysis treatment. He also stated that when he kept asking for information, the facility put a grievance on his behalf. However, there's been no resolution, and it has been over two months. Further record review documented Resident #90 was a long-term resident and was discharged to the hospital on 11/12/24 and returned to the facility on [DATE]. Review of the grievance log revealed Resident #90 had an active grievance on 12/19/24. Review of the 12/19/24 grievance/concern report documented by Social Services revealed Resident #90 reported his items have not returned to him since he came back from the hospital. In the same form under resolution, it stated Spoke with resident and brother, request receipts so items can be replaced. The report was signed by Staff I, Social Services Director and the Administrator on 12/19/24. No other documentation or investigation was noted in the grievance report. During an interview conducted on 03/04/25 at 3:19 PM with Staff I, Social Services Director, who stated she has worked at the facility for about a year. She stated that any staff member can assist a resident with a grievance, and all grievances come to social services where they will be distributed to the proper department to be investigated; once the department has resolved the grievance, the report is returned to social services. Staff I stated if they have not received a resolve report from the department, usually within a week, social services will follow up with the department. In addition, she stated any unresolved grievances are discussed in the morning meetings with the administration team. Staff I stated she filed the grievance on behalf of Resident #90. She also noted that she spoke with Resident #90 and his brother to request receipts for the items in order to replace them. In addition, she stated that when a resident is discharged to the hospital, the nursing staff packs resident's belongings in a box and maintenance personnel places the boxed items in the storage room. She stated she spoke with the resident and informed him of the ongoing investigation (however, when asked for documentation of the investigation, none was provided). During an interview conducted on 03/04/25 at 3:35 PM with Staff L, Registered Nurse (RN) and Unit Manager, who stated she has worked at the facility for [AGE] years and a unit manager for 2 years. She stated that if a resident is discharged to the hospital, the items will be boxed and placed in the storage room; if the resident is long term care, the personal belongings are usually held in their room for a week or so. Staff L stated once the resident returns to the facility maintenance brings the belongings back to the resident's room. She stated that for Resident #90 they have looked in the storage but have not found any of his items. She noted speaking to the resident about obtaining receipts to replace the items. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the storage room and an interview were conducted on 03/04/25 at 3:59 PM with Staff K, Maintenance Assistant. He stated that he has worked at the facility for 2 years. He stated nursing staff will contact him when a resident's boxed items need to be picked up and stored and are only stored in one room. Staff K stated that he has looked for Resident #90's boxed items but has not found anything. He noted that they keep a discharged Resident Storage (DRS) Log in the storage room. He stated he picks up the box from nursing, then brings it to the storage room and he writes the following information in the Storage log: Resident's name, room number, date stored, how many boxes, if family is notified and if family picks the box up. Review of the DRS log for 2024 revealed Resident #90's boxed items were never registered as stored in the storage room. A copy of the DRS 2024 log was obtained. During an interview conducted on 03/06/25 at 3:08 PM with the Administrator, who stated she has been at the facility since October 2024 as the Assistant Administrator, and has been the Interim Administrator since 02/03/25. She stated that during morning meetings Social Services would let the team know of any unresolved grievances. She stated she spoke with Resident #90's brother regarding the missing items, and she mentioned that they would reimburse the items if he can find the receipts; however, she did not discuss with the brother or Resident #90 about any reimbursement for any current expenses the brother has done to replace Resident #90's clothing. She stated she believes Staff L spoke with the resident and explained the reimbursement process and that the items cannot be found. At this time, the Administrator was shown Resident #90's grievance report (which shows her signature), and she acknowledged that the report was not filled out correctly and that no follow-up or investigation was done.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to assist during dining and provide nutritional supplements in a timely manner for 1 of 6 sampled residents reviewed for nutrition (Resident #288); and the facility failed to accurately assess the nutritional status of 1 out of 2 sampled residents reviewed for tube feeding (Resident #158). The findings included: 1. Record review revealed that Resident #288 was admitted to the facility on [DATE] with diagnoses of Macular Degeneration and Muscle Wasting. The Admission Minimum Data Set (MDS) assessment dated [DATE] showed that Resident #288 had a Brief Interview of Mental Status (BIMS) score of 12, which was moderately cognitively impaired. Section B of this MDS showed that Resident #288's vision was severely impaired. In an observation conducted on 03/03/25 at 12:32 PM, Resident #288 was noted in her room with the lunch tray. Resident #288's family member was at the side table assisting Resident #288 with her lunch tray. The meal was noted to have pork steak, mashed potatoes, green beans, and Jello. No nutritional supplements were noted on the meal tray. In this observation, the Resident's family member said that she usually had no one at the bedside to assist her with her meals and that she was blind. In an observation conducted