STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105666	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lanier Rehabilitation Center	12740 Lanier Road Jacksonville, FL 32226

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30905 Based on resident interviews, Resident Council (RC) minutes review, staff interviews, and facility policy and procedure review, the facility failed to 1) Ensure that the Dietary Manager attended the February 2025 meeting at the group's invitation to discuss food concerns, 2) Ensure issues of resident care and life in the facility were addressed by failing to review resident rights and inform residents of updates to the facility's policies and procedures, even though Resident Council forms were marked as though they had. The findings include: During an interview on 02/17/25 at 11:55 AM with the Resident Council President, Resident #23, and Resident #56, who both attend the meetings on a regular basis, Resident #23 stated he did not get to read the Resident Council minutes. He did not sign off on them to verify whether or not they were correct. He did not receive copies of the minutes. He stated usually the staff from the Activities Department attended the meetings and took the minutes. The Activities Director (AD) wrote notes on a sticky note or whatever she can find. He used to be asked to read the minutes and sign off on them to verify that they were correct, but he had not been permitted to do so in at least the last six months. He could not remember exactly how long it had been. The previous month's minutes were not read at the meetings to ensure that they had been recorded accurately. He said he thought they should be read as part of the appropriate process for the council meetings. He was aware that the council could meet without facility staff present but stated they had never tried to do so. He thought that some of the residents who attended the meetings were afraid to voice concerns due to fear of retribution. He stated the Social Services Director (SSD) was vindictive and attended the meetings. He did not want to give specific examples of why he thought this was true. He was hesitant to speak about it. Resident #56 stated the SSD just stands there and glares at us. She stated it made her feel uncomfortable and intimidated. Resident #23 gave this writer verbal permission to read the monthly meeting minutes. He again stated he did not know what was in them. He was not sure that all of the concerns expressed by the residents during the meetings were being documented, but he agreed to review the minutes with this writer to ensure that the minutes were accurate. He stated the staff did not go over the old business to ensure prior concerns had been addressed. They only talked about new business. He was told that he had to invite the appropriate department head to the meeting if the residents had a concern with a certain department. Resident #56 stated she attended the meetings. She confirmed everything the President, Resident #23, stated. Neither resident was sure about how to contact the Ombudsman for assistance, and they confirmed that this information had not been discussed or provided by facility staff during their council meetings. They both confirmed that the facility staff did not review any of the residents' rights during their council meetings. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Lanier Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12740 Lanier Road Jacksonville, FL 32226	

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the quarterly Minimum Data Set (MDS) assessment, dated 01/13/2025 for Resident #23, revealed he was assessed as having a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points, indicating no cognitive impairment. A review of the quarterly Minimum Data Set (MDS) assessment, dated 12/10/2024 for Resident #56, revealed she was assessed as having a BIMS score of 13 out of a possible 15 points, indicating no cognitive impairment. A BIMS score of 13-15 points indicates intact cognition. Copies of a summary of the meeting minutes were provided on 02/18/2025 for the months of 12/2024, 01/2025 and 02/2025. For each month, a type-written summary of the meeting was typed up on a piece of plain copy paper. They were not on a standard facility form. (Copies obtained) At the bottom of each month's summary were the signatures of the Activities Director (AD), Resident #23 and the Administrator. A review of the summary for the month of December 2024 revealed it covered smoking rules, residents who were a fall risk waiting for assistance in the cafeteria, the monthly party, outings to Walmart, not giving money to staff-go only to the business office for financial transactions, keeping hallways clear for housekeeping, laundry and floor techs. (Copy obtained) A review of the summary for the month of January 2025 revealed it covered the smoke porch, customer service by nursing staff, vending machine purchases-do not ask staff. Dietary will be invited to a meeting to discuss dietary concerns. (Copy obtained) A review of the summary for the month of February 2025 revealed it covered the monthly outing to a buffet restaurant, not giving money/personal items to staff, a new computer for residents' use in the dayroom, and a reminder to respect each other and staff. (Copy obtained). On 02/18/2025 copies of the Resident Council minutes for the months of 09/2024, 10/2024 and 11/2024 were requested, and on 02/19/2025 the standard facility forms for the Resident Council minutes were provided for the months of 09/2024 through 02/2025. (Copies obtained) A review of the Resident Council Minutes facility form for the month of September 2024 read: Start time 10 AM. Resident #23, President, present. Three other unsampled residents were noted to have been in attendance. The AD and the SSD were present. The minutes from the previous meeting were not read and approved or read and corrected. Old business was resident choice of activities and monthly parties. No new business was recorded. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was not on the form. (Copy obtained) (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident Council Minutes facility form for the month of October 2024 read: Start time 1 PM. Residents #23, #56 and #57 were present. Five other unsampled residents were documented as having been in attendance. The AD and the SSD were present. The minutes from the previous meeting were not read and approved or read and corrected. Old business was left blank. No new business was recorded. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was not on the form. (Copy obtained) A review of the Resident Council Minutes facility form for the month of November 2024 read: Start time 1:35 PM. Residents #23 and six unsampled residents were documented as present. Five other unsampled residents were in attendance. The SSD was present. The minutes from the previous meeting were read and approved and read and corrected. Old business was left blank. New business was recorded as food/snacks/drinks, cigarettes and once a month outings. All preference for food, drink or other items such as cigarettes you would like to purchase, you must go to the business office or social services. All financial transactions will only be done in the business office. No staff are allowed to get residents money/credit card to buy items. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was on the form. (Copy obtained) A review of the Resident Council Minutes facility form for the month of December 2024 read: Start time 10 AM. Residents #23 and twelve other unsampled residents were documented as having been in attendance. The AD and the SSD were present. The minutes from the previous meeting were read and approved or read and corrected. Old business read: No old business. New business was recorded as smoke porch, Walmart, birthday parties, happy hours. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was on the form. (Copy obtained) A review of the Resident Council Minutes facility form for the month of January 2025 read: Start time 1 PM. Residents #23, #57 and thirteen other unsampled residents were documented as having been in attendance. The AD, the SSD, the Director of Nursing, and the Administrator were noted as present. The minutes from the previous meeting were read and approved or read and corrected. The Old Business section was left blank. New business was recorded as concerns about the smoke porch, and residents talking inappropriately to other residents/staff. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was on the form. (Copy obtained) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lanier Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 12740 Lanier Road Jacksonville, FL 32226	

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident Council Minutes facility form for the month of February 2025 read: Start time 10 AM. Residents #23, #57, #17 and eight other unsampled residents were documented as having been in attendance. The AD and the SSD were present. The minutes from the previous meeting were read and approved or read and corrected. The Old Business section was left blank. New business was recorded as Walmart, buffet, outings, smoke porch, do not give staff money/gifts, and where to find assignment boards. In the section for review of residents' rights, the word yes was documented. Which rights were discussed was not documented. In the section for review of the facility's policies and procedures that had been developed/revised/updated in the past 30 days, the word yes was documented. Which policies and procedures were discussed was not documented. The signature of Resident #23 was on the form. (Copy obtained) During an interview on 02/19/25 at 11:43 AM with Resident #23, he stated on 02/18/2025, first the AD came and asked him to sign the summaries of the RC meeting minutes. He saw that the Administrator had already signed the forms. He skimmed over the minutes provided and then signed them. About an hour and a half later, the SSD came and asked him to sign another set of the minutes. He told her that he had already signed them. He stated he had never seen the forms before being asked to sign them. During an interview on 02/20/25 at 2:24 PM with Resident #23, he reviewed all the documents provided to this writer regarding the meetings. He took out a magnifying glass and examined the documents and then stated, No, this is not my signature. I thought this might happen. He stated he thought the documents were just made and did not exist prior to this survey. He took bank receipts out of his nightstand and stated, This is my signature. He confirmed that he had attended all of the meetings even though his name was not on some of the forms. He stated his signature was missing on the forms for September and October 2024 because he had never seen the forms before. He stated he thought someone else was signing his name on the forms. During an interview with the Certified Dietary Manager on 02/20/25 at 2:37 PM, she stated she had not been notified that she needed to attend the RC meeting on 02/12/25. She did not know that the residents had concerns about the menu/food. She had attended the meetings in the past, but it had been several months since she did attend. She stated no Resident Council Concern Form was sent to her indicating a concern. During an interview on 02/20/25 at 3:14 PM with Resident #57, she stated she did not remember staff telling them about their rights, and the Dietary Manager did not speak with the group. During an interview on 02/20/25 at 3:21 PM with Resident #17, he stated he went to the February Resident Council meeting. He confirmed that the staff members present did not go over resident rights with the group. They did not read the minutes from the previous meeting. They did not go over the old business. They only talked about new business. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 revealed she was assessed as having a BIMS score of 08 out of a possible 15 points, indicating moderate cognitive impairment. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #17 revealed he was assessed as having a BIMS score of 15 out of a possible 15 points, indicating no cognitive impairment. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/20/25 at 3:50 PM with the Administrator, she confirmed that the summaries of the meetings that had been provided were typed up by the SSD. The minutes for the RC meetings should be on the standard form and all sections should be filled in with the concerns brought to the council by the residents. There should be a time to address old business to make sure the residents' concerns were being met, and the solution to the concerns should be documented or the rationale for not meeting the wishes of the residents should be documented. The staff should go over the resident rights with them and document what rights were covered in the meeting. If there was a concern with one area of care, that department should address the council during the next meeting. She stated, We can do better. During an interview on 02/20/25 at 4:05 PM with the Regional Nurse Consultant, she confirmed that the standard forms were to be used to document the Resident Council Meeting minutes and when a concern was raised, that concern should be put on a grievance form and logged on the grievance log so it could be followed up on. The log should indicate that the concern was voiced during the Resident Council meeting. A review of the policy and procedure titled Resident Council (effective 01/2023 and updated 09/2023) read: Purpose: The Resident Council provides a formal, organized means of resident input into center operations. General Guidelines Information: The center will allow residents to organize into a council group without interference. The center will provide the group with space, privacy for meetings, and staff support. Guidance Steps in the Process: 1. The center provides space and supports the efforts of residents to form a council. 2. a. This representative participates in council meetings only as requested by council members. C. Council minutes will document requests for the center representative's (and other team members') participation. 4. The Council meets for the purpose of: Assisting in the development of policies and procedures, evaluating the center operations, studying problem areas and recommending solutions, making recommendations for improving the center's services, assisting in the development of resident grievances and complaint procedures; assisting in defining resident rights and responsibilities. 5. The Council maintains minutes of all meetings. 6. Grievance process will be followed and reported as required by regulation. 7. The Administrator reviews the minutes, takes appropriate actions, and follows up with the council regarding identified areas of concern and interest. Documentation: Resident Council Minutes (Copy obtained) A review of the facility's policy and procedure titled Grievances - Resident Rights (revised 08/2023) read: Procedure: 4. Upon receipt of a grievance report, the Grievance Official or designee will refer it to the appropriate department head for investigation. 8. The resident, or anyone acting on their behalf filing the grievance, will be communicated with regarding the conclusion of the investigation and the corrective actions that will be taken. 10. The Resident Council are additional forums for voicing grievances. Grievances received from these Councils will be acted upon in accordance with this procedure. (Copy obtained)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records, observations, resident and staff interviews, and a review of facility policies and procedures, the facility failed to implement the person-centered care plan to meet residents' assessed needs for fall prevention for one (Resident #64) of four residents reviewed for falls, from a total survey sample of 27 residents. The findings include: A review for Resident #64's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included personal history of traumatic brain injury, lack of expected normal physiological development in childhood, mood disorder due to known physiological condition, abnormalities of gait and mobility, generalized muscle weakness, osteoarthritis of knee, major depressive disorder, anxiety disorder and obesity. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #64 had a brief interview for mental status (BIMS) score of 15/15 points, indicating that she was cognitively intact and independent with daily decision making. She used a walker to ambulate and was receiving antianxiety, antidepressant, diuretic and anticonvulsant (used to treat seizure disorders or mood disorder) medications. Resident #64 was care planned on 2/17/2025 for risk for falls/ fall related injury related to muscle weakness and limited mobility. The goal was to reduce the risk by the next review date. Interventions included: Call light within reach; Educate to ask for assistance prior to showers; Encourage rest periods throughout the day; Fall Program Sign; Low bed with matts to door side of bed; Maintain safe environment; Non-skid footwear (socks and/or shoes). (Photographic evidence obtained) A review of the nursing progress note dated 12/30/2024 revealed that Resident #64 was found on the floor on her knees next to her bed. Notes indicated she had been assisted to the floor in the shower room this same day. A progress note dated 2/5/2025 noted Resident #64 was observed lying on the floor on the left side of her bed. She stated she wanted to walk and promised she would not do it again. An Interdisciplinary Team (IDT) Progress Note dated 2/5/2025 read, IDT met to review fall from 2/5/25. Resident observed on floor by left side of bed. IDT recommends fall mat to left side of bed. Care plan updated. Will continue POC (plan of care). A Focus IDT Note dated 2/13/2025 read, Resident at risk meeting in progress with IDT to discuss resident's fall on 2/5/2025. Resident was observed by the staff on the floor beside her bed. Assessment revealed no injury or c/o (complaints of) pain. Resident presented with a fall score of 14 (high risk for falls). Preventative fall measures include fall mat to door side of bed . (Photographic evidence obtained) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #64's February 2025 medication administration record (MAR) found she received Wellbutrin XL 150 milligrams (mg) daily for depression (can cause dizziness), buspirone hydrochloride (HCL) 15 mg three times a day for anxiety (can cause dizziness), trazodone (HCL) at bedtime for depression (may cause drowsiness, dizziness), lasix (a diuretic that may increase the need to urinate) 20 mg daily for fluid overload, Eszopiclone 2 mg (a controlled drug that may cause drowsiness) daily at bedtime for insomnia, and depakote (a seizure medication that can be used for mood and may cause fatigue/drowsiness) 250 mg three times a day for mood disorder. (Photographic evidence obtained) An interview was conducted with Resident #64 on 2/17/2025 at 10:03 AM. She stated she has had four falls. When asked what interventions were in place to prevent falls, she said none. Resident #64 explained that she was unable to reposition herself and stand. She slipped in the shower once from a standing position. Before her last fall she said she could walk. She explained that she tried to get out of bed once and fell , and was unsure of whether she could bear weight on her legs or walk. During the interview the resident was lying on the left side of her bed near the edge of the mattress. There was no bed rail or enabler in place. The resident was on a bariatric mattress and bed (a hospital bed designed for obese individuals). A reacher/grabber tool was observed on a chair against the far wall at the foot of Resident #64's bed. It was out of her reach. The room was decorated with multiple personal items on the left side of the bed on the floor and bedside table. (Photographic evidence obtained) An observation of Resident #64 on 2/18/2025 at 10:48 AM found her still in bed. There were no fall mats, no sign posted in the room and the reacher was across room on the chair against the far wall. (Photographic evidence obtained) Resident #64 was observed on 2/19/2025 at 10:03 AM in bed with no fall mats on the floor, no posted signage and the reacher still across the room on the chair. Her belongings were still stacked to her left on the table and floor. When asked how she retrieved her personal items, she stated she was unable to reach her reacher. It was handed to her per her request. Additional observations on 02/19/2025 at 2:29 PM, and on 2/20/25 at 9:30 AM, found Resident #64's room remained void of fall mats or signage. (Photographic evidence obtained) An interview was conducted with Certified Nursing Assistant (CNA) G on 2/19/2025 at 1:55 PM. She stated she knew the interventions in the plans of care for all residents because they were in the Kardex (a quick reference form that lists care plan interventions) in the electronic medical record keeping system. An interview was conducted with Unit Manager F on 2/19/2025 at 2:37 PM. When asked about the fall program signs referenced in the resident's care plan, Unit Manager F presented a sign explaining that it was supposed to be posted in resident rooms. The sign was 8x10 inches in size on bright orange paper and laminated. It read, Call, Don't fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with CNA D on 2/20/2025 at 9:43 AM. She stated when she arrived in the mornings, she conducted rounding with the offgoing CNA. Changes in residents' care plans were communicated to the CNAs by the nurse and showed up in the Kardex. CNA D explained that she provided care for Resident #64 who had not ambulated after the last fall. Prior to that fall, she was very active and required minimum assistance with ambulation and daily care. The CNA was asked to review the Kardex for fall interventions. She read the fall interventions, which