STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105685	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah House	9945 Central Park Blvd N Boca Raton, FL 33428

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, interview, observation and record review, the facility failed to provide adequate Activities of Daily (ADL) care as evidenced by lack of showers and hair wash care, for 1 of 4 sampled residents, Resident #1. The findings included:Review of the policy titled Menorah House Activities of Daily Living (ADL), provided by the Director of Nursing (DON), documented in the Policy Statement: Purpose---to establish a consistent and effective approach to providing care and support to residents with ADL needs, ensuring dignity, independence, and well-being. Scope: This policy applies to all residents and staff members involved in providing care and assistance with ADLs.Procedures: A. Assessment.B. ADL Assistance: Respect and Dignity:.Individualized Approach:.Assistive Devices:.Documentation:.C. Specific ADL areas: Bathing and Hygiene: Provide a safe and comfortable environment for bathing. Offer choices regarding bathing times and methods. Assist with personal hygiene tasks, such as shaving, brushing teeth, and hair care.Ensure staff are aware of the policy and procedures for providing ADL care. E. Monitoring and Evaluation: Regularly monitor resident outcomes related to ADLs, documenting any changes in abilities or needs. Evaluate effectiveness of the ADL policy and procedures, making necessary adjustments to ensure optimal care. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Gastroesophageal Reflux Disease (GERD), and Epilepsy. The record documented she had a Brief Interview Mental Status (BIM) of 14, indicative of intact cognition.Record review of the Resident #1's Activities of Daily Living (ADL) Care plan initiated 02/20/26 indicated Focus: Resident needs assistance with ADL care related to multiple factors including weakness/decreased mobility status post (s/p) recent hospitalization / illness. Both the resident and staff believe resident is capable of increased independence in at least one ADL prior to returning to the community. Interventions: Encourage and assist with all ADL tasks as indicated, as tolerated by the resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. Observe resident for changes in ADL capabilities. Notify nurse, therapy and/or MD as indicated.Goal: Resident will maintain or improve current level of function through next review date. A telephone interview was conducted on 03/04/26 at 9:47 AM with Resident #1's relative and Emergency contact #1, in which he stated that he just found out ?today' on 03/04/26 that Resident #1 had not been fully washed and showered and her hair had not been washed since her admission to the facility last month on 02/20/26. The relative said that he had spoken with the Administrator about this, and he said that he would address it, but Resident #1 had not had her hair washed in twenty-one (21) days. This bothered both him and the resident, immensely. On 03/04/26 at 1:08 PM an observation was conducted of Resident #1 who was observed sitting up in her wheelchair, eating her lunch and dressed in a purple sweater wearing black pants and socks. The resident's Oxygen was infusing at 3 liters via an Oxygen tank at the table in the Bistro dining area. Resident #1's hair was noted to be hanging down loosely, pulled over to the side and her scalp was somewhat dry and the hair was oily, in appearance. The resident voiced that her scalp was itchy. During an interview conducted with Resident #1 on 03/04/26 at 1:50 PM, she stated she had not been provided with a full body bath/shower and hair wash since residing in this facility (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from her admission on [DATE]. She said that this concerned both her and her relative. Review of the Certified Nursing Assistant (CNA) Task List revealed that there were only three (3) documented, computerized refusals for personal hygiene (which includes combing hair, shaving, applying makeup, washing/drying face and hands, for this resident). This excludes baths, showers and oral hygiene during the resident's 12-day facility stay.Review of the Shower List for the Galilee Short Term Unit revealed that Resident #1's room number had been hand-written in on this list, assigning and designating her to receive a shower on Mondays, Wednesdays and Fridays (three days per week). Further record review of the computerized CNA Task section entitled: Monitor - Weekly Showers/Skin Observation. and the Showering Schedule paper Form, revealed that both were left blank and not completed. A direct observation was conducted on 03/04/26 at 2:45 PM, of Resident #1 being provided a full-body shower and hair wash for the first time in her bedroom's shower, in the shower chair, by two (2) CNA staff members. During an interview conducted on 03/04/26 at 3:08 PM, with the Director of Therapy, she stated that Resident #1 is alert and very oriented and does not refuse care and services with her. She stated the resident is weak, she does tire easily and exhibits some shortness of breath (SOB) related to her medical condition, but there were no complaints of pain, at the time. She stated the resident's ability is getting a little better and she was she making some progress slowly in therapy. The resident also uses a wheelchair