on 03/04/25 at 8:18 AM, Resident #288's tray was barely touched, and no staff was in the room to assist her with her meal. The breakfast tray was noted to have regular fortified oatmeal, french toast, sausage patty, juice, and a carton of milk that was not opened. A continued observation at 12:28 PM showed that the breakfast tray was taken away by staff. In an observation conducted on 03/04/25 at 12:28 PM, Resident #288 was in the room eating her lunch meal without staff assistance. She was observed trying to eat her food with her hands. Continued observation at 12:42 PM showed no staff in the room and Resident #288 ate about 20% of her meal. The lid covers were not taken off from her drinks or the banana pudding container. A review of the Weights log showed the following weights for Resident #288: On 02/21/25, a weight of 124 pounds. On 02/25/25, a weight of 118.6 pounds. On 02/27/25, a weight of 118.2 pounds. The nutrition follow up note dated 02/28/25 showed the following: Resident #288 had a significant weight loss of 4.7% in 7 days. Resident #288 requires assistance with meals for all feedings. Discussed the importance of good intake with all meals. In this note, Staff B, Registered Dietitian recommended to add Magic Cup (nutritional supplement) for lunch and dinner to provide an additional 580 calories and 18 grams of protein a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 02/21/25 showed that Resident #288 had an impaired cognitive function related to dementia. Impaired visual function related to Glaucoma and Macular Degeneration. It further showed that the Resident needed one person's assistance for eating and was at nutritional risk with nutritional supplements in place. A review of the Medication Administration Record did not show that an order for Magic Cup was placed after it was recommended on 02/28/25. In an interview conducted on 03/04/25 at 12:30 PM with the Food Service Director, he stated that the facility's Dietitian enters the Magic Cup into the electronic system as an order. He then puts the order in the meal tracker, which shows up on the meal ticket for the specific residents. In an interview conducted on 03/06/25 at 9:13 AM with Staff A, a Registered Dietitian, he stated that the Magic Cup is added to the task section in the electronic system. It has also been added to the meal tracker for the kitchen staff and will show up on the meal ticket. He was responsible for adding the supplements to the electronic system and the meal tracker. Once added, the Magic Cup would come up on the tray for lunch and dinner every day. When asked by the Surveyor, Staff A could not show the Magic cup on the meal tracker or in the electronic system and then said, she must have overlooked it. A weight was taken on 03/06/25 as per the Surveyor's request, which showed that Resident #288 was 114 pounds. This showed a significant weight loss of 8% from 02/21/25 to 03/06/25. 2. A record review revealed that Resident #158 was admitted to the facility on [DATE] with diagnoses of Dementia, Muscle Wasting, and Protein Calorie Malnutrition. The Quarterly Minimum Data Set (MDS) dated [DATE] showed that Resident #158 had a Brief Interview of Mental Status score of 08, which is moderate cognitively impaired. A review of the Physician's Orders showed an order for tube feeding Jevity 1.5 (tube feeding type), 240 milliliters to be administered 3 times per 24 hours during waking hours, dated 02/05/25. In an observation conducted on 03/03/25 at 12:40 PM, Resident #158 was observed in the room eating his lunch tray. The meal ticket was noted as a mechanical soft bite size. Resident #158 ate 100% of his lunch meal independently. In an interview conducted on 03/04/25 at 8:24 AM, Resident #158 stated that he ate all his breakfast this morning. A review of the Medication Administration record showed that for February 2025, Resident #158 received tube feeding bolus feeding 3 times a day. The Quarterly Nutrition Evaluation dated 02/5/25 showed the following: Resident #158 was on a Regular diet with Jevity 1.5, 240 milliliters bolus feeding three times a day. He appeared well-nourished and hydrated, enjoying his meals and getting enough food. He continued with weight gain and decreased tube feeding and meal intake. It was recommended to further decrease the tube feeding at this time due to the continued good meal intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 03/06/25 at 8:44 AM, Staff C, Licensed Practical Nurse, stated that Resident #158 was on tube feeding bolus 3 times a day, that it was given as ordered, and that he was tolerating the feeding well. A review of the Monthly Nutritional Risk Evaluation dated 03/05/25 completed by Staff B, Registered Dietitian, showed the following: High-risk category because Resident #158 was on tube feeding. For the Enteral feeding order (section D), Staff B completed the Not Applicable (NA). Staff B completed NA for the number of calories from the enteral feeding. For the amount of protein provided by the Enteral feeding, Staff B completed NA, and for the total free water provided by the Enteral feeding, Staff B completed NA. In this note, Staff B did not address the calories and protein provided by the tube feeding. In an interview conducted on 03/06/25 at 8:51 AM, with Staff A, Registered Dietitian, he stated that Resident #158 was on bolus tube feeding 3 times a day which provided an extra 1080 calories and 45.9 grams of protein. When asked about section D that was completed by Staff C, Staff A stated that it should have been filled out with the correct information. He further said that the goal was to wean Resident #158 off the tube feeding and provide his nutritional needs by mouth.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews and record reviews, the facility failed to provide proper care and documentation of the tracheostomy and failed to assess the resident for self-care of tracheostomy for 1 of 1 sampled resident reviewed for tracheostomy care (Resident #87). The facility also failed to properly date the oxygen tubing for 1 of 1 sampled resident reviewed for oxygen therapy (Resident #4); and failed to properly store the nebulizer mask for 1 of 1 sampled resident reviewed for respiratory therapy (Resident #21). The findings included: Review of the facility's policy titled, Tracheostomy Suctioning Competency Skills Checklist undated, revealed the following: Purpose: Tracheostomy (Trach) care is the process of aseptically cleaning the tracheostomy tube and soma site. The buildup of mucus and rubbing of the tracheostomy tube can irritate the skin around the stoma. The skin around the stoma should be cleaned at least twice a day to prevent odor, irritation, and infection. Procedure: Gather supplies: trach care kit or gather supplies non-sterile gloves, sterile gloves, trach ties (if soiled), suction kit, disposable inner cannula, extra sterile, saline and non-sterile 4 x 4's, bag to discard dressing/items in. Prepare trach care kit and supplies on worksurface area. Put on sterile gloves found in kit. Review of the facility's policy titled, Policy and Procedure Oxygen Therapy November 2023, revealed the following: Policy: Oxygen is provided to residents based on physician's orders to supplement oxygen as needed per disease process. Procedure: 2. Practice standard precautions. Education: 5.Oxygen Devices a. Nasal cannula v. Change out weekly and as needed (PRN). vi. Place in a labeled bag when not in use. (continued on next page)

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Deerfield Beach Health and Rehabilitation Center	401 East Sample Road Pompano Beach, FL 33064

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Partial Rebreather Mask ix. Place in a labeled bag when not in use. 1) Record review for Resident #87 revealed the resident was admitted to the facility on [DATE] with diagnoses that included the following: Tracheostomy Status, Dependence on Supplemental Oxygen, and Malignant Neoplasm of Pharynx. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #87 had a Brief Interview for Mental Status (BIMS) of 14 out of 15, which indicated that he was cognitively intact. Review of the Physician's Orders showed that Resident #87 had an order dated 01/14/25 for Trach care: Cleanse tracheostomy site with normal saline, pat dry. Change inner cannula. Cover with drain sponge daily and as needed, during the day shift. Review of the February and March 2025 Treatment Administration Record (TAR) documented that Resident #87 received tracheostomy care as per the physician's orders indicated above. Additionally, a review of the March 2025 TAR audit report revealed Resident #87's Trach care was documented as administered on 03/01/25 at 7:53 AM, 03/02/25 at 8:08 AM, 03/03/25 at 8:00 AM and on 03/05/25 at 11:41 AM. On 03/04/25 no documentation or administration time was documented for Trach care. A review of the Care Plan dated 01/24/25 documented that Resident #87 had behavioral problem of intermittently removing inner cannula with interventions to document behaviors and explain procedures to the resident. A review of the Care Plan dated 02/12/25 documented that Resident #87 was noted to refuse trach care, with interventions to encourage participation/interaction by the resident as possible during care and give clear explanations of all care activities. Record review of the nursing progress notes from 02/12/25 to 03/05/25 revealed no documentation of Resident #87 refusing trach care or have been observed performing self-tracheostomy care. In addition, there was no record of an assessment conducted by the facility to assure Resident #87 can self-perform trach care safely and aseptically. During the initial tour conducted on 03/03/25 at 12:07 PM, Resident #87 was observed with a tracheostomy and was walking with his walker in the hallway towards the nurses' station; however, the tracheostomy was not covered. Resident #87 stated he was waiting for the nurse to do his breathing treatment. On 03/03/25 at 3:15 PM, Resident #87 was again observed in the hallway near his room standing with his walker and was holding a clean Trach collar. He then stated he was waiting for the nurse to help him change the collar. He was then asked who cleans the Trach, he pointed to himself. He stated he knows how to do it, but it is hard to change the collar by himself. An interview was conducted on 03/04/25 at 1:09 PM with Staff J, Registered Nurse (RN), who stated she has worked at the facility for 18 months. She stated that if a resident refuses treatment or medication, she writes it in the progress notes and calls the physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 03/05/25 at 1:50 PM with Resident #87, who was asked if the nurse had provided Trach care today. He stated no but would like the nurse to change his trach collar. He stated he has had the Trach for 6 years and has learned how to change the canula and clean the trach prior to coming to the facility; however, he was not educated on how to clean it in this facility, and there has not been a nurse present when he does the Trach care. During an interview conducted on 03/05/25 at 2:55 PM with Staff H, Licensed Practical Nurse (LPN) who stated she has worked at the facility for [AGE] years. She acknowledged that she has not performed Trach care for Resident #87 today; however, he often lets her know when he wants his trach collar changed. She stated that she only changes the collar and cleans the area around the trach and Resident #87 usually cleans the inner canula and sometimes he is seen with the canula in his hand. Staff H also stated that Resident #87 does not often require suction and therefore, she does not do it. At this time, this surveyor mentioned to Staff H that Resident #87 has been waiting for her to change his collar and will observe her provide Trach care to Resident #87. While waiting for Staff H to provide Trach care, Resident #87 was observed in the hallway with his walker and was coughing. He walked into his room, grabbed a towel, walked back into the hallway and placed the towel over the Trach to catch the phlegm as he was trying to bring it up. Then, Resident #87 was asked if the nurse assist him to remove the phlegm using the suction machine, he