

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Menorah House		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on observations, interviews, and record review, the facility failed to provide the correct consistency for the pureed diet to 2 of 15 sampled residents to receive pureed consistency foods (Residents #113 and #85). The findings included: A review of the International Dysphagia Diet Standardization Initiative (IDDSI) revealed the following: pureed food texture does not require chewing, smooth with no lumps, is not sticky, and holds its shape on a spoon. It further showed that the food should not be sticky because it can stick to the cheeks, teeth, the roof of the mouth, or the throat. 1). A chart review revealed Resident #113 was readmitted to the facility on [DATE] with diagnoses of Dysphagia and Cognitive Communication Deficit. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #113 had severe cognitive impairment. A review of the Physicians' orders revealed an order for a Low Concentrated Sweets (LCS) diet, Pureed texture, and thin liquids, dated 05/18/26. During an observation conducted on 07/07/26 at 12:03 PM in the Bistro dining room, Resident #113 was eating her lunch. The meal ticket listed pureed hamburger, pureed hot vegetables, and pureed bread. Closer observation of the lunch meal showed that the pureed bread had a cheese-like cottage consistency, and the pureed hamburger was lumpy, uneven, and sticky. 2). A chart review revealed Resident #85 was readmitted to the facility on [DATE] with diagnoses of Parkinson's and Dysphagia. The Quarterly MDS assessment dated [DATE] showed Resident #85 had a Brief Interview of Mental Status (BIMS) score of 11, indicating a moderate cognitive impairment. An order dated 07/24/25 indicated a need for a no-added-salt diet with a pureed texture and nectar consistency. During an observation conducted on 07/07/26 at 12:06 PM in the Bistro dining room, Resident #85 was eating her lunch. The meal ticket listed pureed hamburger, pureed hot vegetables, and pureed bread. Closer observation of the lunch meal showed that the pureed bread had a cheese-like cottage consistency, and the pureed hamburger was lumpy, uneven, and sticky. During an observation conducted on 07/08/26 at 12:04 in the Bistro dining room, Resident #85 was eating her lunch. The meal ticket listed pureed beef Burgundy, pureed rice, pureed green beans, and pureed roll. Closer observation of the lunch meal showed that the Pureed roll had a cottage cheese-like consistency, with lumps. In an interview conducted on 07/10/26 at 10:38 AM with the facility's Speech Language Pathologist, she stated that for the pureed diet consistency, the food needs to be of a smooth consistency, no lumps, clumps, or pieces, and completely blended.		

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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and chart review, the facility failed to provide the appropriate liquid consistency for 1 of 7 sampled residents, who required nectar-thick liquid (Resident #120). The findings included:Record review revealed Resident #120 was admitted to the facility on [DATE] with diagnoses of Parkinson's and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that Resident #120 had a Brief Interview of Mental Status (BIMS) score of 10, indicating low-to-moderate cognitive impairment. A review of the physician's order showed a no-added-salt diet with regular texture and nectar-thick liquid consistency, dated 02/04/25. In an observation conducted on 07/08/26 at 8:38 AM, Resident #120 was in the room with his breakfast tray. His meal ticket was noted as follows: no added salt; regular diet with nectar-thick liquids. Closer observation revealed a 16-ounce Styrofoam cup of water, a thin liquid that was not thickened at the bedside. In an observation conducted on 07/08/26 at 9:59 AM, Resident #120 was noted in bed with a 16-ounce Styrofoam cup of water, a thin liquid that was not thickened at the bedside, and a straw inside the cup.In an interview conducted on 07/08/26 at 10:05 AM, Resident #120 asked the Surveyor if they could hand him the cup of water at the bedside. In an interview conducted on 07/08/26 at 10:00 AM with the unit manager, Staff A, a Registered Nurse, stated that the Certified Nursing Assistants provide water cups at the bedside every shift. They also have a binder in the dining room (Bistro) listing all residents on fluid restrictions and diets. They also have access to electrical records and are encouraged to review the residents' diets before providing the water. In an interview conducted on 07/08/26 at 10:12 AM with Staff B, a Certified Nursing Assistant (CNA), she oversees the provision of water to her assigned residents. She checks whether the residents are on thickened liquids before providing water. She checks the computer and the binder located in the Bistro dining room. When asked if Resident #120 was on thickened liquids, she said yes. When she asked if she had given him water this morning, she said no.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional food service safety standards on 2 of 3 visits to the main kitchen. The findings included: In a visit to the main kitchen conducted on 07/07/26 at 8:45 AM, the following concerns were noted: Staff D, Dietary Staff, was observed in the main production food area without a facial mustache covering. Staff E, Dietary Staff, was noted in the main food production area with only half her hair covered. Two large packets of ground beef were noted in the walk-in refrigerator, placed there on 07/03/26. A large garbage can was observed in the food production area without a lid. 7 white dinner plates were noted with deteriorated/scratched coding on the side where the food stands. The walk-in freezer was full of debris on the floor, and the main door had ice buildup at the bottom. The dishwasher curtains were noted with debris and dry food particles. During this observation, the dishwasher was started, and the final rinse reached 150 degrees Fahrenheit instead of the required 180 degrees Fahrenheit. One of the kitchen vents was noted to have a discolored, rust-like appearance, debris, and condensation. In a second visit to the main kitchen on 07/09/26 at 11:45 AM, a Hydriion strip was used to test the sanitation solution of a red bucket. The strip showed 100 (range: 100 to 400), indicating an insufficient sanitizing solution in the red bucket. A 3rd visit to the main kitchen on 07/10/26 at 11:40 AM during the lunch tray line showed the following: A facility thermometer was used to take the temperature of 2 cold fruit salads. It showed an internal temperature of 55.9 and 55.4 degrees Fahrenheit, not the recommended 40 degrees Fahrenheit or below. A serving of pureed fruit salad had an internal temperature of 53.5 F, not the recommended 40 F or below. In an interview conducted on 07/12/26 at 12:30 PM with the facility's Administrator he was informed of the findings.		