and rolling walker, with therapy. The Therapy Director stated Resident #1's physical abilities and limitations as follows: for Physical Therapy (PT), she was able to walk twenty (20) feet, she was minimum to moderate assistance for ambulation, and she required contact guard while ambulating in front of the wheelchair with a walker. Resident#1 was able to transfer from chair to bed with moderate assistance. For Occupational Therapy (OT), Resident #1 was able to complete grooming with standby assistance, she attempted to complete upper body bath but requested breaks due to fatigue and SOB. For upper body dressing, she requires supervision, for lower body dressing she was minimal assistance, for toileting she was moderate assistance and for hygiene and grooming she required supervision; she does participate. An interview was conducted on 03/04/26 at 3:15 PM, with Staff D, Certified Nursing Assistant (CNA), regarding Resident #1 and showering. Staff D acknowledged that Resident #1 had previously verbalized her a desire to have a full-body shower and hair wash. Staff D revealed that she had not previously assisted this resident with a full shower and hair wash, nor was she aware of whether this was done by any other staff members on the day or evening shifts. Staff D stated she had not relayed the resident's concern or inquiry about a shower directly to the nurse.An interview was conducted on 03/04/26 at 3:28 PM, with Staff E, CNA, who indicated that Resident #1 should be getting a shower at least three (3) times per week. She acknowledged that she had not done so, and she was not aware of any other staff member having done this either on the day or evening shifts. Staff E mentioned that Resident #1 had refused once. However, Staff E revealed that she had not returned to try and offer a shower and hair wash again to the resident. She said that she had not documented this anywhere in the record for that time, nor had she notified the nurse of any reasons why it had not been done for this resident. An interview was conducted on 03/04/26 at 3:54 PM with Staff F, Licensed Practical Nurse (LPN), who acknowledged that she was not sure whether or not resident had received a full shower and hair wash, but she had not been made aware of, or told by any of the aides that Resident #1 had been refusing hair washes and showers, at any time. During an interview conducted on 03/04/26 at 4:44 PM, with Staff C LPN, Unit Manager for Galilee unit, regarding Resident #1 not having received a full shower and hair wash, Staff C acknowledged that this information had not been documented anywhere in the nurses' progress notes, or captured in the resident's care plan. Record review revealed Resident #1's room number was hand-written on the facility schedule for showering as three (3) times per week. Prior to the day of this survey, Resident #1 had not been provided with a full shower and hair wash, until after surveyor intervention. There was no documentation in the nurses' progress notes dated 02/20/26 through 03/04/26. There was no notation on the Medication Administration Record's Behavior Monitoring section dated 02/21/26 through 03/04/26 or anywhere (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in Resident #1's original ADL care plan. There were no descriptions of any type of behaviors or refusals for care or showers, from this resident, by the facility staff. The DON acknowledged on 03/04/26 at 4:50 PM that the resident should have received appropriate and adequate ADL care and services, as indicated.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, record review and interview, the facility failed to ensure that it provided Wound Care and Treatment in a sanitary manner, for 2 of 2 sampled residents observed for Wound Care Resident #4 and Resident #1. The findings includedReview of the facility policy titled, Menorah House Wound Management Program, provided by the Director of Nursing (DON) effective January 2025 documented in the Policy Statement: Our mission is to facilitate resident independence, promote resident comfort, and preserve resident dignity. All caregivers are responsible for preventing, caring for, and providing treatment for wounds and skin alterations.Purpose: The purpose our Wound Management Program is:.To provide treatment that promotes the prevention of wounds and skin breakdown and the healing of existing wounds, when desired or possible. To improve resident outcomes and quality of life by providing prevention and treatment or management of skin breakdown and wounds. Process: In order to ensure our residents have access to the appropriate assessment and management to prevent, treat, maintain, or oversee palliative wounds, this facility will have an ongoing organized approach to wound care. This facility will employ the following pertinent aspects of wound care to achieve the mission of this wound Management Program:.Appropriate local wound care including management of bioburden, bacterial colonization, and infection.Preventative measures for pressure injury and other wounds as possible or allowed. Review of the policy titled Menorah House Treatment Procedure (inside room) provided by the DON documented in the Policy Statement: 9. Knock on resident's door. Wait for response. Remind resident that you are there to do a dressing change.10. Clean field should be arranged per facility protocol. 1) Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included Diffuse Traumatic Brain Injury, Diabetes Mellitus Type II, Dementia, Seizures, Hypertension and Atherosclerotic Heart Disease. He had a Brief Interview Mental Status (BIM), indicative of severe impairment. On 02/27/26, the Physician's Order documented, Clean sacral wound with normal saline pat dry, apply collagen and calcium alginate with dry dressing daily and every day shift for sacral wound. Record review of the Resident #4's Pressure Ulcer Care plan initiated 11/05/25 and revised 11/17/25 indicated Focus: Resident #4 has a pressure ulcer to Sacrum . Interventions:.Complete weekly skin checks.Document status of wound and healing progress. Monitor for signs/symptoms (s/s) of infection. Report changes to Medical Doctor (MD) as indicated. Encourage and assist resident to participate with toileting and hygiene as tolerated.Goal: Resident #4's pressure ulcer will show signs of healing as evidenced by decrease in size, improved appearance, and be free from infection by/through review date. On 03/04/26 at 11:34 AM, a Sacral Wound Care Dressing Change observation was conducted for Resident #4 performed by Staff A, Licensed Practical Nurse (LPN), and assisted by Staff B, Certified Nursing Assistant (CNA). Resident #4 was observed lying in bed, at the time. Staff A and Staff B were observed retrieving wound care supplies, as well as other personal protective equipment (PPE) from a caddy located just outside of the resident's room, prior to performing this procedure. Staff A checked the physician's order and verified the resident's identity. Resident #4 expressed permission for this Surveyor to observe the wound care. Staff A prepared her supplies and placed them on the covered bedside table, after washing her hands for 30-45 seconds. Staff A donned a pair of clean gloves. As she proceeded to remove the old dressing from the resident's sacrum, she was not observed placing a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean barrier down between the resident's uncovered sacral skin wound and his diapered bottom. Then, Staff A left Resident #4's bedside to wash her hands in the bathroom, leaving Resident #4's bare, exposed and unprotected wound, to rest directly atop the contaminated diaper and contaminated Hoyer lift net padding, positioned below the resident, until she returned to continue the wound care dressing change. During the cleaning and treatment process of the resident's wound care, Staff A was observed, on multiple occasions, as allowing Resident #4's bare, uncovered sacral wound to touch and come into contact with his contaminated diaper, as well as, with the contaminated Hoyer lift net padding, below the then cleaned Sacral wound care area, throughout the Wound Care Observation; with no clean barrier in place, at any time. 2) Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Gastroesophageal Reflux Disease (GERD), and Epilepsy. She had a Brief Interview Mental Status (BIM) 14, indicative of intact cognition. On 02/24/26 the Physician's Order documented, Cleanse Mid- back with normal saline. pat and dry apply Medi-honey to the wound base and cover with dry dressing daily. Record review of the Resident #1's Pressure Ulcer Care plan initiated 02/20/26 indicated, Focus: Resident #4 has a pressure ulcer to Right Back.Interventions:.Complete weekly skin checks.Document status of wound and healing progress. Monitor for signs/symptoms (s/s) of infection. Report changes to Medical Doctor (MD) as indicated. Encourage and assist resident to participate with toileting and hygiene as tolerated.Goal: Resident #1's pressure ulcer will show signs of healing as evidenced by decrease in size, improved appearance, and be free from infection by/through review date. A Mid-upper Back Wound Care Dresing observation conducted on 03/04/26 at 2:37 PM, for Resident #1with Staff A, assisted by Staff B. Staff A and Staff B were observed performing a dressing change, without placing a clean barrier between the resident's bare, uncovered back wound area and the contaminated bedding below. Throughout the entire procedure, she was allowing the resident's bare, uncovered back area wound to come into contact with the contaminated bedding as she proceeded to clean and treat the resident's unprotected wound directly atop the contaminated bedding, An interview was conducted with Staff A on 03/04/26 at 3:44 PM, regarding her changing of the resident's wound care dressings atop contaminated surfaces without first placing a clean barrier field down. She acknowledged that she had not done so, but she was unable to provide any plausible explanation for not having done this. An interview was conducted on 03/04/26 at 4:10 PM with Staff C, LPN Unit Manager for Galilee unit, regarding the Wound Care Nurse having changed the resident's wound care dressings atop contaminated surfaces, without first placing a clean barrier field down. She acknowledged that this should have been done. The DON acknowledged on 03/04/26 at 4:24 PM that the dressing changes for both residents should have been performed, in a safe and sanitary manner. Based on review of policy and procedure, observation, record review and interview, the facility failed to ensure that it provided Wound Care and Treatment in a sanitary manner, for 2 of 2 sampled residents observed for Wound Care Resident #4 and Resident #1. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings included