STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105837	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd Boynton Beach, FL 33436

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that the facility failed to provide 1 (Resident #127) of 1 sampled residents with the right to choose schedules and make choices that include sleeping and waking times. The findings included: On 10/07/24 at 1 PM, an interview was conducted with Resident #127, in the Main Dining Room (MD) concerning issues at the facility. The alert and oriented resident stated that she would like to be able to attend the breakfast meal in the MDR (8:30 AM) but staff will not get her up, provide morning care and dressed until 10 AM after numerous requests. The resident also stated that she is late for Skilled Therapy sessions daily, which are scheduled at 10 AM. She has repeatedly requested from nursing to be ready for the therapy session but this also has not been resolved. Following the interview the surveyor stated to the resident to request from nursing staff to be up and prepared for the breakfast meal in the MDR on 10/08/24. On 10/08/24 at 8:30 AM the surveyor observed the resident in her room who was awake and in bed. Staff had failed again to honor her request to attend the breakfast meal in the MDR and would be again late for her schedule therapy 10 AM appointment. On 10/08/24 at 2 PM the surveyor met with the Director of Nursing and reviewed the resident's issues. The DON stated that the issues would be resolved. A subsequent observation conducted on 10/11/24 at 8 AM noted the resident to be up and dressed and in the wheelchair going to the MDR. The resident stated that she has been ready for the past 2 days at 7:30 AM and has attended the breakfast meal and therapy sessions on time. The resident voiced how happy she was and increased the quality of her life. During the review of the clinical record of Resident #127, it was noted an admitted [DATE] with diagnoses that included Dysphagia, Failure to Thrive, and Lower Leg Wound. Further review of clinical record noted an MDS date 08/02/24 that indicated a BIMS score of 9 (non-cognitive impairment), no mood issues, and independent with eating.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, safe, clean, and comfortable interior for 2 of 3 resident units (200 and 300), 1 of 1 physical therapy room, and 1 of 1 main dining room. The findings included: During the initial resident tours conducted by the surveyors on 10/07/24 - 10/08/24, and the Environment Tour conducted with the Director of Maintenance on 10/11/24, the following were noted: 200 Unit: room [ROOM NUMBER]: Large areas of peeling room wallpaper, and numerous small black holes to room floor. room [ROOM NUMBER]: Exterior of wood bed frame in disrepair (A-bed). room [ROOM NUMBER]: Room floor had large cracks in the linoleum, exterior pf wood bed frame in disrepair (A-bed), Room floor stained and in disrepair, exterior of over-bed tables (X 2) stained and rust laden, room walls in disrepair, and exteriors of room dressers (x 2) worn, broken, and in disrepair. room [ROOM NUMBER]: Privacy curtain soiled and stained (A-bed), and room floor numerous small black holes in linoleum. room [ROOM NUMBER]: large area of room floor was peeling up, exterior of bathroom shower handrails (X 2) were stained and rust laden, and exterior of over-bed table was stained and rust laden (B-bed) . room [ROOM NUMBER]: Bathroom floor soiled and heavily stained, and room floor soiled and stained. room [ROOM NUMBER]: Bathroom floor soiled and heavily stained, and exterior of over-bed table stained and rust laden (A-bed). room [ROOM NUMBER]: Bathroom floor soiled and heavily stained, and room waste basket cracked and broken. room [ROOM NUMBER]: Bathroom floor soiled and heavily stained, and exterior of over-bed table stained and rust laden (A-bed). Hallway/Corridor: Large carpet stains outside entrance to room [ROOM NUMBER]. 300 Unit: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: Room windows soiled and build-up of green algae. Hallway/Corridor: Heavy urine odor outside of room [ROOM NUMBER]. Community Shower #1: Privacy curtain of toilet area does not promote resident privacy when in use, and 1 of 3 light fixtures not working. Community Shower #2: Two of 3 light fixtures not working. Nourishment Room: Door gasket had large tear and requires replacement. Nurses Station: Exterior of wall vent and surrounding wall area covered with black mold type matter. Skilled Therapy Department: Parallel Bars: The wood floor area of 2 of 2 parallel bars noted to be heavily worn, stained and non-slips strips require replacement. Parallel Bars: The hand and arm stabilization bars of 2 of 2 parallel bars were broken, loose held together with zip ties and in need of immediate replacement. Practice Stair Case: The exterior of the stairs (6) were soiled, stained and the non-skid foot strips require replacement . Storage Room: Four ceiling tiles appeared to have water/leak damage and in need of repair and replacement. Bathroom: Two ceiling tiles appeared to have water/leak damage and in need of repair and replacement Main Dining Room: Windows: Twelve of twelve windows were noted to be soiled and heavy build-up of green-algae matter. Following the tours the findings were again reviewed and confirmed with the Administrator and Director of Maintenance.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to provide activities on an ongoing basis for 2 of 5 residents reviewed for activities (Resident #62 and #81). The findings included: A review of the facility's policy Activity Program, revised 08/2023, documented: Each center provides an ongoing program of activities designed to meet (in accordance with the comprehensive assessment) the interests and physical, mental, and psychosocial well-being of each resident. Document the resident's participation in activities or refusal to participate in activities in the progress notes as need. 1. Resident #62 was admitted to the facility on [DATE] with diagnoses included Dementia and Stroke. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and was dependent for activities of daily living. Resident #62 was care planned for person-centered care, with an intervention enjoys participating in their favorite activities. A record review for Resident #62 revealed an Activities Evaluation dated 07/26/24 that documented the resident was able to make needs known, and was staff dependent for participation in activities. The evaluation further documented the resident had interests in sports, music, outdoor activities, conversation/talking, movies/TV, and interested in participation in special event parties/happy hour and ice cream/food socials. The resident needed assistance getting to and from activities via wheelchair. A review of Resident #62's progress notes revealed an activity note dated 06/10/24 at 15:14 that documented: Resident was unavailable for activity programs in bed sleeping today. Further review of Resident #62's records did not reveal any other documentation of the resident's participation or refusal of activities. Resident #62 was observed in his room sleeping in bed in a hospital gown on 10/07/24 at 11:30 AM. The TV was observed off. Resident #62 was observed in his room in bed sleeping in bed in a hospital gown on 10/08/24 at 10:30 AM, and again at 2:00 PM. The TV was off. Resident #62 was observed in his room awake and alert, dressed, sitting up in a recliner chair on 10/11/24 at 11:00 AM. The TV was off. Resident #62 was observed in his room awake and alert, dressed, sitting up in a recliner chair on 10/14/24 at 11:00 AM. The TV was off. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Activities Director on 10/14/24 at 12:00 PM. The Activities Director stated a resident's participation in activities was charted in the resident's progress notes. The Activities Director acknowledged the last time Resident #62 participated in activities according to the resident's progress notes was on 06/10/24. 2. Resident #81 was admitted to the facility on [DATE] with diagnoses included Stroke. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and was dependent for activities of daily living. Resident #81 was care planned for person-centered care with an intervention enjoys participating in their favorite activities. A record review revealed an Activities Evaluation dated 07/24/24 that documented the resident was able to make needs known, and was staff dependent for participation in activities. The evaluation further documented the resident had interests in sports, music, outdoor activities, conversation/talking, and movies/TV. The resident needed assistance getting to and from activities via wheelchair or walker. A review of Resident #81's progress notes revealed an activity progress note dated 07/25/24 at 5:13 PM that documented: Quarterly review: [Resident #81] is mostly in bed resting or sleep in bed, haven't been up to activity programs. Activity staff will continue to encourage resident to attend programs. Further review of Resident #81's records did not reveal any other documentation of the resident's participation or refusal of activities. Resident #81 was observed in her room sleeping in bed in a hospital gown on 10/07/24 at 11:30 AM. The TV was observed off. Resident #81 was observed in her room in bed sleeping in bed in a hospital gown on 10/08/24 at 10:30 AM, and again at 2:00 PM. The TV was off. Resident #81 was observed in her room awake and alert, in bed on 10/11/24 at 11:00 AM. The TV was off. Resident #81 was observed in his room awake and alert, in bed on 10/14/24 at 11:00 AM. The TV was off. An interview was conducted with the Activities Director on 10/14/24 at 12:00 PM. The Activities Director stated a resident's participation in activities was charted in the resident's progress notes. The Activities Director acknowledged the last time Resident #81 had documentation for activities participation was on 07/25/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36734 Based on record review and interview, the facility failed to address high blood glucose levels for 1 of 1 sampled resident (Resident #195). The findings included: Resident #195 was admitted to the facility for respite care on 09/20/24- 09/23/24. A review of Resident #195's orders revealed an order dated 09/20/24 for sliding scale insulin Novolog before meals and at bedtime. The resident was to receive 2 units of insulin for blood glucose level of 251-400. A review of Resident #195's blood glucose levels revealed a level of 438 on 09/22/24 at 6:51 AM. Further record review did not reveal any documentation of physician notification of a blood glucose level outside of the parameter of greater than 400. An interview was conducted with the Director of Nursing (DON) on 10/14/24 at 12:00 PM. The DON stated for a sliding scale insulin order, it will usually document to call physician if the blood glucose level is greater than 400. The DON further stated even if there was no order to call for a blood glucose level greater than 400, the nurse should have called as that was the standard of practice.

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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** 50370 Based on observations, interviews and record reviews, the facility failed to adequately supervise a resident on enteral feeding who was self-administering fluids, for 1 of 2 residents reviewed with gastrostomy tube feeding (Resident #116). The findings included: Resident #116 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory failure with Hypoxia (low oxygen concentration in the blood), Dysphagia (Swallowing difficulty), and Cognitive communication deficit. Review of annual MDS (Minimum Data Set) Section C, dated 08/14/24 revealed a score of 06 indicating, impaired cognitive function. MDS Section K under Nutritional Approaches revealed yes to a feeding tube (PEG {percutaneous endoscopic gastrostomy-an abdominal opening through a tube that goes straight into the stomach}). Further review of Nursing Care Plan created on 08/23/24, with a target date of 11/18/24, revealed the following foci: decreased nutritional status, and dehydration related to Acute respiratory failure, and head and neck cancer. The documented goals for Resident # 116 were: to tolerate tube feeding flushes as ordered, to be free from signs and symptoms of dehydration, and to be free from significant weight changes. The interventions included: assistance with meals as needed, diet as ordered, observe diet tolerance, and observe for dehydration. Record review of Dietary Progress Notes dated 09/11/24 related to enteral feeding review, revealed resident is NPO (nothing to be given by mouth), that tube feeding provides 2280 kcal (Kilocalorie), 97 g (Grams) of proteins, 2695 ml (Milliliter) of fluids plus an additional 240 ml of fluid flushes every 4 hours. It documented a weight of 146.8 pounds, and a BMI (Basal Metabolic Index) of 23, indicating normal. Additional notes revealed that Resident #116 was found taking food from meal carts and hiding milk in nightstand drawer, has failed swallow studies and had PEG tube prior to facility admission. Additional documentation revealed that Resident #116 remains ambulatory and walks around the facility several times a day. A review of orders dated 09/26/24 revealed an NPO diet. On 09/27/24, an order for enteral feed related to Dysphagia was documented as Jevity 90 ml/hr (Milliliter per hour) for 16 hours, on at 6:00 PM, off at 10 AM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional record review of Dietary Progress notes dated 10/11/24 related to enteral feeding, revealed that Resident is NPO, that tube feeding provides 2755 kcal, 118 g of protein, 2714 ml of fluids, plus 240 ml flushes every 4 hours, which indicated greater than 100 percent of estimated nutritional needs. A Jevity feeding at 100 ml/hour for 16 hours, with one can bolus during the day was documented. It further revealed that Resident #116 was status post hospitalization , with some weight loss, and an increased needs related to being mobile, with history of refusing gastrostomy tube feeding, and diuretic treatment. Additional documentation revealed a recorded weight of 128 pounds and a BMI of 20, indicating underweight. In an observation on 10/14/24 10:39 AM, Resident # 116 was observed lying in bed, with head slightly elevated on a pillow. He had a red carton of 8 ounces whole milk between his thighs. He was attaching a [NAME] syringe on an open portal of the gastrostomy tube located on his abdomen and started emptying the contents of the 8 ounces whole milk carton on the [NAME] syringe, pouring down to the gastrostomy tube opening. This surveyor searched for staff for assistance. Two Staff, Staff B, a CNA (Certified Nursing Assistant), and the DON (Director of Nursing), were approaching were asked to go inside Resident #116's room. The DON put on gloves and told the resident that he is not allowed to feed himself through the gastrostomy tube. She disconnected the [NAME] syringe from the gastrostomy tube port then closed it with a cap. She then bagged the milk and took it outside Resident #116's room. In an interview with the DON on 10/14/24 at 10:52 AM, she stated that Resident #116 is not allowed to perform enteral feeding by himself. In an interview with Resident #116 on 10/14/24 at 10:55 AM, he stated he was hungry, and staff do not provide enough food for him, so he decided to feed himself. Resident #116 was observed tapping his abdomen while he was talking to this Surveyor. During an interview with Staff H, a CNA, on 10/14/24 11:10 AM, she stated that Resident #116 goes to the dining room every morning. She added that she does not see him eating, but she sees him going there.