STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105680	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Lauderhill	2599 NW 55th Ave Lauderhill, FL 33313

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to ensure that residents were treated in a dignified manner during dining for 8 of 21 sampled residents, Resident #8, Resident #19, Resident #29, Resident #76, Resident #90, Resident #5, Resident #26 and Resident #83; and failed to provide assistance with Activities of Daily Living (ADLs) regarding dining for 1 of 1 sampled resident reviewed for ADLs, Resident #73. The findings included: Record review revealed Resident #19's Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 07, indicating moderate to severe cognitive impairment. Record review revealed Resident #90's Quarterly MDS assessment dated [DATE] showed a BIMS of 03, indicating severe cognitive impairment. Record review revealed Resident #73's Quarterly MDS assessment dated [DATE] had a BIMS score of 03, indicating severe cognitive impairment. Record review revealed Resident #83's Quarterly MDS assessment dated [DATE] had a BIMS score of 03, indicating severe cognitive impairment. In an observation conducted on 09/09/24 in the main dining room from 12:10 PM to 12:30 PM, 21 residents were observed eating their lunch meals in the main dining room. Three (3) round tables were observed with the following: a. A table had two residents sitting for the lunch meal. Resident #8 was observed eating her lunch meal while Resident #19 was still waiting on their lunch meal. b. Three residents were sitting at a table for the lunch meal. Resident #29 and Resident #76 were eating their lunch meals, while the third, Resident #90, was still waiting on his lunch meal, observing the other two residents eating. c. Two residents sat at a table for the lunch meal. Resident #5 was eating his lunch meal while Resident #73 was waiting for her lunch meal. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 09/09/24 at 12:40 PM, Resident #26 was eating her lunch tray in the room, and her roommate, Resident #83, did not get her lunch tray. The observation continued at 1:05 PM, 25 minutes later, and Resident #83 did not get her lunch tray. It was at 1:15 PM, 35 minutes later, that Resident #83 received her lunch tray. An interview was conducted on 09/11/24 at 2:50 PM with Staff A, Certified Nursing Assistant, (CNA), who stated she was educated on dignity during dining. She always knocks on the door before entering the room and ensures she sits down at an eye level while feeding residents. An interview was conducted on 09/11/24 at 3:00 PM with Staff E, Registered Nurse, who stated he was educated on treating residents dignifiedly during dining. When serving in the main dining room, they must ensure that one table at a time is served to all residents before moving on to the next table. 2. Record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses to inlcude Hyperlipemia, Alzheimer's Disease, a History of falling, and Muscle Weakness. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Section GG of the MDS revealed Resident #73 needs substantial maximum assistance for eating. In an observation conducted on 09/09/24 at 9:35 AM, Resident #73 was noted in the room with the breakfast tray untouched. Closer observation revealed that Resident #73's roommate was already done eating her breakfast tray. In an interview conducted on 09/09/24 at 9:40 AM, Resident #73's family member stated she [Resident #73] needs assistance with her eating and someone to check in on her during mealtimes. She holds food and liquids in her mouth and, at times, forgets to swallow, [Resident #73] eats better when staff assisting her to eat, and she (familiy member) was worried [the residnet] was skinny and did not eat much. An observation conducted on 09/10/24 at 12:55 PM revealed Resident #73 eating her lunch meal with no staff in the room. A closer observation revealed that Resident #73's tray was 100% untouched. At 1:10 PM, 15 minutes later, the tray was still 100% untouched. The observation was continued at 1:25 PM, 30 minutes later, and no staff member in the room was assisting Resident #73 with her lunch tray. The lunch meal was about 5% consumed. An interview was conducted on 09/9/24 at 12:30 PM with Staff A, Certified Nursing Assistants (CNA), who stated that some days, Resident #73 eats about 40% of her meals, and some days, she needs assistance from staff. Staff A stated Resident #73's eating habits are not predictable. Review of the Care Plan initiated on 01/4/2023 showed Resident #73 has impaired cognition related to dementia. Resident #73 is at nutritional risk related to an altered diet and impaired cognition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/10/24 at 3:21 PM with the Staff MDS Coordinator, who stated she would look at the rehab report and the initial evaluation to determine what status to code residents under Section GG for eating. She stated she often spends time with the residents to get to know them and find out what they are able to do and what they can not do. After spending time with the residents, she gets to know them and what they can and cannot do. When asked by the surveyor what it means when a resident is coded in the MDS for 'substantial maximum assistance for eating,' she stated the following, the resident cannot finish the meal without someone assisting them. This means that they need lots of help during mealtimes, and they have maximum assistance from staff who would be right next to them to assist them at all times.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation and interview, the facility failed to ensure the bathroom Emergency call light system was accessible and within easy reach of the residents and staff members for 7 of 53 residents observed (Resident #95, Resident #45, Resident #3, Resident #29, Resident #17, Resident #76 and Resident #23), in the secure, locked unit. The findings included: Review of the facility policy and procedure on 09/12/24 at 11:44 AM, titled, Call Bell System, provided by the Administrator effective date 11/30/14, documented, in part, in the Policy Statement: Resident must have, at all times, a system to notify staff when assistance is needed Procedure: .will be placed within reach of any resident . Record review revealed Resident # 95 was admitted to the facility on [DATE] with diagnoses that included Dementia, Diabetes Mellitus Type II, Hypertension and Depression. Resident #95 ambulates in and out of her bathroom throughout the day. She had a documented Brief Interview Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Record review revealed Resident # 45 was readmitted to the facility on [DATE] with diagnoses that included Autistic Disorder, Schizophrenia, Parkinsonism and Hypertension. The resident's BIMS score was not documented but it indicated moderate cognitive impairment. Record review revealed Resident #3 was readmitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Schizophrenia, Dementia, Parkinsonism and Generalized Anxiety Disorder. Resident #3 self-propels in his wheelchair in and out of his bathroom throughout the day. He had a BIMS score of 2 indicating severe cognitive impairment. Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis affecting the right dominant side, Dementia, Diabetes Mellitus Type II, Major Depressive Disorder and Repeated falls. Resident #29 self-propels in her wheelchair in and out of her bathroom throughout the day. She had a BIMS score of 4, indicating severe cognitive impairment. Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses that included Heart Failure, Depression, Diabetes Mellitus Type II, Anxiety Disorder and Hypertension. She had a BIMS score of 4, indicating severe cognitive impairment. Record review revealed Resident #76 was readmitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis affecting right dominant side, Diabetes Mellitus Type II, Cerebral Infarction, Anemia and Unsteadiness on feet. Resident #76 self-propels in his wheelchair in and out of his bathroom throughout the day. He had a BIMS score of 14, indicating he was cognitively intact. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #23 was readmitted to the facility on [DATE] with diagnoses that included Dementia, Systolic Congestive Heart Failure, Depression, Epilepsy, Asthma, Parkinsonism, Altered mental status and Hypertension. Resident #23 self-propels in his wheelchair in and out of his bathroom throughout the day. He had BIMS score of 8, indicating moderate cognitive impairment. During an observational room tour conducted of the 100-hallway locked area unit, between the three (3) days of 09/09/24 through 09/11/24, the following four (4) resident rooms were observed to have their bathroom Emergency call lights not accessible and not within easy reach for the residents and facility staff's use. Photographic Evidence Obtained. a. On 09/09/24 at 10:53 AM, Resident #95's bathroom was observed to have the bathroom Emergency cord was noted to be tied around the bathroom bar. On 09/10/24 at 10:04 AM, Resident #95's bathroom was still observed to have the bathroom Emergency cord was noted to be tied around the bathroom bar. On 09/11/24 at 9:20 AM, Resident #95's bathroom was still observed to have the bathroom Emergency cord was noted to be tied around the bathroom bar. b. On 09/09/24 at 11:21 AM, Residents #45's and Residents #3's bathroom was observed to have no pull cord attached to the bathroom Emergency call system in the bathroom. On 09/10/24 at 10:08 AM, Residents #45 and #3's bathroom was still observed to have no pull cord attached to the Emergency call system in the Resident's bathroom. On 09/11/24 at 9:23 AM, Residents #45 and #3's bathroom was still observed to have no pull cord attached to the Emergency call system in the Resident's bathroom. c. On 09/09/24 at 11:48 AM, Residents #29 and #17's bathroom was observed to have the bathroom Emergency call light cord wrapped around the bathroom handrail. On 09/10/24 at 10:15 AM, Residents #29 and #17's bathroom was still observed to have the Emergency call light cord wrapped around the bathroom handrail. On 09/11/24 at 9:25 AM, Residents #29 and #17's bathroom was still observed to have the bathroom Emergency call light cord wrapped around the bathroom handrail. d. On 09/09/24 at 12:07 PM, Residents #76 and #23's bathroom Emergency bathroom cord was tied to the toilet faucet connection above the toilet x 1 on the first day of the survey. Following the observational room tour, an interview was conducted on 09/11/24 at 9:31 AM with the Maintenance Director, the Housekeeping Director, the Director of Nursing (DON), the Regional Nurse, the Regional Maintenance Director and the Administrator, regarding the residents' bathroom emergency call lights all being observed as inaccessible. Each acknowledged that the residents' bathroom call lights should be readily accessible for both the residents and staff use, in the event of an emergency. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Three (3) of the four (4) residents bathroom's emergency call lights had not been made easily accessible and within reach, to both the residents and staff for those resident rooms, until after surveyor inquisition/intervention. On 09/12/24 at 11:36 AM, Residents #29 and 17's room was still observed, on a fourth (4th) observation, with the Administrator present, to have the bathroom emergency call light in the exact same position as it had been on three (3) previous days, wrapped around the bathroom handrail. The Administrator further recognized and acknowledged that on 09/11/24 at 10:31 AM, the facility should ensure that the bathrooms' emergency call lights should always be readily accessible and within reach for both resident and staff use, in the event of an emergency.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record reviews, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 2 of 2 sampled residents reviewed for high risk medications, Residents #2 and #32. The findings included: 1. Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with a most recent readmission on 08/05/24. The diagnoses included in part the following: Unspecified Intracapsular Fracture of Left Femur Subsequent Encounter for Closed Fracture with Delayed Healing, and Type 2 Diabetes Mellitus without Complications. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 08/09/24 revealed in Section C, a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Documented in Section N under high risk medications: 'antiplatelet is taking' was answered 'no'; and 'anticoagulant was taking' was answered 'yes'. Review of the Physician's Orders for Resident #2 revealed an order dated 08/06/24 for aspirin 81 mg give 1 tablet by mouth daily for CAD (Coronary Artery Disease). Review of the current and discontinued Physician's Orders for Resident #2 revealed no order for an anticoagulant. 2. Record review for Resident #32 revealed the resident was admitted to the facility on [DATE] with a readmission on 03/04/24. The diagnoses included in part the following: Unspecified Fracture of Left Femur Initial Encounter for Closed Fracture, History of Falling and Anemia. Review of the MDS assessment for Resident #32 dated 06/08/24 revealed in Section C, a BIMS score of 3 indicating severe cognitive impairment. Documented in Section N under high risk medications: 'antiplatelet is taking' was answered 'no', and 'anticoagulant is taking' was answered 'yes'. Review of the physician's orders for Resident #32 revealed an order dated 06/04/24 for Procrit Injection Solution 20,000 unit/ml, inject 20,000 units subcutaneously one time a day every Tuesday and Saturday for anemia. Review of the current and discontinued physician's orders for Resident #32 revealed no order for an anticoagulant or antiplatelet. An interview was conducted on 09/11/24 at 11:07 AM with the MDS Coordinator who stated she started working at the facility in October 2023. When asked what medications are classified as an anticoagulant, she stated Eliquis / Apixaban and Clopidogrel / Plavix are some of the anticoagulants. When asked what medications are classified as an antiplatelet, she said sometimes aspirin, but it would depend on the dosage. She stated if they are on a low dose aspirin (81 mg), she would not consider that an antiplatelet, only if it were a higher dose of 325 mg. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The MDS Coordinator then stated if she has any question, she will confer with the Corporate MDS person. When asked about how she determines if a resident is on an anticoagulant or antiplatelet, she said she would look at the orders for the resident and based on if they were ordered or received either an anticoagulant or antiplatelet within the 7 day look back period (prior to the MDS date), she would mark it in Section N of the MDS. When asked if Procrit is an anticoagulant or an antiplatelet, she said no it is neither. The MDS Coordinator called the Corporate MDS personnel and asked if Eliquis / Apixaban and Clopidogrel / Plavix were anticoagulants. The Corporate MDS personnel stated Eliquis / Apixaban is an anticoagulant and Clopidogrel / Plavix are antiplatelets. When the MDS coordinator was asked about Resident #2, she acknowledged the resident was on aspirin 81 mg and the MDS dated [DATE] documented in Section N, Resident #2 was taking an anticoagulant. The MDS Coordinator stated that was a mistake, it should not be an anticoagulant, it should have been antiplatelet. When asked about Resident #32, she acknowledged the resident had not ever had an order for an antiplatelet or anticoagulant. She further acknowledged the MDS for Resident #32 dated 06/08/24 documented the resident was receiving an anticoagulant. The MDS Coordinator stated Resident #32 received 1 injection Procrit and that was why she had indicated in the MDS that the resident was on an anticoagulant. The MDS Coordinator stated she did not know why she did that, and she may have gotten the medications confused. She acknowledged she had made a mistake with the coding of anticoagulant for Residents #2 and #32. She then stated I guess I was overwhelmed.

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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** 39026 Based on observation, interview and record review, the facility failed to implement a care plan for Post Traumatic Stress Disorder (PTSD) and failed to implement a care plan for an anticoagulant for 1 of 24 sampled residents, Resident #88. The findings included: 1. Record review revealed Resident #88 was admitted to the facility post hospitalization on [DATE], with admitting diagnoses that included Unspecified Cirrhosis of Liver, Coronary Artery Disease, Non-Alzheimer's Dementia, and Post Traumatic Stress Disorder. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 08/15/24, documented a Brief Interview for Mental Status (BIMS) score of 8 indicating the resident had moderate cognitive impairment. Section I of this MDS revealed the resident had Post Traumatic Stress Disorder (PTSD). Review of the record revealed there was no care plan that addressed PTSD. An interview was conducted with the MDS Coordinator on 09/10/24 at 3:10 PM, who was responsible for putting a care plan in place for PTSD. The MDS Coordinator stated this would be her job. She was asked why there was no care plan for PTSD for this resident and she stated she would put one in today. 41837 2. Record review for Resident #88 revealed the resident was admitted to the facility on [DATE] with diagnoses including in part: Essential (Primary) Hypertension and Unspecified Atrial Fibrillation. Review of the MDS assessment for Resident #88 dated 08/15/24 documented in Section C, a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment. In Section N, documented under Anticoagulant, is taking - yes. Review of the physician's orders for Resident #88 revealed an order dated 08/16/24 for Eliquis (Apixaban) 5mg, give 1 tablet by mouth two times a day for A-fib (Atrial Fibrillation). Review of the physician's orders for Resident #88 revealed an order dated 08/15/24 for Anticoagulant Medication - monitor for discolored urine, black tarry stools every shift. Review of the Care Plan for Resident #88 revealed no care plan for the anticoagulant or for risk of bleeding. An interview was conducted on 09/11/24 at 11:07 AM with the MDS Coordinator who stated she has been working at the facility for less than 1 year and started in October 2023. When asked if a resident is on an anticoagulant would the resident have a care plan related to anticoagulant for at risk for bleeding. She stated, of course they would have to have a care plan for risk of bleeding if they are on an anticoagulant. She said that is very important.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record review, the facility failed to ensure residents received assistance with making eye appointment for 1 of 1 sampled resident reviewed for vision, Resident #89. The findings included: Record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Dementia Unspecified Severity with Agitation, Altered Mental Status, Delirium Due to Known Physiological Condition, and Psychotic Disorder with Hallucinations Due to Known Physiological Condition. Review of the Minimum Data Set (MDS) for Resident #89 dated 05/22/24 documented in Section B under Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision was answered yes. Documentation in Section C revealed a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. A telephone interview was conducted on 09/10/24 at 10:22 AM with the family member of Resident #89 who stated she brought it to attention of staff that she would like the resident seen by eye doctor about 2 months ago because the resident had no eyeglasses. She had bought the resident a pair of over the counter reading glasses in the meantime. The family member stated the social worker told her they would have the eye doctor see the resident, but she has not heard of any appointment being set or of the resident having seen the eye doctor. An interview was conducted on 09/10/24 at 2:02 PM with the Social Service Director (SSD) who was asked if Resident #89 was seen by the eye doctor. She said she believes the resident was seen by the eye doctor, but they have not received the paperwork yet. An interview was conducted on 09/11/24 at 2:00 PM with the SSD who was asked about the documentation for the eye exam for Resident #89. The SSD stated the resident had not been seen by the eye doctor. The SSD stated she had spoken to Resident #89 and the resident had informed her that a family member had brought her some glasses. When brought to the SSD attention that the resident has severe cognitive impairment, the SSD said I know but I thought the glasses were lost and then they were found. The SSD acknowledged she did not arrange for Resident #89 to be seen by the eye doctor as requested by Resident #89's family member. The SSD further acknowledged she did not have any additional conversation with the family member regarding eyeglasses after she spoke to the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 identify weight loss, and provide nutritional intervention in a timely manner for 2 of 5 sampled residents reviewed for nutrition, Resident #32 and Resident #7. The findings included: Review of the facility's policy, titled, Weighing the Resident, revised on 05/06/2022, showed the following: Record weight and alert nurse to any significant change. Notify the Physician of any significant weight change and consult the Dietitian. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses that inclluded Muscle wasting, History of falling, Dementia, Muscle weakness, and Anemia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 had a Brief Interview of Mental Status (BIMS) score of 03 indicating severe cognitive impairement. In an observation conducted on 09/10/24 at 8:48 AM, Resident #32 received her breakfast tray. At 9:00 AM, the Director of Nursing (DON) came into the room and sat near Resident #32 to help her with the breakfast tray. At 9:03 AM, the DON left the room with the breakfast tray and said to the surveyor, She does not want to eat. I will bring her cereal from the kitchen. In an observation conducted on 09/11/24 at 8:45 AM, Resident #32 received her breakfast tray. At 9:00 AM, Resident #32 was observed eating on her own and only ate one bite of her bread and a few teaspoons of the cereal. Continued observation at 9:15 AM, which was 30 minutes later, revealed Resident #32 did not eat any more of the food on her breakfast plate from the earlier observation at 9:00 AM. Review of the physician's orders showed the following: give 120 milliliters (ml) of nutritional support three times a day, dated 08/30/24; give a house shake with lunch one time a day, dated 09/04/24; and give a regular texture diet, dated 03/04/24. Review of Resident #32's weight log showed the following weights: On 05/06/24, 130.8 pounds (#). On 06/03/24, 129.8 #. On 07/02/24, 125.4 #. On 08/06/24, 121.6 #. The weight loss over 2 months was 6.4% weight loss. The weight on 09/03/24 showed a weight loss of 8.9% in 3 months from 06/03/24 to 09/03/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Nursing Assistants, (CNAs), documentation of the amount of meals consumed revealed that from 08/13/24 to 08/30/24, Resident #32's daily intake (3 meals a day) was an average of 46%. Review of the Clinical Dietitian's progress note dated 08/30/24 showed the following: trending non-significant weight loss past 180 days. Resident #32 is eating between 25% and 50% of her meals. Suggest increasing nutritional supplements 120 ml to 3 times a week. This clinical note addressing the above weight loss was completed 24 days after the 6.4% weight loss was identified on 08/06/24, with a weight of 121.6 pounds. Review of the Clinical Dietitian's progress note dated 09/04/24 showed the following: significant weight loss in 90 days. Resident #32 is eating between 25% and 50% of her meals. An additional house shake (nutritional supplement) was added to the lunch meal for additional calories and protein. An interview was conducted on 09/11/24 at 10:06 AM with the facility's Clinical Dietitian, who started working in the company for about one year. She stated she comes into this facility one time a week as well. A significant weight loss is when a resident loses 5% in one month, 7.5% in 3 months, and 10% in 6 months. A severe weight loss will populate in the electronic system, letting her know if any residents have severe weight loss. She will try to follow up on the residents within 24 to 48 hours. She would address any trending weight loss as soon as she could, within 24 hours to 48 hours. Resident #32 weight loss trend was addressed about 24 days later. When asked by the surveyor why she addressed the weight loss 24 days later, she did not know. In an interview conducted on 09/12/24 at 1:00 PM, with the Director of Nursing, she was told of the findings. 50370 2. Record review revealed Resident #7 was admitted on [DATE] with the diagnoses that included Essential Primary Hypertension, Type 2 Diabetes, Hyperlipidemia, and Atherosclerotic Heart Disease. Review of the Minimum Data Set (MDS) assessment dated [DATE], in Section C revealed a Brief Interview of Mental Status (BIMS) score of 03 indicating the resident had severe cognitive impairment. Section K of MDS revealed no complaints or difficulty or pain when swallowing. Additional data under Section K showed Resident #7 weighed 116 pounds (Lbs/#) on 08/05/24 indicating no weight loss of 5 % in the last month and no weight loss of 10% or more in the last 6 months. Review of the laboratory result dated 05/28/24 revealed Resident #7 had low total protein of 6.0 g/dl (gram per deciliter is the sum concentrations of all individual serum protein), indicating resident's level was on the bottom spectrum of the normal values of 6 g/dl to 8.3 g/dl.) and an albumin level of 3.0 gm/dl. (indicating below the normal range of 3.5 to 5.5 grams per deciliter which could indicate an underlying medical condition related to kidney, liver, and heart and could also indicate nutritional deficiencies). Review of records showed a nutrition care plan for altered nutrition and hydration, swallowing problems related to coughing or chocking during meals or swallowing medications. Care plan for potential pressure ulcer, impaired cognition related to dementia, complications of diabetes mellitus, previous CABG (Coronary Artery Bypass Graft) related to Hypertension and lifestyle choices were noted. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Assessment, titled, Nspire Daily Skilled Notes, dated 09/09/24, documented, in part, the following: ADL (Activities of Daily Living) status is assisted, Resident receives PT (Physical Therapy), and OT (Occupational Therapy), swallowing problems were not noted. Review of Task under Percentage of Meals eaten showed the following data for Resident 7: 0n 08/30/24, consumed 25% at breakfast, 50% at lunch and 75% at dinner. On 08/31/24, consumed 25% at breakfast, 74% at lunch 75% at dinner. On 09/01/24, consumed 0% for breakfast, 50% at lunch, and 75% at dinner. On 09/02/24, consumed 50% at breakfast, 75% at lunch, 100% at dinner. On 09/03/24, consumed 50% at breakfast, 50% at lunch, 25% at dinner. Review of weight records showed the following data: 114.2 pounds on 09/03/24, 117.2 pounds on 08/30/24; 116.2 pounds on 08/05/24; 119.4 pounds on 07/05/24; 120.8 pounds on 06/03/24; 125 pounds on 05/02/24, and 122.2 pounds on 04/03/24. This indicated a weight loss of 2.66 % in a month and 6.55 % weight loss in 6 months. Review of the physicians' order dated 11/03/22 showed that Resident #7 was to be provided with one carton (120 ml [milliliters]) of NSA (No Salt Added) House Shake, twice daily with lunch and dinner. On 02/05/24, the orders showed the resident was to receive a regular textured diet order. On 08/02/24, an order was documented to give Resident #7 snacks daily at HS (hour of sleep) one time at night. On 09/09/24, an order for a NSA supplement was added, increasing the supplement to three times 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	Review of the Registered Dietician (RD) notes, dated 06/03/24, showed the facility staff addressed Resident #7's moderate protein calorie malnutrition by documenting fluctuating appetite (mostly eating 25-50% of meals, and occasionally 75 0r 100 of meals). Review of the RD notes, dated 06/03/24, documented Resident #7 had 5.6 % weight loss in 5 months (126.4 Lbs weight on 02/05/24 to 120.8 Lbs on (06/03/24). Additional notes documented a 4.2 Lbs weight loss in one month (120.8 Lbs on 06/03/24 from 125.0 Lbs. on 05/02/24) with a BMI (Basal Metabolic Index) of 19.5. Review of the RD notes, dated 06/03//24 documented the following interventions: to monitor laboratory (albumin, total protein, pre-albumin), weight and PO [oral] intake, to continue aggressive PCM (Protein Calorie Malnutrition) treatment with supplements, house shake one carton BID (two times a day) at lunch and dinner, NSA (No Salt Added) of 120 ML (milliliters), QID (4x a day). It added that staff assist with meals. In an interview with Resident #7 on 09/10/24 at 09:30 AM, she stated she sometimes does not like to eat, and only drinks tea in the morning. During lunch observation on 09/10/24 at 1:30 PM, Resident # 7's lunch tray remained untouched. There was no supplement noted on the meal table. There was no assistance from staff observed. Resident #7 returned her meal tray to the meal cart with staff observing. Staff did not ask if she wanted to have an alternate lunch. During an observation conducted on 09/11/24 at 9:26 AM, Resident #7 stated that she drank tea, but did not touch breakfast. The breakfast tray was delivered before 9:00 AM and remained untouched at 9:50 AM. No staff approached the resident to encourage her to eat or asked her if she wanted something else. In an interview with Staff I, Certified Nursing Assistant (CNA), on 09/11/24 at 9:30 AM, she stated that Resident #7 eats when the food is interesting. She stated that Resident #7 eats only 50% of her meal most of the time. When asked if she had seen Resident #7 drinking nutritional supplement during breakfast and lunch, she stated no. When asked if she assisted Resident #7 in eating, she answered no. She stated Resident #7 likes to drink tea but refuses food on the breakfast tray. When asked if she offered Resident #7 a different breakfast, she responded, no. She added that Resident #7 likes to eat her lunch. An interview was conducted with the Registered Dietician (RD) on 09/11/24 at 10:06 AM. She said that she was not concerned about Resident #7's weight loss because it was a weight loss trend and not a weight trigger for significant weight loss in the electronic system. When the surveyor reviewed with her the weight loss of Resident #7, which went down to 114.2 pounds on 09/03/24, from 117.2 pounds on 08/30/24, and 125 pounds on 05/12/24, she stated she knew about the weight loss trend, but it was not significant weight loss and considered it not important. When asked by the surveyor why she modified the nutritional supplement order to 3 times a day on 09/09/24, she stated that she increased the volume of the supplement because of Resident #7's weight loss trends. During an interview with the Director of Nursing (DON) on 09/12/24 at 2:00 PM, the above findings were reviewed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to follow the physicians' orders for tube feeding for 1 of 1 sampled resident reviewed for nutrition, Resident #69. The findings included: Record review revealed Resident #69 was readmitted to the facility on [DATE] with diagnoses that included Hemiplegia, History of falling, Muscle Weakness, and Chronic Kidney Disease. Review of the Physician's orders revealed the following: a. On 09/04/24, Enteral feeding continuous with Jevity 1.5 (tube feeding formulary type), at 75 milliliters (ml) an hour for 20 hours or until 1500ml has infused with off feeding time at 10:00 AM. b. On 09/10/24. Enteral feeding is continuous with Jevity 1.5 (tube feeding formulary type) at 75 milliliters (ml) an hour for 20 hours or until 1500ml has been infused. c. On 09/11/24. Enteral feeding two times a day for one day bolus feeding with Jevity 1.5 (237ml) times 2 for one day. Review of the weight log for Resident #69 showed the following: On 05/02/24, a weight of 121 pounds. On 06/03/24, a weight of 118.6 pounds. On 07/05/24, a weight of 113 pounds. On 08/07/24, a weight of 111 pounds. On 08/19/24, a weight of 110.8 pounds. On 09/03/24, a weight of 107 pounds. This showed a 9.8% weight loss in 3 months. In an observation conducted on 09/10/24 at 7:30 AM, Resident #69 was noted in bed with the tube feeding running at 75ml an hour, which started on 09/10/24 at 6:00 AM. The tube feeding was noted at the 1000ml mark out of a 1000ml capacity bottle. In an observation conducted on 09/10/24 at 10:15 AM, Resident #69 was noted in bed with the tube feeding running at 75ml an hour, which started on 09/10/24 at 6:00 AM. The tube feeding was noted at the 850ml mark out of a 1000ml capacity bottle. The tube feeding that started at 6:00 AM in the morning, running at 75ml an hour, should have been at the 700ml mark out of a 1000ml capacity bottle. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 09/10/24 at 11:30 AM, Resident #69 was noted in bed with the tube feeding running at 75 ml an hour which started on 09/10/24 at 6:00 AM. The tube feeding was noted at the 750ml mark out of a 1000ml capacity bottle. The tube feeding that started at 6:00 AM in the morning running at 75ml an hour should have been at the 600ml mark out of 1000ml capacity bottle. In an observation conducted on 09/10/24 at 1:00 PM, Resident #69 was noted in bed with the tube feeding running at 75 ml an hour which started on 09/10/24 at 6 :00AM. The tube feeding was noted at the 600ml mark out of a 1000ml capacity bottle. The tube feeding that started at 6:00 AM in the morning running at 75ml an hour should have been at 475 ml mark out of 1000ml capacity bottle and not at the 600ml mark as observed. In an observation conducted on 09/11/24 at 12:47 PM, Resident #69 was noted in the room with the tube feeding running. The tube feeding was noted with Jevity 1.5 at 75ml an hour, which started on 09/11/24 at 6:45 AM. About six hours later, the tube feeding bottle was noted at the 900ml mark out of the 1000ml capacity bottle. Review of the Clinical Dietitian progress note dated 08/23/24 revealed the following: weight loss trigger with no enteral feeding intolerances reported per nursing. Feeding increases related to significant weight loss. Review of the Clinical Dietitian progress note dated 09/06/24 revealed that Resident #69 has been losing weight, and the Dietitian updated the orders to change to continuous feedings. Review of the care plan dated 04/19/24 showed that Resident #69 requires tube feeding and needs to see the doctor's orders for current tube feedings. Resident #69 will maintain adequate nutritional and hydration status. An interview was conducted on 09/11/24 at 1:32 PM with Staff C, Licensed Practical Nurse, who stated she provided Resident #69 with bolus tube feeding at 9:30 AM this morning and at 12:00 PM today. She further said that Resident #69 is tolerating her tube feeding well. An interview was conducted on 09/11/24 at 1:42 PM with the Registered Dietitian, who stated she was told by nursing there was a malfunctioning of the tube feeding pump for Resident #69, and an order was placed for bolus feeding to meet the additional feeding of her needs for the tube feeding that started this morning. She confirmed that the tube feeding observed on 09/10/24 at 10:15 AM should have been at the 700ml mark and not at the 850ml mark as observed. The Registered Dietitian stated that she changed the tube feeding order from bolus to continuous to ensure that Resident #69 received the estimated calories and protein needs. An interview was conducted on 09/11/24 at 2:00 PM with the Director of Nursing, who stated Resident #69 used to pull her tube feeding out, which may have caused some of the weight loss. When asked for any documentation regarding the tube feeding behaviors, she was not able to provide any further documentation.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, record and policy review, the facility failed to timely assess a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) and failed to provide psychosocial services to meet the need for PTSD diagnosis for 1 of 1 sampled resident reviewed for PTSD, Resident #88. The findings included: The facility's policy, titled, PTSD Procedure and Policy, effective 08/14/20 and revised 11/20/20, documented, in part, Upon admission, all residents will be screened for potential PTSD using a standardized tool, such as the PTSD Checklist for DSM-5 (PCL-5) and Residents identified with PTSD will be offered individualized care plans that include: trauma-informed therapy or counseling, medication management (if appropriate). Record review revealed Resident #88 was admitted to the facility post hospitalization on [DATE], with admitting diagnoses that included Unspecified Cirrhosis of Liver, Coronary Artery Disease, Non-Alzheimer's Dementia, and Post Traumatic Stress Disorder. Review of the Minimum Data Set (MDS) assessment documented the Brief Interview for Mental Status (BIMS) with a score of 8, indicating moderate cognitive impairment. Section I of this MDS revealed the resident had PTSD. An interview was conducted with the resident on 09/10/24 at 1:25 PM. He stated he was a veteran, has PTSD and was in the hospital with a flashback before he was admitted here. He stated sudden loud noises remind him of the war like a car backfiring or loud car noises. An interview was conducted with Staff F, Registered Nurse (RN), on 09/10/24 at 1:40 PM, who stated she was aware of the PTSD diagnosis but was unaware of the triggers. She stated that he never spoke about it. An interview was conducted with the Social Service director on 09/10/24 at 1:45 PM. She was asked what she would do with a resident admitted with PTSD. She stated she does not deal with PTSD and she thinks a nurse does. When asked who would do a care plan for PTSD, she stated that the surveyor should talk to the MDS person. An interview was conducted with the MDS Coordinator on 09/10/24 at 3:10 PM, who stated she had been working in this facility for 11 months. She was asked what was the process if a resident was admitted with a diagnosis of PTSD. She stated the resident would be followed by psychiatry. She was asked who would talk to the resident about why he had PTSD and what his triggers were. She stated she would rather the psychiatrist talk to him about that. The MDS coordinator was asked if the resident had been seen by a psychiatrist yet and she stated she would put him on the list to be seen. The surveyor asked why has the resident not been seen since he has been here for a month already and she did not know. She stated that it is her job to put a care plan in for PTSD. She was asked why there was no care plan for PTSD for this resident and she stated she would put one in today. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PTSD policy was received by the surveyor on 09/12/24 at 10:00 AM and reviewed. An interview was conducted with the Regional Nurse Consultant who stated they have no PTSD tool. If they did, the Social Service Director would do the assessment. She stated that no resident has been screened with the PTSD checklist because they are not using the tool at this time and will have to re-evaluate this policy. An interview was conducted with the Psychiatrist on 09/12/24 at 11:50 AM, who had completed the assessment of Resident #88 that morning (09/12/24). The Psychiatrist stated the resident is confused and he has a lot of brain problems and encephalopathy and his current ammonia level is normal. He is hearing voices and hearing soldiers marching and because he is hallucinating he started him on Seroquel. (Seroquel is an antipsychotic medication used for the treatment of schizophrenia, bipolar disorder and major depressive disorder.) He does not seem distressed by it. He will see him next week. He thinks someone admitted with PTSD should be seen by a psychiatrist but since no one made him aware of it, he is seeing him today.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, record and policy review, the facility failed to provide psychosocial services to meet the need for Post Traumatic Stress Disorder (PTSD) diagnosis for 1 of 1 sampled resident reviewed for PTSD, Resident #88. The findings included: The facility's policy, titled, PTSD Procedure and Policy, effective 08/14/20 and revised 11/20/20, documented, in part, Upon admission, all residents will be screened for potential PTSD using a standardized tool, such as the PTSD Checklist for DSM-5 (PCL-5) and Residents identified with PTSD will be offered individualized care plans that include: trauma-informed therapy or counseling, medication management (if appropriate). Review of the job description for the Director of Social Services revealed the purpose of the job position is to ensure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. The duties and responsibilities of the Social Service Director include conduct and document a social services evaluation, including identification of resident problems/needs. Record review revealed Resident #88 was admitted to the facility post hospitalization on [DATE], with admitting diagnoses that included Unspecified Cirrhosis of Liver, Coronary Artery Disease, Non-Alzheimer's Dementia, and Post Traumatic Stress Disorder. Review of the Minimum Data Set (MDS) assessment documented the Brief Interview for Mental Status (BIMS) with a score of 8, indicating moderate cognitive impairment. Section I of this MDS revealed the resident had PTSD. An interview was conducted with the resident on 09/10/24 at 1:25 PM. He stated he was a veteran, has PTSD and was in the hospital with a flashback before he was admitted here. He stated sudden loud noises remind him of the war like a car backfiring or loud car noises. An interview was conducted with the Social Service director on 09/10/24 at 1:45 PM. She stated she had been working in the facility for one year. She was asked what she would do with a resident admitted with PTSD. She stated she does not deal with PTSD, and she thinks a nurse does. When asked who would do a care plan for PTSD she stated that the surveyor should talk to the MDS person. Review of the social services evaluation for Resident #88 dated 08/23/24 did not include the diagnosis of PTSD. Question 12 of the assessment asks, Have you even been through anything life threatening or traumatic? The question was answered as N/A. On 09/11/24 at 10:21 AM, the Social Service Director was asked why she marked N/A for question 12 on the evaluation. She stated the resident did not answer the question regarding PTSD. She put N/A but she should have put refused to answer. She stated she does not know what his triggers are and why he has PTSD. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PTSD policy was received by the surveyor. An interview was conducted with the Regional Nurse Consultant who stated they have no PTSD tool. If they did, the Social Service Director would do the assessment. She stated that no resident has been screened with the PTSD checklist because they are not using the tool at this time and will have to re-evaluate this policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interview and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 of 6 sampled residents reviewed for medication reconciliation, Residents #19 and #306. The findings included: 1. Record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses that included the following: Obesity, Other Abnormalities of Gait and Mobility and Muscle Weakness (generalized). Review of the physician's orders for Resident #19 revealed an order for Tramadol HCL 50mg give 50mg by mouth every 12 hours as needed for pain. Review of the Medication Monitoring / Control Record for Resident #19 for the medication Tramadol HCL 50mg documented the medication was given on 07/15/24 at 9:00 PM and again on 08/25/24 at 4:33 PM. Review of the MAR for Resident #19 for the month of July 2024 revealed no documentation for the medication Tramadol HCL 50mg being administered on 07/15/24. Review of the MAR for Resident #19 for the month of August 2024 revealed no documentation for the medication Tramadol HCL 50mg being administered on 08/24/24. An interview was conducted on 09/12/24 at 11:30 AM with Staff C, Licensed Practical Nurse (LPN) who was asked about the process for documenting when a controlled medication is administered, Staff C stated when you remove a controlled medication from the cart, you are supposed to sign it off on the Medication Monitoring / Control Record and sign it off as given on the Medication Administration Record in the resident's chart. When asked about the Medication Monitoring / Control Record for Resident #19, she acknowledged there was no date or time documented on the Medication Monitoring / Control Record and stated that is a problem. An interview was conducted on 09/12/24 at 12:30 PM with Staff H, Registered Nurse (RN), who stated she has worked at the facility for 4 months. When asked about the Medication Monitoring / Control sheet for Resident #19's Oxycodone, she stated she should have put the day and time on the form but believes she got distracted that day. She acknowledged she did not complete the Medication Monitoring / Control Record with the day and time. 2. Record review for Resident #306 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, the following: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus. Review of the physician's orders for Resident #306 revealed an order dated 09/06/24 for Oxycodone HCL 5mg give 1 tablet every 6 hours as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105680	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Lauderhill	2599 NW 55th Ave Lauderhill, FL 33313

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Monitoring / Control Record for Resident #306 for the medication Oxycodone HCL 5mg revealed the medication was signed out but did not indicate the date or time. Review of the Medication Administration Record (MAR) for Resident #306 for the month of September 2024 revealed the medication Oxycodone HCL 5mg was documented as administered on 09/10/24 at 2:41 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to provide the appropriate diet consistency for a Mechanical soft diet for 2 of 27 residents, Residents #7 and #41, during dining observation. This had the potential to affect 27 residents who were on a mechanical soft diet. The findings included: Review of the facility's 'National Dysphagia Diet Level 3 Advanced' revealed the following: The advanced diet consists of food of varying textures except for very hard, sticky, or crunchy foods. Foods need to be served moist and ground, chopped, or in bite-size pieces less than 1 inch long. It further showed foods to avoid, such as undercooked fibrous, tough, or stringy vegetables, such as cabbage, asparagus, and celery. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Review of orders revealed an order, dated 02/8/23, for a No Added Salt (NAS) diet with Mechanical soft texture. Review of the MDS dated [DATE] showed that Resident #41 had a BIMS score of 09, which indicated the resident had moderate cognitive impairment. A review of orders revealed an order for a Regular Mechanical soft diet dated 12/08/22. Review of the facility's menu showed the following foods for Monday 09/09/24 for the lunch meal: Glazed meatloaf, mashed potatoes, red cabbage, wheat roll, margarine, apple pie, and coffee, or juice. In an observation conducted on 09/09/24 at 12:20 PM in the main dining room, Resident #73 was observed eating her lunch meal with the MDS Coordinator feeding her the lunch meal. The meal tray consisted of a mechanical soft diet with mashed potatoes, chopped meatloaf, and cooked red cabbage. The cabbage was in strips of approximately 2-3 inches in size. Resident #73 was observed coughing after taking a bite of the cooked red cabbage. The surveyor attempted to cut through the cooked red cabbage with a fork. A force was used to cut through the red cabbage, which was hard to cut. In an observation conducted on 09/09/24 at 1:10 PM, Resident #41 was eating his lunch meal in his room with no staff in attendance. The meal plate was noted with the following: chopped meatloaf, mashed potatoes, bread and cooked red cabbage with each piece about 2-3 inches long. In an interview conducted on 09/12/24 at 10:34 AM, Staff G, Speech Language Pathologist, stated that residents on a mechanical soft diet at the facility follow the Level 3 Advanced Dysphagia diet. Vegetables should be cooked so that a fork can crush through them without forced use. The vegetables needs to be within the width of the fork that is used. She was aware that the cooked red cabbage on Monday 09/09/24 for the lunch meal was inappropriate for the diet consistency of the mechanical soft diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She spoke to the Clinical Dietitian and the Dietary Manager regarding the lunch that was served on Monday. She questioned how long it was cooked and stated that it was still tough to cut and not cooked enough before being served to residents on a mechanical soft diet.

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	105680	A. Building B. Wing	09/12/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40153 Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This was observed during 1 of 3 visits conducted in the Main Kitchen. The findings included: In a tour of the Main Kitchen conducted on 09/09/24 at 9:00 AM with the Kitchen Manager, the following were noted: a. Small flying insects were noted in the dishwashing area near an opened round garbage dumpster. A Drainage treatment system that was not connected was noted underneath the dishwashing machine. In this observation, the Kitchen Manager said that she called an outside company to come and treat the flying insects that were observed last week in the kitchen. She did not know why the treatment system was disconnected and said, It is not connected to the main tube. She then proceeded to connect the treatment system to the correct tubing. b. The walk-in refrigerator had an internal thermometer, which showed a temperature of 55 degrees Fahrenheit and not the recommended 40 degrees Fahrenheit or below. The walk-in refrigerator was noted to have water condensation, and the carton boxes were not cold to the touch and felt wet. In this observation, the kitchen manager stated that the internal thermometer was probably not working and removed it from the walk-in refrigerator. c. The Dry Storage Room had a reach-in freezer that had an internal thermometer that showed a temperature of 38% and not the recommended 0 degrees Fahrenheit or below. In this observation, the kitchen manager stated that the internal thermometer was probably not working and removed it from the reach-in freezer. d. The walk-in freezer contained an opened package of frozen tortillas that were not labeled or dated for the expiration date. e. In the Dry Storage Room, one package of cheesecake filling was opened and observed at the bottom of the box. The Dietary Manager discarded the opened package and cleaned the bottom of the box. f. In an observation conducted on 09/10/24 at 8:53 AM, Staff D, Activity Coordinator, was sitting near Resident #73 for her breakfast meal. When asked for her name by this Surveyor, Staff D stopped feeding Resident #73 and looked into her pocket, touching keys and pens with her bare hands, looking for her name badge. She then continued feeding Resident #73 without washing her hands first. 50370