stated no and that he knows how to use the suction machine and sometimes does use it to clear out the phlegm. At 3:15 PM, Resident #87 was still waiting for Staff H to provide trach care. This surveyor returned to the nurses' station to locate Staff H. There were a few staff members at the nurses' station including the nurse supervisor and the Staff Development Coordinator (SDC). The nurse supervisor asked the surveyor if the incoming nurse could provide the trach care since it was change of shifts. The nurse supervisor, the SDC, and the Director of Nursing (DON) were informed that Staff H had documented in Resident #87's TAR that she had already provided Trach care this morning, however she did not perform the care. A tracheostomy care observation was conducted on 03/05/25 at 3:24 PM with Staff H for Resident #87. Staff H gathered the supplies from the medication storage room in a zippered bag. Staff H was joined by the SDC for assistance. Staff H introduced herself to Resident #87 and advised that she was going to perform tracheostomy care. The resident's room door was closed for privacy. Staff H and the SDC washed their hands, donned on gown, mask and gloves. Then, the bedside table was cleaned and waited to dry then, the protector was placed on table, and the supplies were laid out on the table which included saline, a trach care kit, and a trach collar. Staff H removed the collar from the package and adjusted the straps and then placed it back in the package. Resident #87 was asked to lay down and the soiled collar was removed. At this time, Resident #87 had a cough with phlegm, and he used a towel to clean up the phlegm from the trach opening (Neither nurse asked the resident if he wanted to be suctioned). Then Staff H removed her gloves and washed her hands. She returned to the bedside table and opened the trach care kit and removed the sterile gloves, however, did not put the sterile gloves on, instead picked up the saline container and reached inside of the trach care kit without donning the sterile gloves. At this point, the SDC told her to get another trach kit from the drawer next to the resident's bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Without performing hand hygiene, Staff H opened the second trach care kit and dumped all its contents on the bedside table including the sterile gloves package which ended up under the sterile gauze. She was about to move aside the sterile supplies to get to the gloves when the SDC mentioned to her to get another kit. Staff H got another kit from the drawer and without performing hand hygiene grabbed the sterile gloves package and fumbled with the sterile gloves and was unable to put them on and touched all the sterile gloves with her ungloved right hand. At this point, the SDC asked if it was okay to take over the procedure. The surveyor agreed. The SDC went to retrieve another trach care kit from the drawer but there were no more and stated she would get a few from the storage room. The SDC left the room for about 7-8 minutes during this time Resident #87 was sitting at the edge off his bed waiting. The SDC returned to Resident #87's room with a few trach care kits, saline and clean scissors. The SDC followed sterile procedure, the soiled disposable inner cannula was removed and replaced with a new clean cannula. On 03/06/25 at 10:40 AM, an interview was conducted with the SDC. She stated that currently in the facility there is only one resident that has a Trach. She acknowledged that Staff H was educated on 11/09/23 and on 12/07/23 after last year's re-certification survey, in which Staff H had difficulty performing Trach care during that survey. She also stated that competencies are provided if a resident is admitted to the facility with a Trach or as needed. If there is no resident admitted to the facility with a Trach throughout the year, then the education is done annually since there is no need to provide the trach care. In addition, she acknowledged that all nurses performed the Trach care procedure 100% after last year's survey and therefore there was no need to conduct competencies throughout the year. During an interview on 03/06/25, the surveyor discussed these concerns with the Facility Administrator and the DON. 50370 2) Record review revealed Resident # 4 was admitted to the facility on [DATE] with diagnoses that included Gastroesophageal Reflux Disease without Esophagitis, and Dependence on Supplemental Oxygen. A review of the admission Minimum Data Set (MDS) assessment dated [DATE], documented the resident is rarely or never understood, regarding cognition. A record review of orders dated 01/15/25 revealed oxygen at 2 Liters per minute via nasal cannula continuously for shortness of breath; Change and date respiratory equipment tubing weekly & prn (as needed). Review of the Medication Administration Record (MAR) revealed a check mark and initials on 02/26/25 parallel to change oxygen tubing & set-up weekly every night shift every Wednesday, label tubing with date when changed, with an order date of 01/15/2025 at 10:54 PM. A further review of March MAR did not reveal an oxygen tubing change on 03/03/25. The MAR box for change oxygen tubing & set-up every night shift, every Wednesday, label tubing with date when changed, with an order date of 01/15/25 had an x, indicating it was not done on 03/03/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of page 9 of the March MAR on the box with change oxygen tubing & set-up weekly as needed, label tubing with date when changed with an order date of 01/15/24, with a PRN (as needed), had no check mark, x mark, numbers and initials on 03/03/25, indicating it was not done. During an observation conducted on 03/03/25 at 11:54 AM, Resident #4's oxygen tubing had a date of 03/3/25. 3) A record review revealed Resident #21 was admitted to the facility on [DATE] with the diagnoses that included Shortness of Breath, Major Depressive Disorder, and Metabolic Encephalopathy. A review of Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating impaired mental cognition. A review of orders dated 02/16/25 revealed to change nebulizer set up and tubing every week, every night shift, and every Wednesday, label tubing with date when changed and as needed. An additional review of orders dated 12/23/24 revealed to change the oxygen tubing and set up weekly, every night shift, every Wednesday, label tubing with date when changed. An additional review of the MAR dated 02/2025 revealed a check mark with numbers and a letter on 02/26/25 parallel to change nebulizer set up and tubing every week every night shift, every Wednesday, label tubing with date when changed, with an order date of 02/17/25 at 2:59 PM, indicating the nebulizing tubing and set up were changed. A further review of 02/2025 the MAR revealed a checkmark with numbers and a letter on 02/26/25 parallel to the box of change oxygen tubing & set-up weekly every night shift, every Wednesday, label tubing with date when changed, with an order date of 12/22/24 at 8:02 AM, indicating the oxygen tubing was changed. On the MAR order box indicating to change nebulizer set up and tubing every week as needed, label tubing with date when changed, PRN, with an order date of 02/17/25 at 2:59 PM, there were x marks observed from 02/01/25 to 02/16/25, and empty boxes from 02/17/25 until 02/28/25 indicating there were no changes done. Additional review of the MAR on the box with change oxygen tubing & set-up weekly as needed, label tubing with date when changed, PRN, with an order date of 12/22/2024 at 8:02 AM , revealed no x, letters, and numbers indicating there were no activities during the month of February. During an observation conducted on 03/03/25 at 11:04 AM, Resident #21's green nebulizing tubing was not enclosed in a plastic bag. It was on top of a portable oxygen machine. A plastic bag was on top of the green nebulizing tubing with black ink written data including 02/20/25, venti R, Resident#21's room number, and nasal cannula. In an interview conducted with Staff N, Registered Nurse (RN) on 03/03/25 at 11:55 AM, was asked how they care for oxygen tubing and nebulizing tubing, responded that We change them according to doctor's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview conducted with Staff T, Licensed Practical Nurse (LPN) on 03/03/25 at 12:10 PM, was asked how she cares for resident with oxygen, and nebulizing treatments, responded I make sure the nebulizing tubing is contained in a plastic bag when not in use. I make sure that I check the oxygen tubing, and the nebulizing tubing are cleaned and dated.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to identify a resident's Post-Traumatic Stress Disorder (PTSD) trigger to deliver competent trauma informed care and failed to initiate a care plan identifying a specific PTSD trigger for a trauma informed care for 1 of 1 sampled resident (Resident #103), reviewed for [NAME]-Informed Care. The findings included: A review of the facility's policy titled, Trauma Informed Care revealed one of the policy purposes is for accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The document also revealed the Admission Nurse will: attempt to obtain additional information regarding triggers from family, resident representative, resident and records; communicate the PTSD (Post Traumatic Stress Disorder) to team using 24-hour report, shift to shift report progress notes and Kardex. Additionally, the document revealed that Social Services will develop a comprehensive person-centered care plan that addresses specific triggers and appropriate interventions. A review of a document titled' Trauma-Informed Care revealed to know the resident triggers (p. 8, Provide Person Centered Care); and all Staff that care for a resident will need to know their triggers and interventions that minimize or eliminate re-traumatization (p. 9, Take aways). A record review of document dated 11/11/24 and titled In Service Training Record for Trauma Informed Care Policy, with objectives to provide services for residents who have experienced mental or psychosocial adjustment difficulty, or who have history of trauma or have diagnoses of PTSD, revealed the signatures of 40 attendees including Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and Unit Managers (UMs). Review revealed Resident #103 was admitted to the facility on [DATE] with diagnoses that included Disease of the Spinal Cord, Quadriplegia, Major Depressive Disorder, and PTSD. A further record review of the Minimum Data Set (MDS) assessment dated [DATE], Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating good mental cognition. A review of progress notes by the Advanced Practice Registered Nurse (APRN) related to Psychiatry consult, dated 03/05/25, revealed Resident #103's diagnoses included Depression, Major in remission, Generalized Anxiety Disorder, PTSD, and Schizoaffective Disorder. The following were the recommendations: To include a continuing monitoring of mood or behavioral changes, efficacy, and side effects, and Psychiatry to be notified. There were no written recommendations related to Resident #103's PTSD trigger. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of other notes found on the Medication Administration Record (MAR) dated March 2025 revealed Psychiatry, Dietary, Restorative, Physical Therapy (PT), and Occupational Therapy (OT) consults, Activities of Daily Living (ADL), Neuro education and retraining group treatment when appropriate, with resident/care giver education and discharge planning. There was no information regarding Resident #103's PTSD trigger. A review of a care plan initiated on 07/16/23, with a revision date of 09/17/24 and a target date of 03/17/25, in Point Click Care (PCC is a Nursing Home Electronic Health Record {EHR}), revealed Trauma Informed Care, with a focus on quadriparesis and suicidal ideations. The documented goals were: Staff will make efforts to avoid flashback or trigger; Staff will assist in managing the resident's response to the trigger; and the frequency or severity of resident's trauma-related signs and symptoms will not increase. There was no focus for Resident #103's PTSD and the resident specific trigger was not identified. The care plan interventions include: Coordinate psychology or psychiatric services on admission and as needed; Encourage to express feeling, concerns and thoughts; Provide with meaningful activities. There were no documented goals, or interventions related to Resident #103's PTSD trigger. A review of a care plan initiated on 11/05/24, with a target date of 03/17/25 revealed a focus on Trauma-Informed Care. The documented goals were: The frequency or severity of resident trauma related signs and symptoms will not increase; Coordinate support groups as requested; Encourage to express feeling, concerns and thoughts, Observe for reported symptoms of a trigger. There were no documented focus, goals, or interventions for PTSD specific trigger for Resident #103. A review of the Certified Nursing Assistant (CNA) Task form dated 02/22/25 to 03/06/25 revealed check marks for behavior monitoring but no monitoring for Resident #103's specific trigger. In an interview conducted with Resident #103 on 03/04/25 3:00 PM, was asked how long he knew about his PTSD, responded Since 2001. He added that it started after a ceiling fell on him while he was sleeping. When asked if anything triggers his PTSD, he stated, Yes, loud noises. When asked if facility Staff had asked him about his triggers, he responded, No Staff from the facility ever asked me about my triggers. In an interview conducted on 03/04/25 at 3:19 PM with Staff W, Licensed Practical Nurse (LPN), was asked if she had known Resident #103's triggers, responded, Sometimes Resident #103 get scared. She added there was no documentation in PCC that identifies Resident #103's triggers. When asked if she had asked Resident #103 if there are thoughts, sound, and smell, that could trigger him, she responded, she had never asked the resident. In an interview conducted on 03/04/25 at 3:43 PM with Staff P, Certified Nursing Assistant, CNA, who has been working in the facility for almost [AGE] years, was asked regarding PTSD responded, I do not know PTSD. When asked again if she received in service regarding PTSD, responded, Yes. When asked if there is a resident on residing at the facility who has PTSD, she responded, No one has PTSD on this unit. When informed that Resident #103 has PTSD, she responded, she has never taken care of Resident #103, and she has never answered his call light. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff R, RN, on 03/05/25 at 3:53 PM, who has been working in the facility for [AGE] years, was asked regarding PTSD, responded, It is a stress problem when a resident has problems in his house. She added that she cares for a lot of these residents by talking to them. When asked if she knew how to identify triggers for residents with PTSD(s), she responded, The way they are talking. When asked if there is a current resident with PTSD on her unit, she responded, No. When asked if she knew Resident #103 has PTSD, she did not respond. When asked if she knew any PTSD triggers for Resident #103, she responded, Agitation, talking, needing something, and talking loud. When asked how she identified and avoided triggers for Resident #103, she responded that she avoided triggers by talking to him and helping him. When asked again about Resident #103's triggers for clarification, she responded, When he needs help or something. When asked regarding any of her PTSD training and in-service, she responded, There were no in services regarding PTSD. When asked how she documents PTSD in PCC, she responded , I never had a problem with the resident. He never reacted or received a trigger from him during my shift. When asked again about the Resident#103's PTSD trigger, she responded The trigger is when he has a problem. When asked on how to document PTSD trigger in PCC, she responded There is no documentation of PTSD in progress notes, but she is able to check the care plan for PTSD. In an interview conducted on 03/04/25 at 4:10 PM with Staff I, Social Worker (SW), who stated she has been working in the facility for almost 2 years, was asked regarding the process of admitting a PTSD resident, responded she will initiate a trauma care plan and make a referral to both a Psychiatrist and a Psychologist, which would be documented as consultation orders by Staff Nurses. When asked if the PTSD triggers are documented in the resident's care plan, she responded, We initiate a Trauma- Informed care plan, talk to resident and ask what the triggers are. When asked about common resident triggers, she emphasized, The triggers sometimes feel like a little depressed. She added that she will document the PTSD, speak with the resident, and identify the resident's PTSD triggers. When asked how she would coordinate and communicate the care of PTSD diagnosed residents with Nurses, she responded, Most of the time there is no trigger, so I based my care plan based on the PTSD diagnosis. She added that if there is no trigger, there is nothing to report to the Nurses. The Nurses can continue providing care for the resident like they normally would care for other residents, and because the PTSD diagnosed resident is seen by both the Psychiatrist and Psychologist, the medications might be controlling the PTSD. In another interview with Resident #103 with Staff I, SW on 03/04/25 04:36 PM, was asked about his triggers, responded, She knows that my triggers are loud noises. Staff I, SW did not say a word and just looked at the resident on 03/04/25 at 4:39 PM. In an interview with Staff Q, SW on 03/06/25 10:50 AM, who has been working in the facility for 1.5 years, was asked if the facility has a PTSD resident, responded, There is one. When asked if this resident told her about his triggers, she responded, I had few and short encounters with the resident. During those encounters, he never mentioned his triggers, and he is being followed by a Psychologist.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, record review and interview, it was determined that the facility failed to ensure that it maintained sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents, in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The findings included: Record review of the facility policy and procedure titled, Staffing provided by the Director of Nursing (DON) effective August 2024 documented in the Policy Statement: The Administrator and the DON are responsible to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident, as required by federal law and sufficient state law requirements (including minimum staffing ratios. The projected staffing plans are re-evaluated on an ongoing basis through reviews conducted by the Facility. The facility Administrator and the DON should evaluate staffing on a daily basis. Procedure: Establish Facility Projected Staffing Levels. 1. Monitor the census and resident special care needs daily .3. Adjust staffing throughout the day based on census and resident special care needs changes. 4. Develop daily staffing patterns that allocate positions per unit, per shift, and by assignment. 5. Monitor to ensure minimum Staffing Standard levels are always maintained Ongoing Monitoring. 1. Monitor open position and call-offs throughout the day and respond to staffing needs as needed . On the Staffing Calculations Form for the three (3) months of January, February and March 2025 it was documented that the licensed nursing staff daily average hours were recorded as less than 1.0 hour on two (2) days: Sunday 01/26/25 and Sunday 02/09/25 for dates-of-service (DOS). Resident #126 was readmitted to the facility on [DATE] with diagnoses which included Paraplegia, Anxiety Disorder, Major Depressive Disorder, Hypotension and Polyneuropathy. She had a Brief Interview Mental Status (BIM) score of 15 indicative of intact cognition. An interview was conducted with Resident #126 on 03/03/25 at 1:40 PM, in which she indicated that it does bother her that on the weekends, the facility is sometimes short staffed affecting her overall care needs. During an interview conducted on 03/05/25 at 4:30 PM with the current Staffing Coordinator, she indicated that she was aware of the regulations for reporting sufficient nurse staffing. However, she acknowledged that she had still underreported, in the time frame of 01/26/25 thru the current two (2) week schedule ending on: 03/01/25, the licensed nursing staff daily average hours less than 1.0 hour (1 nurse to 40 residents), on the following two (2) days: Sunday 01/26/25 and Sunday 02/09/25 for DOS; due to call-offs that were not replaced. On 03/06/25 at 10:50 AM an interview was conducted with Staff D, a CNA (Certified Nursing Assistant), in which she verbalized that sometimes the facility is short-staffed on the weekends and she may be asked to sometimes stay over or work a little later. (continued on next page)

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	105622	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Beach Health and Rehabilitation Center	401 East Sample Road Pompano Beach, FL 33064

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 03/06/25 at 10:52 AM with Staff S, a Registered Nurse (RN), in which she verbalized that sometimes the weekend staffing could be low in which they would be short a nurse on the floor, due to a call-off. An interview was conducted with the Director of Nursing (DON), on 03/06/25 at 3:20 PM regarding the licensed nursing staff daily average hours recorded as below/less than 1.0 hour for DOS and she also acknowledged that staffing needs are to be provided per the regulations. A side-by-side record review was conducted with the Administrator in which it was revealed for the three (3) months of January, February and March 2025 that the licensed nursing staff daily average hours were recorded as less than 1.0 hour on two (2) days, for DOS. In fact, there were two (2) weekend days identified during the time frame of 01/26/25 thru the current two (2) week schedule ending on: 03/01/25, as having low licensed nursing staff hours. The Administrator further recognized and acknowledged on 03/06/25 at 3:25 PM that sufficient nursing staff should have been maintained, on a 24-hour basis, for DOS.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation and interview, the facility failed to secure medication carts for 3 of 8 sampled medication carts observed (Medication cart back and front C-wing area and back area of B-wing); and, failed to ensure keys to the medication carts are secured at all times, for 1 of 8 sampled Medication carts observed, (D-wing). The findings included: Record review of the facility policy and procedure titled, Storage of Medication provided by the Director of Nursing (DON) reviewed 2007 documented in the Policy Statement: Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications .are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access 1) During an observational tour of the C-wing on 03/04/25 at 9:53 AM, the Medication cart for the C-wing back area residents, was observed to be left unlocked, unattended and accessible in the hallway to residents, employees and visitors. Staff J, a Registered Nurse (RN), was observed walking away from the unlocked medication cart, going into the medication room behind a closed door and leaving the medication cart out of her line of sight for several minutes. Photographic Evidence Obtained. An interview was conducted on 03/04/25 at 9:55 AM with Staff J, in which she acknowledged that the medication cart was unlocked and should have been secured. 2) On 03/04/25 at 2:59 PM during a subsequent hallway round of the C-wing, it was observed that the Medication cart for the C-wing front area residents, had been left unlocked, unattended and accessible for residents in the hallway, to residents, employees and visitors. There was no nurse observed near or in the vicinity of the unlocked medication cart. An interview was conducted on 03/04/25 3 PM with Staff T a Licensed Practical Nurse (LPN), in which she acknowledged that the medication cart was unlocked and should have been secured. On 03/04/25 at 3:02 PM an interview was conducted with Staff G, an RN, Unit Manager (UM) for the C-wing, in which she also acknowledged that the medication carts should have been locked and secured. 