instructed: Call light within reach, encourage rest periods, fall program sign, low bed with mats to the door side, and non-skid footwear. (Photographic evidence obtained) CNA D returned to Resident #64's room with this writer and confirmed that the resident did not have fall mats at the bedside and there was no signage alerting staff that she was a fall risk. An interview was conducted with Licensed Practical Nurse (LPN) C on 2/20/2025 at 10:02 AM. LPN C stated she conducted a walk through and bedside reporting with the offgoing nurse daily. Any changes to the care plan were communicated to the staff by the Unit Manager (UM) after the morning meeting. The Nurse then provided that information to the CNAs. Residents with frequent falls were placed in the Fall Focus program. LPN C stated she was familiar with the care required for Resident #64 and stated the last fall for this resident was on 2/5/2025; however, she was unaware of the interventions put in place after that fall and would have to contact the MDS (minimum data set)/Care Planning designee. LPN C was asked to review Resident #64's most recent care plan and verify interventions in place for falls. After reviewing the care plan, she stated the interventions for falls included: Call light within reach, encourage rest periods, fall program sign, low bed with mats to the door side, and non-skid foot wear. LPN C returned to Resident #64's room with this writer and confirmed that there were no fall mats on the door side of the bed or signage indicating the resident was in the fall program per the resident's care plan. An interview was conducted with the Director of Nursing (DON) on 2/20/2025 at 2:57 PM. He explained that falls were reviewed each morning and depending on the interventions, the UM was responsible for going to that specific room after the meeting and ensuring that all interventions were in place. The Fall Focus meetings were held weekly and interventions were discussed. They conducted rounds first, then had the focus meeting and placed an IDT note in the chart. Residents were reassessed after falls. The observations of Resident #64's room all four days of the survey were shared with him. He shook his head and said, That shouldn't have happened. A review of the facility's Fall Management Process (undated) instructed under the section titled IDT Review of Fall Management Process that falls would be reviewed at an IDT Fall Focus Meeting by members such as the DON (Director of Nursing), Assistant DON, Staff Development Coordinator, Unit Manager, Rehab Program Manager, etc . The Follow Up Meetings section instructed: Each week at the fall focus meeting, enter an updated summary note in the record; Ensure intervention(s) are in place; Update interventions as needed, and; Document effectiveness of current interventions and any new recommendations. (Photographic evidence obtained)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records, observations, resident and staff interviews, and a review of facility policies and procedures, the facility failed to 1) Ensure resident rooms were free of accident hazards per the plan of care, and ensure assistive devices were available to prevent accidents for one (Resident #64) of four residents reviewed for falls, and 2) Ensure residents' safe use and storage of personal cleaning products to prevent accidental access by other residents for one (Resident #24) of five residents reviewed for environmental safety, from a total survey sample of 27 residents. The findings include: 1. A record review for Resident #64 revealed that she was admitted to the facility on [DATE]. Her diagnoses included a personal history of traumatic brain injury, lack of expected normal childhood physiological development, mood disorder, abnormalities of gait and mobility, generalized muscle weakness, osteoarthritis of knee, major depressive disorder, anxiety disorder and obesity. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #64 had a brief interview for mental status (BIMS) score of 15/15 points, indicating that she was cognitively intact and independent with daily decision making. She used a walker to ambulate and was on antianxiety, antidepressant, diuretic and anticonvulsant (used to treat seizure disorders or mood disorder) medications. Resident #64 was care planned on 2/17/2025 for risk for falls/ fall related injury related to muscle weakness and limited mobility. The goal was to reduce the risk by the next review date. Interventions included: Call light within reach; Educate to ask for assistance prior to showers; Encourage rest periods throughout the day; Fall Program Sign; Low bed with mats to door side of bed; Maintain safe environment; Non-skid footwear (socks and/or shoes). (Photographic evidence obtained) A review of Nursing Progress Notes revealed that Resident #4 had two falls on 12/30/2024, and another on 2/5/2025. An Interdisciplinary Team (IDT) Progress Note dated 2/5/2025 read, IDT met to review fall from 2/5/25. Resident observed on floor by left side of bed. IDT recommends fall mat to left side of bed. Care plan updated. A Focus IDT Note dated 2/13/2025 read, Resident at risk meeting in progress with IDT to discuss resident's fall on 2/5/2025. Resident was observed by the staff on the floor beside her bed. Preventative fall measures include fall mat to door side of bed . (Photographic evidence obtained) A review of Resident #64's February 2025 medication administration record (MAR) found she received wellbutrin XL 150 milligrams (mg) daily for depression (can cause dizziness), buspirone hydrochloride (HCL) 15 mg three times a day for anxiety (can cause dizziness), trazodone (HCL) at bedtime for depression (may cause drowsiness, dizziness), lasix (a diuretic that may increase the need to urinate) 20 mg daily for fluid overload, eszopiclone 2 mg (a controlled drug that may cause drowsiness) daily at bedtime for insomnia, and depakote (a seizure medication that can be used for mood and may cause fatigue/drowsiness) 250 mg three times a day for mood disorder. (Photographic evidence obtained) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lanier Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12740 Lanier Road Jacksonville, FL 32226	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #64 on 2/17/2025 at 10:03 AM. She stated she has had four falls. When asked what interventions were in place to prevent falls, she said none. Resident #64 explained that she was unable to reposition herself and stand. She slipped in the shower once from a standing position. Before her last fall, she said she could walk. She explained that she tried to get out of bed once and fell , and was unsure of whether she could bear weight on her legs or walk. During the interview, the resident was lying on the left side of her bed near the edge of the mattress. There was no bed rail or enabler in place. The resident was on a bariatric mattress and bed (a hospital bed designed for obese individuals). A reacher/grabber tool was observed on a chair against the far wall at the foot of Resident #64's bed. It was out of her reach. The room was decorated with multiple personal items on the left side of the bed on the floor and bedside table. (Photographic evidence obtained) An observation of Resident #64 on 2/18/2025 at 10:48 AM found her still in bed. There were no fall mats, no sign posted in the room, and the reacher was across room on the chair against the far wall. (Photographic evidence obtained) Resident #64 was observed on 2/19/2025 at 10:03 AM in bed with no fall mats on the floor, no posted signage, and the reacher was still across the room on the chair. Her belongings were still stacked to her left on the table and floor. When asked how she retrieved her personal items, she stated she was unable to reach her reacher. It was handed to her per her request. Additional observations on 2/19/2025 at 2:29 PM, and 2/20/2025 at 9:30 AM, found Resident #64's room remained void of fall mats or signage. (Photographic evidence obtained) An interview was conducted with Unit Manager F on 2/19/2025 at 2:37 PM. When asked about the Fall Program signs referenced in the resident's care plan, Unit Manager F presented a sign explaining that it was supposed to be posted in resident rooms. The sign was 8x10 inches in size, on bright orange paper, and laminated. It read, Call, Don't fall. An interview conducted with Certified Nursing Assistant (CNA) D on 2/20/2025 at 9:43 AM. She stated she conducted rounding with the offgoing CNA when she arrived in the morning. Changes in residents' care plans were communicated to the CNAs by the nurse and were in the Kardex (quick reference document for care plan interventions). CNA D stated Resident #64 had not ambulated since her last fall. Prior to that fall, she was very active and required minimal assistance with ambulation and daily care. The CNA was asked to review the Kardex for fall interventions. She did, and reported it instructed: Call light within reach, encourage rest periods, fall program sign, low bed with mats to the door side. (Photographic evidence obtained) CNA D returned to Resident #64's room with this writer and confirmed that the resident did not have fall mats at the bedside or signage alerting staff she was fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) C on 2/20/2025 at 10:02 AM. LPN C stated she conducted a walk through and bedside reporting with the offgoing nurse daily. Any changes to the care plan were communicated to the staff by the Unit Manager (UM) after the morning meeting. The nurse then provideed that information to the CNAs. Residents with frequent falls were placed in the Fall Focus program. LPN C stated she was familiar with the care required for Resident #64 and explained that the last fall for this resident was on 2/5/2025; however, she was unaware of the interventions put in place after that fall. LPN C was asked to review Resident #64's most recent care plan and verify interventions in place for falls. Upon reviewing the care plan, she stated the interventions for falls included: Call light within reach, encourage rest periods, fall program sign, low bed with mats to the door side, and non-skid foot wear. LPN C returned to Resident #64's room with this writer and confirmed that there were no fall mats on the door side of the bed or signage indicating the resident was in the fall program per the resident's care plan. An interview was conducted with the Director of Nursing (DON) on 2/20/2025 at 2:57 PM. He stated falls were reviewed each morning and depending on the interventions, the UM was responsible for going to that specific room after the meeting and ensuring all interventions were in place. The Fall Focus meetings were held weekly and interventions were discussed. They conducted rounds first, then had the focus meeting and placed an IDT note in the chart. Residents were reassessed after falls. The observations of Resident #64's room all four days of the survey were shared with him. He shook his head and said, That shouldn't have happened. A review of the facility's Fall Management Process (undated) instructed under the section titled IDT Review of Fall Management Process, that falls would be reviewed at an IDT Fall Focus Meeting by members such as the DON, Assistant DON, Staff Development Coordinator, Unit Manager, Rehab Program Manager, etc . The Follow Up Meetings section instructed: Each week at the Fall Focus meeting, enter an updated summary note in the record; Ensure intervention(s) are in place; Update interventions as needed, and; Document effectiveness of current interventions and any new recommendations. (Photographic evidence obtained) 2. An observation of Resident #24's room was conducted on 2/17/2025 at 10:19 AM. The room was double occupancy and Resident #24's bed was on the window side of the room. A can of aerosol disinfectant spray was observed on his bedside table, which was on the door side of his bed between his bed and his roommate's. Only a privacy curtain divided the room. On the window side of his bed, between the bed and the wall, was a plastic container of bleach wipes. Resident #24 was in his bed, but his eyes were closed and he did not respond to the surveyor's presence. On 2/18/2025 at 10:02 AM, the aerosol disinfectant spray in Resident #24's room was still present on his overbed table on the central side of the room. The bleach wipes were still in the same location. (Photographic evidence obtained) (continued on next page)

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Lanier Rehabilitation Center	12740 Lanier Road Jacksonville, FL 32226

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #24's room on 2/19/2025 at 1:38 PM, found the can of aerosol spray was gone. The bleach wipes remained on the window side of his bed. Resident #24 was awake and stated, They took my Lysol! Why did they take my Lysol? I use that and the wipes to keep my room sanitized so I don't catch everything that comes into this building. He said the man in charge removed the can. Resident #24 was asked if other residents ever wandered into his room confused that it might be their room. He stated yes, that did happen on occasion. He was asked if he had been offered a key to his bedside table top drawer, which had a lock on it. Resident #24 stated that due to limited or no use of both of his hands, he would not be able to use a key to unlock and lock his top drawer. He demonstrated that he could depress a can of aerosol with the side of his thumb. Resident #24 stated he wanted his Lysol spray back and asked if he was going to get in trouble. A review for Resident #24's medical record found he had a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating that he was cognitively intact and able to make decisions independently. He not been assessed or care planned for safe storage of personal cleaning supplies. The Administrator was asked for a policy or protocol on keeping cleaning supplies at bedside on 2/19/2025 at 2:35 PM. She stated she would look. On 2/19/2025 at 2:50 PM, the Regional Clinical Director (RCD) came to the conference room to report that there was no written protocol. The facility offered lock boxes to residents who were safe to keep such items at bedside. She was advised of the observations, and that Resident #24 did not have fine motor skills in either hand, so would be unable to manipulate a key and lock. The RNC said in that case, they would offer to keep the items at the nurses' station. When asked if the resident's assigned CNA should have recognized cleaning supplies in his room she said, yes, she would have expected that to be reported. An interview with Resident #24 on 2/20/2025 at 9:44 AM revealed that no