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to monitor residents' weights for 2 of 9 residents reviewed for Nutrition, Residents #32 and 89. The findings included: The facility's policy, 'Weight Measurements' revised 08/2023, documented: Frequency of measurements and calculations Residents are weighed weekly, monthly or according to physician orders. Residents should be weighed at the same time of day, in similar clothing and using the same scale. Any significant or progressive weight loss or gain is noted and reported to the resident's attending physician, family, or responsible party, and documented in the medical record. Note: All new admits are weighed weekly for 30 days. 1). Resident #89 was admitted to the facility on [DATE]. According to the resident's admission Minimum Data Set (MDS) assessment, dated 08/20/24, Resident #89 had a Brief Interview for Mental Status (BIMS) score of 10, indicating that the resident was 'moderately' cognitively impaired. Resident #89's diagnoses at the time of the assessment included: Hypertension, Renal insufficiency, Diabetes Mellitus, Hyponatremia, Muscle weakness, Lack of coordination, Cognitive communication deficit. Resident #89's orders included: Regular diet, Regular texture, Thin Liquids consistency - 08/29/24 Med Pass 2.0/Ready Care 2.0 two times a day for nutrition support give 120 ml by mouth twice a day - 09/25/24. Resident #89's Care plan for nutrition, initiated on 08/30/24, documented, Resident is at risk for decreased nutritional status & dehydration related to Type 2 DM, Hypertension, meds that may cause Gi upset/edema, liberalized diet to promote po (oral) intakes, need for nutrition supplements, decreased po intakes. Interventions to the care plan included: * Weights as ordered Date Initiated: 08/30/2024 Review of Resident #89's health records showed that there were no orders for weights to be taken. During an interview, on 10/08/24 09:31 AM, with Resident #89, when asked about any concerns with weight loss or weight gain, Resident #89 replied, I have lost weight since I have been here. The food is prepared food - not like mama cooked. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #89's weight upon admission was documented as 120 pounds. There were no other weights documented in the resident's electronic health record since the admission weight. During an interview, on 10/11/24 at approximately 8:30 AM, with Staff B, Restorative CNA, when asked about taking residents' weights, Staff B stated that the Restorative CNAs received a list of residents to be weighed based on orders and requests/recommendations from the Diet Tech. After obtaining the weights they are to provide the hand written documentation to the Diet Tech. The Diet Tech then puts the information in the resident's electronic health record. During an interview, on 10/11/24 at 9:40 AM, Staff A, Restorative CNA, Staff A provided this Surveyor with hand-written documentation of residents' weights. Staff A documented Resident #89's weight as 89 pounds for the month of September 2024. When asked, Staff A could not recall the exact date that the weight was taken. Staff A provided this Surveyor with hand-written documentation of weights from 10/10/24. The document showed that Resident #89 weighed 113 pounds. During an interview, on 10/11/24 at 10:03 AM with the Diet Tech, when asked about the facility's policy for obtaining residents' weights, the Diet Tech replied, A lot of times, I put them in the computer. I have not seen the weight for September, but before I put them in the computer, I have to go and make sure. I have not seen it. The Diet Tech further stated that residents are to be weighed on admission and then weekly for the next 4 weeks and monthly thereafter unless otherwise determined, when there is a weight loss, weekly or as indicated. 50370 2). Resident # 32 was admitted on [DATE] with diagnoses including Atrial fibrillation, Cognitive communication deficit, Hypothyroidism, Glaucoma, Dementia, and Anemia. Review of MDS (Minimum Data Set) Section C, dated 09/03/24, revealed a BIMS (Brief Interview of Mental Status) score of 05, indicating impaired cognitive function. Section E 0800, pertaining to rejection of care, revealed a response of zero, indicating the behavior was not exhibited by Resident #32. Further record review of Nursing Progress Notes between 08/01/24 and 10/10/24, revealed Staff E, a Licensed Practical Nurse (LPN) documented as follows: Resident has history of COPD (Chronic Obstructive Pulmonary Disease), and experiences occasional SOB (shortness of breath) with exertion. There were no documentations that Resident #32 refused to be weighed on all the above dates. There were no documentation of Resident #32's Physician was made aware of resident's refusal to be weighed on the above dates. A further review of Nursing Progress Notes dated 09/04/24, revealed a documentation by a Staff I, an RN (Registered Nurse), noting Resident #32 has been very pleasant and weight is stable. IDT (Interdisciplinary team reviewed the POC (Plan of Care) and it was updated. There was no recorded weight on this progress note. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional Nursing Progress Notes dated 09/12/24, documented by Staff K, LPN, revealed head to toe visual evaluation for skin check completed. Left lower leg wound care done by wound care Nurse and wound care Doctor. There was no documentation of Resident # 32's refusal to be weighed. A record review of Nursing Progress Notes documented by Staff J, a LPN, dated 09/24/24 revealed Resident is stable, no complaint voiced, appetite is good. There was no documentation of Resident #32's refusal to be weighed. Further review of Nursing Progress Notes written by Staff J, LPN, dated 09/26/24 revealed no mood indicators and behaviors displayed by resident. It added that resident #32 has intermittent confusion. Additional notes were Nursing services provided, turned and repositioned, positioning devices applied. There was no documentation of Resident 32's refusal to be weighed. Record review of Nursing care plan dated 09/04/24, revealed the following foci: Resident is at risk for decreased nutritional status, and dehydration, related to past medical history of Sepsis, Dementia, UTI (Urinary Tract Infection), Advanced age and limited mobility. The goals documented are as follows: Resident will be free from significant weight changes through the review date; Resident will consume adequate foods and fluids to meet estimated nutritional needs through the next review date. The following interventions were documented as follows: Assist with meals as needed, monitor diet tolerance, provide food preferences and substitutions, monitor po (per orem or by mouth) intake, and weights as ordered. Further record review of quarterly Nutrition Note, dated 09/18/24, revealed Resident #32 refused weight for August and September. There were no documentation that Resident #32's Physician was informed of Resident's refusal to be weighed, and the interventions performed by Staff. A review of Progress Notes dated 10/08/24, revealed a Nutrition follow up documenting that Resident #32 refuses to be weighed for 3 months. It added weight loss was suspected based on appearance and intervention. During the Recertification survey on 10/08/24, Staff D, a Dietary Technician, added an order of Ready care 2.0, 120 ml (Milliliters) to be offered BID (twice a day). Staff D, Dietary Technician met with the Resident on the same day to discuss Resident #32's dietary preferences and questioned the resident about complaints of Gastro-intestinal upset. A review of Facility policy titled Weight Measurements revised on 08/23, revealed that the purpose of body weight is a value used to monitor the nutritional status of the resident. Additional notes related to frequency and calculations revealed that residents are weighed weekly, monthly, or according to physician orders. Any significant weight loss or gain is noted and reported to the attending physician, family, or responsible party, and documented in the medical record. Page 1 of the document revealed the types of scales and the indications for each usage. Bed scale is appropriate for a non- ambulatory or acutely ill resident who is bed-bound. Page 2 and 3 of the same document revealed various procedures of measuring weight using a standing scale, bed scale, chair scale, and specialty bathing system. During an observation on 10/07/24 at 12:30 PM, Resident #32 did not touch the main entree on her meal tray. She had some drinks from the meal tray. She stated food is not great all the time. She wanted something that she can easily digest. She is not sure if she had been seen by a Dietician. Resident looks thin with long fingers. When asked if she is losing weight, she stated she does not know. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd Boynton Beach, FL 33436

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff D, Dietary Technician, on 10/11/24 at 10:06 AM, she stated that Residents are weighed weekly, monthly and or according to physician's orders. When asked how she evaluated Residents nutritional status if they refused to be weighed, she stated that she monitored the daily intake tasks documented by the staff CNAs. When asked if she had visually assessed Resident #32 recently, and if she agreed that this resident weighed 141 pounds, she did not respond. In an observation on 10/11/24 at 2:00 PM, Staff A, CNA, stated that Resident #32 refused to be weighed three times today. During an interview with a Staff E, LPN, on 10/14/24 at 10:50 AM, she stated Resident #32 finally agreed to be weighed on Saturday, 10/12/24. When this Surveyor asked for the weight obtained, Staff E stated she cannot remember. When asked if the result was documented in PCC (Point Click Care), she stated she does not know. When this Surveyor checked PCC on 10/14/24 at 2:30 PM, the last documented weight of 141 pounds was on 07/24/24. During an interview with the Facility's Administrator on 10/14/24 at 2:30 PM, the above information was shared.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that 1 (Resident #6) of 1 sampled residents for dialysis review failed to receive services that include meals and snacks and professional standards of practice to ensure dialysis communication reports are properly completed for each dialysis session. The findings included: 1) During an interview and observation of Resident #6 on 10/11/25 at 8 AM noted resident awake and in bed. Alert and oriented and stated to be leaving for dialysis at approximately 9:30 AM and will return approximately 3 PM. She sated that she is given a bagged lunch to take to dialysis center on each appointment however the dialysis center will not let her eat or drink during dialysis. She stated this has been going on for many months and has complained to dialysis staff previously without resolution. She does get hungry and thirsty during dialysis sessions but is denied food and fluids. Resident stated that she leaves the facility 3 times per week at 9:30 AM and returns from dialysis at approximately 3 PM. On 10/11/24 the surveyor discussed the issues with Resident #6 with the facility's Dietetic Technician who stated she was not aware of the issues but stated she was aware the bagged lunch and snacks given to the resident to take to dialysis sessions come back with the resident to the facility untouched and uneaten. The surveyor requested the technician to contact the resident's dialysis facility and request the policy for consuming food and beverages during dialysis. On 10/11/24 the technician submitted the facility's policy fro Eating and Drinking Hot Liquids on Dialysis which documented all forms of eating or drinking are discouraged for potential burns, increased chance of choking, and increased chance of spreading communicable disease due to cross contamination. The policy further documented that patients may snack and/or drink in the waiting room before or after their treatment. Further interview with the facility's Technician noted the dialysis staff stated they are not asking patients (including Resident #6) if they are thirsty or hungry and bring them to the waiting room to eat and drink. The facility's technician stated to dialysis staff that Resident #6 requests to consume food and fluids on dialysis days before and after treatment. 2) During the review of the clinical record of Resident #6, it was noted an admitted [DATE] with diagnoses of End Stage Renal Disease and Diabetes Type 2. Current physician orders dated 12/27/23 documented dialysis every Monday, Wednesday, Friday, with a dialysis chair time of 10 AM on each scheduled day. Further review of the clinical record by the surveyor noted the review of the Communication Forms that are required to be completed by the facility prior to leaving for dialysis and completed by the dialysis facility following the dialysis session. A review of the form noted that the dialysis center was not completing the communication form on a regular basis which included required documentation of the following: Pre-Dialysis Weight (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post Dialysis Weight Estimated Dry Weight Pre-Dialysis Blood Pressure Post Dialysis Blood Pressure * Given Food/Fluids Condition on Discharge Back to Facility Follow-up Change to Care Type of Dialysis Access Port Condition of Port Medications Given Lab Values * Meal Sent Signature of Staff Completing Form Further review of Resident #6 Dialysis Communication forms from 07/31/24 through 10/07/24 noted that the dialysis facility failure to complete the documents on the following dialysis dates: 10/04/24 - Not completed by dialysis facility 09/30/24 - Not completed by the dialysis facility. 09/27/24 - Not completed by the dialysis facility. 09/18/24 - Not completed by the dialysis facility. 09/06/24 - Not completed by the dialysis facility. 08/28/24 - Not completed by the dialysis facility. 08/19/24 - Not completed by the dialysis facility. 08/16/24 - Not completed by the dialysis facility. 08/14/24 -Not completed by the dialysis facility. 08/02/24 - Not completed by the dialysis facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/31/24 - Not completed by the dialysis facility. On 10/11/24 the surveyor reviewed the issue of failure to document on the dialysis communication form who confirmed the surveyor's findings and discussed the issues with the facility's Director of Nursing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36734 Based on observation, record review, and interview, the facility failed to ensure a medication error rate is not 5% or greater, as evidence by 2 errors out of 26 opportunities for a medication error rate of 7.69%, which affected 1 of 4 sampled residents (Resident #74) The findings included: An observation of a medication administration was conducted on 10/08/24 at 9:00 AM on Resident #74 with Staff K, a Licensed Practical Nurse. Staff K administered one Zyprexa (antipsychotic) 7.5 milligrams (mg) tablet and two Tylenol 325 mg for a total of 650 mg, along with other ordered medications. A review of Resident #74's orders revealed an order dated 06/23/23 for Tylenol 650 mg give 2 tablets three time a day. Further review of the resident's orders revealed an order dated 10/02/24 for Zyprexa 5 mg for gradual dose reduction (GDR). An interview was conducted with Staff K on 10/08/24 at 10:30 AM. Staff K acknowledged the Zypexa order was changed to 5 mg on 10/02/24. Staff K produced a packet of Zyprexa 5 mg dated 10/02/24. The packet had not been used. Staff K stated the old packet of Zyprexa 7.5 mg should have been returned to pharmacy. Staff K further acknowledged she administered two Tylenol 325 mg tablets (650 mg) instead of two Tylenol 650 mg tablets (1300 mg). An interview was conducted with the Director of Nursing (DON) on 10/11/24 at 10:00 AM. The DON acknowledged the above.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that the facility failed to provide special eating equipment and utensils for 6 (Resident #40, #57, #67, #68, #118, and #134) of 9 residents sampled for nutritional review. The findings included: 1) Observation of the lunch meal conducted on 10/07/24 at 12:15 PM noted the meal tray card of Resident #40 to document 2-Handled Cups, Scoop Plate, and Weighted Utensils with meals. Further observation of the lunch meal noted the resident did not receive beverages in 2-handle cups and was served water in a glass cup and coffee in a ceramic regular coffee mug. Interview with the alert resident at the time of the observation noted to state he often does not receive the 2-handled cups and further stated that beverages are easier to drink from the 2-handle cups. Therapy staff indicated to the surveyor during the meal that the resident did not receive the appropriate cups with the meal and that the resident has been assessed to receive the adaptive eating and drinking equipment. Observation of the breakfast meal in the Main Dining Room on 10/08/24 at 8:45 AM, it was again noted that the resident was served milk and coffee in regular cups. Review of the clinical record of Resident #40 noted an re-admitted [DATE] with current diagnoses of Hemiplegia, Hemiparesis, Diabetes Type 2, and Dysphagia. Current physician orders included Patient to receive Scoop Dish, Weighted Utensils, and and 2-Handled Cup with Lid to facilitate increased independence with self feeding and reduce spillage (07/09/24). Review of Occupational Therapy Treatment of service from 06/27/24 - 07/10/24 documented patient with weight loss but can feed self with use of weighted utensils, scoop dish, and 2-handled cups. Review of current care plans dated 10/08/24 documented the problem of Nutritional Risk that included the intervention of Adaptive equipment as ordered: scoop dish, weighted utensils, and 2-handled cup with meals. 2) Observation of the lunch meal in the Main Dining Room on 10/07/24 at 12:15 PM noted the Resident's #57 meal tray card to document Large Grip Utensils, Scoop Plate, and Sipper Cup with the meal. Further observation noted that the resident was not given Large Grip Utensils with the lunch meal. The resident stated to the surveyor that he often is not issued the Utensils or the scoop plate or sipper cup with meals in the dining room or in room with meals. He further stated that the built-up utensils, scoop plate, and sipper cup allow him to eat more easily and independently. Interviews with therapy staff during the lunch meal observation noted that the resident was not issued the Large Grip Utensils with the meal and has been assessed for the use of the utensils. Review of the clinical record of Resident #57 noted an admitted [DATE] with current diagnoses of Diabetes, Protein-Calorie Malnutrition, and Muscle Weakness. Current physician orders included Large Grip Utensils, Scoop Plate, and Sipper Cup with meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Occupational Therapy notes from the certification period of 03/21/24 - 05/04/24 documented that Resident #57 has arthritis in both hands with decreased gross grasp and unable to close hands. Patient will benefit from adaptive feeding equipment to facilitate improved self feeding independence. Use of 2-handled mug, built-up utensils, and scoop dish to ensure adequate nutrition and hydration. Review of current care plans dated 09/10/24 documented the problem of Risk for Decreased Nutritional and Dehydration Status with the documented intervention of Adaptive Equipment: Large grip Utensils, Sippy Cup, and cup with handles with every meal. 3) During the observation of the lunch meal in the Main Dining Room on 10/07/24 at 12:15 PM, it was noted Resident's #67 meal tray card to document a Mini Coated Spoon and Scoop Plate with the meal. Further observation noted that the Mini Coated Spoon was not served with the meal and the resident received a regular Built-up Spoon with the meal. It was noted the resident was having difficulty biting and eating the foods with the regular spoon. Interviews with therapy staff during the meal observation were noted to state the resident was not given the appropriate mini coated spoon with the meal and has been assessed for the need of the mini coated spoon. Review of the clinical record of Resident #67 on 10/11/24 noted that the resident was readmitted on [DATE] with current of diagnoses of Depressed Mood, Dysphagia, and Aphasia. Current physician orders noted Patient to use mini-coated spoon and scoop plate with meals dated 05/22/23. Review of Occupational Therapy Discharge Summary from service period of 05/2223 - 06/02/22 documented patient requires mini coated spoon and scoop plate for self feeding. Review of current care plans dated 10/02/24 document the problem of Decreased Nutritional and Hydration Status with the intervention including Adaptive Equipment as ordered : Mini Coated Spoon and Scoop Plate. 4) Observation of the lunch meal conducted on 10/07/24 at 12:15 PM noted the meal tray card of Resident #68 to document 2-Handled Cups, Scoop Plate, and Weighted Utensils with meals. Further observation of the lunch meal noted the resident did not receive beverages in 2-handle cups and was served water in a glass cup and coffee in a ceramic regular coffee mug. Interview with the alert resident at the time of the observation noted to state he often does not receive the 2-handled cups and further stated that beverages are easier to drink from the 2-handle cups. Therapy staff indicated to the surveyor during the meal that the resident did not receive the appropriate cups with the meal and that the resident has been assessed to receive the adaptive eating and drinking equipment. During the observation of the breakfast meal in the Main Dining Room on 10/08/24 at 8:45 AM it was again noted that a serving of milk and orange juice were served in a glass drinking cup . Review of the clinical record of Resident #68 noted re-admitted [DATE] with diagnoses of Seizures, Hemiplegia and Hemiparesis. Current physician orders noted 2-Handle Cups and Scoop Plate with Meals. Review of Occupational Therapy Treatment from service period of 09/22/24 - 11/07/22 documented the addition of adaptive equipment including scoop dish, and large grip utensils to minimize spillage. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current care plans dated 7/24/24 documented the problem of Decreased Nutrition and Hydration Status with the intervention of Adaptive Equipment as ordered: 2-handled cup and scoop plate. 5) Review of the clinical record of Resident #118 noted an admitted [DATE] with diagnoses of Anemia, Seizures, and Dysphagia. Current physician orders included Soft and Bite Sized Diet with Mildly Thickened Liquids (08/21/24) , and Patient to use Scoop Plate, Large Grip Utensils, and 2-Handled Cup/Low Flow Restricted Cup with all meals. During the review of Occupational Treatment Encounter for the service period of 05/06/24 - 08/19/24 noted documentation of need for self feeding with lidded cup with 2-handles, large grip utensils, and scoop dish to increase independence with self-feeding and decreased spillage. Review of current care plans dated 09/24/24 documented the problem of Decreased Nutritional Status and Hydration with the documented intervention of Adaptive Equipment as ordered: 2-handled cup, built-up utensils and scoop plate. 6) Observation of the lunch meal conducted on 10/07/24 at 12:15 PM noted the meal tray card of Resident #134 to document 2-Handled Cups, Scoop Plate, and Weighted Utensils with meals. Further observation of the lunch meal noted the resident did not receive beverages in 2-handle cups and was served milk and juice a glass cup. Interview with the alert resident at the time of the observation noted to state he often does not receive the 2-handled cups and further stated that beverages are easier to drink from the 2-handle cups. Therapy staff indicated to the surveyor during the meal that the resident did not receive the appropriate cups with the meal and that the resident has been assessed to receive the adaptive eating and drinking equipment. During the observation of the breakfast meal in the Main Dining Room on 10/08/24 at 8:45 AM it was again noted that a serving of milk and orange juice were served in a glass drinking cup . Review of the clinical record of Resident #134 noted a re-admitted [DATE] with current diagnoses of Gastro Hemorrhage, Respiratory Failure, Diabetes, and Protein-Calorie Malnutrition . Current physician orders noted Patient to use 2-Handled Cup, Scoop Plate, and Weighted Utensils with all meals (09/04/24). Review of current care plans dated 10/08/24 documented the problem of Decreased Nutritional Status with the documented intervention of Adaptive Equipment as ordered; 2-handled cup, scoop plate and weighted utensils.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 01948 Based on observation, interview, and record review, it was determined that the main dining room space was not being properly utilized during meal service for 40 of 40 facility residents. The findings included: During the observation of the lunch meal in the Main Dining Room (MDR) on 10/07/24 at 12 PM, it was noted that the entire dining room space was not being utilized for the meal service. Specifically, approximately only half of the dining space was being utilized for the residents(38 wheelchair bound) . During the meal observation it was noted that 40 residents were in attendance and numerous residents complained and became upset and angry due to having their wheelchairs moved from their table so other residents in wheelchairs could get into the dining area. During the observations, three sampled residents (Resident 's # 40, #57 and #127) complained to the surveyor of constantly being moved during meal services (Lunch & Dinner). Staff (A, D, and E) were also noted to state to the surveyor about the difficulty the residents have constantly repositioning/moving during meal services. Further observation noted that the main dining space being utilized for the lunch meal was furnished with 13 dining tables and 36 of the 38 residents in attendance were wheelchair bound. Further observation noted that the space not being utilized for meal were furnished with 3 tables of which only 4 wheelchair bound residents were in attendance. On 10/08/24 at 11 AM, at the request of the surveyor the dining room spaces being utilized for meals were measured by the Director of Maintenance. The measurements noted that the main area was 1200 square feet and the connecting ding area not being utilized was measured at 560 square feet. The Director stated that he did not know why the entire dining area is not being utilized for resident meals and confirmed that there is a problem of space constraints and continuous moving of residents during meals. Continuous observation of the lunch meals on 10/08/24, 10/11/24, and 10/14/24 confirmed the surveyor's findings of residents being continuously moved during meal service and complaining of the issue.