3) On 03/05/25 at 11:50 AM during a third subsequent hallway round of the B-wing, it was observed that the medication cart for the back-end B-wing area, was left unlocked, unattended, and accessible to residents, employees and visitors; out of the line of sight of the nurse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 11:52 AM an interview was conducted with Staff U, an LPN, in which she acknowledged that the medication cart should have been kept locked. During an interview conducted on 03/05/25 at 11:53 AM with Staff N, an RN/UM for the B-wing, also acknowledged that the medication cart should have been locked. In fact, the medication carts were not locked and secured, until after surveyor intervention. The DON further recognized and acknowledged on 03/04/25 at 3:38 PM, that all three (3) of the medication carts should have been locked and secured, at all times. 41837 4) During an interview on 03/03/25 at 10:00 AM Resident # 337 stated she has to sometimes wait to get her pain medication and she can only have it every 6 hours as needed. When she was in the hospital she was getting the same medication every 4 hours. On 03/04/25 at 5:05 PM an observation was made of a set of keys in the narcotic book located on top of the med cart located and the D Wing nursing station. During an interview conducted on 03/04/25 at 5:00 PM with Resident #337 stated she requested pain medication (Oxycodone) at 4:00 PM today and still has not received the medication and it has been about an hour, she was told her nurse hasn't come. During an interview conducted on 03/04/25 at 5:05 PM with Staff Registered Nurse (RN) who stated she has worked at the facility for [AGE] years. When asked about the keys on the med cart located at the D Wing nursing station, she stated another nurse brought her keys to the med cart and she had something in her hand and she told the other nurse to just put the keys in the narcotic book that was left on top of the med cart. During an interview conducted on 03/04/25 at 5:15 PM with the Registered Nurse Unit Manager (RN UM) stated she left to go on a break off the floor and gave her keys to the Registered Nurse (RN) Supervisor so a nurse could go into the med cart to get the pain medication to administer to Resident #337. During an interview conducted on 03/04/25 at 5:29 PM with the RN Supervisor who was asked about the keys left on the med cart next to D Wing nursing station, he stated the other nurse was busy so he just left the keys on the cart in the narcotic book. When asked if he thought this was best practice, he smiled at the surveyor and stated probably not.

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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. 41837 Based on observations, interviews and record review the facility failed to ensure an effective QAPI plan in place to prevent repeated deficiencies for 3 out of 10 previously cited deficiencies (F584 Safe/Clean/Comfortable/Homelike Environment, F692 Nutrition/Hydration Status Maintenance , F695 Respiratory/Tracheostomy Care and Suctioning). The findings included: Review of the facility's policy titled, Quality Assessment, Assurance, and Compliance (QAA&C) Committee with an effective date of August 2024 included in part the following: The facility will form a QAA&C Committee, designed to review and analyze facility based-evidence data, develop, and implement process improvement plans, monitor effectiveness of plans, and ensure resources are allocated to ensure improvements. Quality Assurance Performance Improvement (QAPI) requires a systematic review of data, identification of the root cause(s) of the systems variances, and implementation of corrective actions using Plan, Do, Study, Act (PDSA). QAPI plans should be developed identifying the root cause(s) of the variance, addressing specific residents impacted, identification and protection of other residents that may be impacted, staff education and competency, and monitoring of the plan of action. 1. F584 Safe/Clean/Comfortable/Homelike Environment cited 11/09/23 included in part the following: failed to ensure all areas and equipment are in good repair. Missing and crumbling plaster and vents with black mold-like substance. Refer to current citation for F584 Safe/Clean/Comfortable/Homelike Environment. 2. F692 Nutrition/Hydration Status Maintenance cited 11/09/23 included in part the following: facility failed to provide nutritional interventions in a timely manner, failed to assist during dining. Refer to current citation for F692 Nutrition/Hydration Status Maintenance. 3. F695 Respiratory/Tracheostomy Care and Suctioning cited 11/09/23 included in part the following: facility failed to provide proper tracheostomy care and maintain a sterile field during tracheostomy care. Refer to current citation for F695 Respiratory/Tracheostomy Care and Suctioning. Review of the QAPI meeting agenda for 12/08/23 documented the committee reviewed the annual survey plan of correction. Review of the QAPI meeting agenda for 01/12/24 documented the committee reviewed the survey citations and audits. Review of the QAPI meeting agenda for 02/09/24 documented the committee reviewed the annual survey corrections and deficiencies. Review of the QAPI meeting agenda for 03/08/24 documented the committee reviewed the annual survey corrections and deficiencies. (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 interview conducted on 03/06/25 at 12:00 PM with the Administrator and the Director of Nursing they stated they have a monthly QAPI meeting. They have had ongoing audits and education, as well as collecting data, tracking and trending since last survey for nutrition (including supplements assisting with feeding), tracheostomy care (education and competencies), and environment (including resident rooms, air conditioning vents). The environment, nutrition concerns and tracheostomy care have been discussed monthly in QAPI as they are an ongoing QAPIs. In summary the facility has collected data and had meetings to discuss QAPI but lacked measurable goals indicating if the individual QAPIs have improved, stayed the same or worsened to know if the QAPI has been effective.