one had come to discuss the safe keeping of his cleaning supplies, nor had they returned his supplies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30905 Based on kitchen food service observations, staff interviews, facility record review, and facility policy and procedure review, the facility kitchen staff failed to follow proper dish sanitation procedures, wash their hands between glove changes, and to allow for air drying after washing dishes to prevent the outbreak of foodborne illness. Hand hygiene, dish sanitation, and air drying is important in health care settings serving nursing home residents due to the risk of serious complications from foodborne illness as a result of their compromised health status. Unsafe sanitation practices represent a potential source of pathogen exposure. The findings include: During the initial kitchen tour on 2/17/2025 at 9:25 AM, the hand sink did not have soap in the soap dispenser. On 2/17/2025 at 9:27 AM, an observation of the dish room and dish washing processes revealed Dietary Aide (DA) J loading the dish machine and running it. The dish machine temperature gauge was observed during the wash cycle and the rinse cycle. The temperature for each cycle did not rise above 69 degrees Fahrenheit ('F). The Certified Dietary Manager (CDM) stated it was a low temperature machine, and it used chlorine bleach to sanitize the dishes. Two staff members were working in the dish room. DA J was loading the dish machine. DA K was scraping and rinsing the dishes in a tub full of soapy water. The CDM explained that the staff filled the tub with hot water from the coffee machine and then put soap in it. Then they ran the dishes through the dish machine. DA J was asked to test the machine's sanitizer level. She did not understand at first due to her first language being Spanish. DA K stated she would test it. She took the test strips and tested the machine. She handed the test strip to the CDM. The test strip was observed to be a very dark purple color, indicating 200+ parts per million (ppm) of chlorine in the water. The CDM was asked how many parts per million of bleach were supposed to be in the water. She stated 50 to 100 ppm. She was asked if the test strip indicated a toxic level of sanitizer in the water. She stated yes, it indicated 200+ ppm, the chlorine level in the dish machine was at a toxic level. (Photographic evidence obtained) During an interview with the CDM on 2/17/2025 at 9:35 AM, she stated the facility's water heater for the kitchen has been out of order for a while now. She then stated she was not sure, but she thought it had been several weeks to a couple of months since the water heater had worked. She said the new water heater was at the facility sitting in a box in the hallway outside the kitchen. The problem is that the company that is contracted to put it in has not been able to come to the facility to do it. The new hot water heater was observed. She stated they had purchased two different water heaters but had to send them back because they were not the right one. She further stated they had been using the dish machine to clean the dishes every day since the water heater broke. She thought that since the sanitizer level was good it wouldn't matter how hot the water was. They were trying to make sure the wash water was hot by using the water from the coffee maker. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Maintenance Director on 2/17/2025 at 10:33 AM, he stated the hot water heater had been out for a few weeks. The old heater rusted through. The supply company sent them the wrong water heater three times and he had to send them back each time, which took time. Finally, they decided to go through a different vendor and now they have the right water heater. We have the new water heater here. The contracted maintenance provider has to install it because it has a gas feed. I'm just waiting on them to come out and do it. The technician that is qualified to do it is on another huge job somewhere else. He stated it was a job that could be done in one day. A review of the manufacturer's specifications for the facility's dish machine ES-4000 read: Low temperature machine. Operating temperatures - Wash cycle 120 'F, Sanitizing Rinse cycle 120 'F. Incoming temperature (minimum) 120 'F. Incoming temperature (recommended) 140 'F. (Copy obtained) A review of work order form #102580 for the initial service call, dated 11/22/2024 between the facility and the contracted provider for the water heater replacement read: Description: Water heater for kitchen/laundry not igniting. Work performed: Found the heat exchanger cracked and unable to repair leak. Shutting water supply off will kill the equipment in the kitchen, recommend monitoring leak and leaving water on. Heater will need to be replaced. (Copy obtained) A review of the shipping receipt for the water heater, dated 1/27/2025, revealed that the water heater was delivered to the facility on this date. (Copy obtained) A review of a letter sent to the facility on company letterhead from the contracted maintenance provider for the installation of the new water heater revealed it read: To whom it may concern: [Contracted Maintenance Provider] is scheduled to install a new water heater at [Facility] on 02/18/2025. (Copy obtained) During a follow-up tour of the kitchen on 2/19/2025 at 11:35 AM, the lunch meal service was observed. DA I was observed plating food on the tray line. She had donned a pair of disposable gloves. At 11:55 AM, she changed gloves without washing her hands in between. She again changed gloves without washing her hands in between at 12:33 PM. On 2/19/2025 at 12:13 PM, DA L doffed her disposable gloves, threw away three #10 cans in the garbage near the rear door of the kitchen and donned new gloves without washing her hands first. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/19/2025 at 12:20 PM, DA J was observed preparing a cake. She had disposable gloves on. She poured the batter into a large sheet pan and then took the pan to the oven and put it in. She took off the disposable gloves she had donned and put them in a cardboard box near the rear door of the kitchen. She then donned new gloves without washing her hands in between at 12:34 PM. She went to the refrigerator, took out a carton of milk, opened it with her gloved hands, and poured the milk in the mixing bowl, then proceeded to mix up the dry frosting mix. She took a wiping cloth and wiped down the prep tables. She doffed the contaminated gloves in the cardboard boxes near the rear door of the kitchen. Without washing her hands, she went to take the cake out of the oven. She donned oven mitts, took the cake to the prep table and donned new gloves without washing her hands. She proceeded to drizzle the frosting over the cake. She then went to the knife storage rack on the wall and took a long serrated cutting knife out of the rack. As she walked back across the kitchen, she dropped the knife on the floor. She picked it up and took it to the ware washing sink, dunked it into the soapy water, rinsed it off in the rinse sink and wiped it with the wiping cloth she had used to wipe down the prep tables. She took the knife over to where the cake was sitting on the prep table and laid it down. She was preparing to cut the cake into servings when she was asked if she thought the wiping cloth had re-contaminated the knife and if she was supposed to allow the knife to air dry after washing it and prior to using it. She did not appear to understand the questions. The CDM explained to her that she could not use the knife and needed to use a clean knife. A review of the dietary staff training for hand washing and glove use, dated 10/22/2024, revealed that DA J attended the training. Staff training was held on 11/1/2024 on hand washing and glove use. Dietary Aides (DAs) J, K, and L attended the training. Staff training was held on 9/7/2024 related to checking the sanitation level ppm in the dish machine. DA K attended the training. The flyer used during the trainings on hand hygiene read: Single use gloves must never be used in place of handwashing, should be used when handling ready-to-eat food. (Copy obtained) A review of the facility's Dishwashing Procedure training flyer revealed it read: Objective: Participants will understand the correct dishwashing procedures and how to record the dish machine temperature and ppm. Air dry dishes and keep in clean area to avoid contamination. Record the dish machine temperatures. Low temperature machine Wash 120 'F - 150 'F, Rinse 120 'F - 150 'F. Any inaccurate temperatures must be brought to the attention of the Dietary Manager immediately. Convert to paper service until temperature is correct. The concentration of the sanitary solution during the rinse cycle is 50 - 100 ppm with chlorine sanitizer on low temperature dish machines. (Copy obtained) A review of the Testing Sanitizer and Temperature in Low Temperature Dish Machines policy and procedure (revised 08/2023) revealed it read: Purpose: Test sanitizing solution and temperature before cleaning each meal's dishes. A proper level is 50 ppm chlorine in rinse water. An appropriate temperature is 120 'F - 160 'F. 7a. Do not exceed 100 ppm on chlorine sanitizing solutions. (Copy obtained) A review of the manufacturer's specifications for the facility's dish machine ES-4000 Dish machine read: Low temperature machine. Operating temperatures Wash cycle 120 'F, Sanitizing Rinse cycle 120 'F. Incoming temperature (minimum) 120 'F. Incoming temperature (recommended) 140 'F. (Copy obtained) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure titled Food and Nutrition - Operational (revised 08/2023) revealed it read: Purpose: Food service employees comply with strict time and temperature requirements and use proper food handling techniques to prevent the occurrence of foodborne illness. Procedures: 1. Clean and sanitize all utensils and food contact surfaces according to center policy or guidelines and per chemical manufacturer's directions. 2. Practice good personal hygiene. Wash and sanitize hands regularly. 4. Use gloves or clean utensils when handling raw or cooked foods which will not be heated prior to serving. b. Change gloves as frequently as handwashing would indicate. Change gloves before and after non-food contact and between contact with raw and cooked food. 11. After dishes are sanitized, do not touch any food contact surfaces. This includes knife blades. (Copy obtained)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on observations, resident and staff interviews, a review of resident records, and the Quality Assurance and Performance Improvement (QAPI) Plan, the facility failed to implement it's performance improvement plan's (PIP) corrective actions to reduce the risk of falling for one (Resident #64) of four residents reviewed for falls, from a total survey sample of 27 residents. The findings include: An observation of Resident #64 on 2/17/25 at 10:03 AM found her lying on the far left side of her bariatric bed (a hospital bed designed for obese individuals) on the edge of the mattress. There was no bed rail or enabler in place. The room was decorated with multiple personal items on the left side of the bed on the floor and bedside table. A reacher/grabber tool was observed on a chair against the far wall at the foot of the bed, out of her reach. There were no fall mats and no signs posted in the room. (Photographic evidence obtained) Resident #64 explained that she had four falls but was unaware of any interventions to prevent future falls. Additional observations of Resident #64 conducted on 2/18/25 at 10:48 AM and on 2/19/25 at 10:03 AM, found her still in bed. There were no fall mats, no signage in place, and the reacher was still out of her reach. When asked during the latter observation (2/19/25) how she retrieved her personal items, she stated she could not reach her reacher and asked that it be handed to her. Observation on 2/20/25 at 9:30 AM, found the room still void of fall mats or signage. (Photographic evidence obtained) A review of Resident #64's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses include traumatic brain injury, lack of expected childhood development, mood disorder, abnormalities of gait and mobility, muscle weakness, osteoarthritis, major depressive disorder, anxiety disorder, and obesity. Resident #64 was care planned on 2/17/25 for risk for falls/ fall related injury related to muscle weakness and limited mobility. The goal was to reduce the risk by the next review date. Interventions included, but were not limited to, a fall program sign in her room and a low bed with mats on the door side of her bed. (Photographic evidence obtained) A review of Nursing Progress notes found that Resident #64 had two falls on 12/30/24 and another on 2/5/2025. An Interdisciplinary Team (IDT) progress note dated 2/5/2025 revealed that the IDT recommended a fall mat on the left side of her bed. A Focus IDT Note dated 2/13/2025 revealed that the team met again to discuss the fall, and that preventative fall measures included a fall mat on the door side of bed . (Photographic evidence obtained) On 2/20/25 at 9:43 AM, during an interview with Certified Nursing Assistant (CNA) D who was assigned to Resident #64, she confirmed that the resident had no fall mats or a posted sign in her room per the care plan. Licensed Practical Nurse (LPN) C also confirmed the absence of the interventions during an interview on 2/20/25 at 10:02 AM. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Performance Improvement Plan (PIP) titled Fall Management (dated 12/19/24), revealed it was spearheaded by the Regional Director of Clinical Services (DCS). It identified that the system correction needed was: 1. Education on fall management program. 2. Education on Code Purple. 3. Ensuring all incident reports were completed correctly, and; 4. Ensuring all interventions were in place. (Photographic evidence obtained) A Fall Assessment QAP (FAQ) form, dated 12/19/24, revealed that Resident #64 fell at 8:40 AM. A huddle at the nurses' station was conducted at 8:40 AM and included five participants including the Registered Nurse (RN)/Unit Manager, LPNs and CNAs. The form indicated that the resident fell in her room trying to get in her bed and indicated that all interventions were in place from the care plan. Frequent checks were initiated to prevent future falls. The form was signed by the Unit Manager. (Photographic evidence obtained) A FAQ form reported that Resident #64 fell on [DATE] at 8:20 AM. A huddle at the nurses' station was conducted at 8:40 AM and included four participants including the Registered Nurse (RN)/Unit Manager, LPNs and CNAs. The form indicated Resident #64 had attempted to walk unassisted. It also asked if all interventions were in place from the care plan, which was answered, yes. The action to be completed by the QAPI team was Fall Program Sign. The form was signed by the Unit Manager. (Photographic evidence obtained) No similar form was available yet for the February 2025 fall. An interview was conducted with the Regional Director of Clinical Services (DCS) on 2/20/25 at 2:47 PM. She explained that she recently sat in on a facility clinical meeting following a fall. She recognized staff were not following the post-fall process properly. In response, she created the fall management PIP and educated the management team, who then educated staff. The Director of Nursing (DON) had the responsibility of monitoring to ensure fall prevention interventions were in place. At least that is what should have been implemented. The DCS was asked for any audits that had been completed since the development of the PIP. The audit tool did not have a section to indicate fall interventions were in place in resident rooms. When asked if the DON was actually going to resident rooms to verify that care plan interventions were in place, the DCS said she was not sure. The DCS was shown the FAQ recommendation that Resident #64 have a fall program sign posted. She was also advised that the fall mats were not in place during the four-day survey, per the resident's care plan. The DCS acknowledged that despite the PIP's corrective action, there was no evidence a system had been implemented to ensure Resident #64's, or other residents with falls, care plan interventions were being verified. She could provide no explanation for this. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Lanier Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12740 Lanier Road Jacksonville, FL 32226	

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with the DON on 2/20/25 at 2:57 PM. He explained that falls were reviewed each morning during a meeting. Depending on the recommended interventions, the UM was responsible to go to that specific room after the meeting to ensure all interventions were in place. Fall interventions were also discussed at weekly fall focus meetings. The observations in Resident #64's room were shared with him. He shook his head and said, That shouldn't have happened. He acknowledged the actions to correct the identified problem in the fall management PIP were not being implemented as written. A review of the facility's policy titled Florida Risk Management and QA&A (Quality Assurance and Assessment) Committee/QAPI Program (revised 8/2923) found it stated the purpose of the committee was to assess resident care practices, review and analyze quality indicators and incident reports as well as opportunities for improvement. Develop plans of action to correct and respond quickly to identify quality deficiencies. (Photographic evidence obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 30905 Based on kitchen food service observations, staff interviews, facility record review, and facility policy and procedure review, the facility failed to ensure that all mechanical equipment in the kitchen was maintained in safe operating condition. The water heater for the kitchen was not operating, thereby the dish machine temperatures failed to reach the appropriate levels. Failure to ensure the dish machine wash and rinse temperatures reached the proper temperature required by the manufacturer's specifications may result in the risk of serious complications from foodborne illness. The findings include: During the initial kitchen tour on 02/17/2025 at 9:27 AM, observation of the dish room and dish washing processes revealed that Dietary Aide (DA) J was loading the dish machine and running it. The dish machine temperature gauge was observed during the wash cycle and the rinse cycle. The temperature for each cycle did not rise above 69 degrees Fahrenheit ('F). The Certified Dietary Manager (CDM) stated it was a low temperature machine and it used chlorine bleach to sanitize the dishes. Two staff members were working in the dish room. DA J was loading the dish machine. DA K was scraping and rinsing the dishes in a tub full of soapy water. The CDM explained that the staff filled the tub with hot water from the coffee machine and then put soap in it. Then they ran the dishes through the dish machine. During an interview with the CDM on 2/17/2025 at 9:35 AM, she stated the facility water heater for the kitchen had been out of order for a while now. She then stated she was not sure but she thought it has been several weeks to a couple of months since the water heater had worked. She said the new water heater was at the facility sitting in a box in the hallway outside the kitchen. The problem is that the company that is contracted to put it in has not been able to come to the facility to do it. The new hot water heater was observed. She stated they had purchased two different water heaters but had to send them back because they were not the right one. She further stated they had been using the dish machine to clean the dishes every day since the water heater broke. She thought that since the sanitizer level was good it wouldn't matter how hot the water was. They were trying to make sure the wash water was hot by using the water from the coffee maker. During an interview with the Maintenance Director on 2/17/2025 at 10:33 AM, he stated the hot water heater had been out for a few weeks. The old heater rusted through. The supply company sent them the wrong water heater three times and he had to send them back each time, which took time. Finally, they decided to go through a different vendor and now they have the right water heater. We have the new water heater here. The contracted maintenance provider has to install it because it has a gas feed. I'm just waiting on them to come out and do it. The technician that is qualified to do it is on another huge job somewhere else. He stated it was a job that could be done in one day. A review of the manufacturer's specifications for the facility's dish machine ES-4000 read: Low temperature machine. Operating temperatures - Wash cycle 120 'F, Sanitizing Rinse cycle 120 'F. Incoming temperature (minimum) 120 'F. Incoming temperature (recommended) 140 'F. (Copy obtained) (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of work order form #102580 for the initial service call, dated 11/22/2024 between the facility and the contracted provider for the water heater replacement read: Description: Water heater for kitchen/laundry not igniting. Work performed: Found the heat exchanger cracked and unable to repair leak. Shutting water supply off will kill the equipment in the kitchen, recommend monitoring leak and leaving water on. Heater will need to be replaced. (Copy obtained) A review of the shipping receipt for the water heater, dated 1/27/2025, revealed that the water heater was delivered to the facility on this date. (Copy obtained) A review of a letter sent to the facility on company letterhead from the contracted maintenance provider for the installation of the new water heater revealed it read: To whom it may concern: [Contracted Maintenance Provider] is scheduled to install a new water heater at [Facility] on 02/18/2025. (Copy obtained)