STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105851	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Court of Boca Raton	6343 via DE Sonrisa Del Sur Boca Raton, FL 33433

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49060 Based on observations, interviews, and record review, the facility failed to ensure a sanitary and clean environment including air conditioning filters for 4 residents' rooms, Rooms 238-B, 235-D, 226-W and 232-B, reviewed for homelike clean environment. The census at the time of survey was 48. The findings included: 1. During an initial tour observation conducted on 09/23/24 at 9:55 AM of room [ROOM NUMBER]-B, it was observed that the air conditioning (AC) filters and vents with black mold-like substance. Photographic Evidence Obtained. An interview was conducted on 09/25/24 at 10:25 AM with the resident residing in this room who stated she always needs O2 and feels short of breath all the time. 2. During an initial tour observation conducted on 09/23/24 at 9:55 AM of room [ROOM NUMBER]-D revealed the AC vent and filters were observed with black mold-like substance. Photographic Evidence Obtained. During an interview conducted on 09/23/24 at 10:10 AM with the resident who resides in this room revealed she is on oxygen most of the time. During an environmental tour conducted on 09/26/24 at 11:30 AM, Staff E, Maintenance Assistant, stated he usually cleans the air-conditioning filers once a week. The surveyor pointed out the black mold-like substance material that was located on top of the air conditioning unit's slits. He further acknowledged all the findings in the rooms. 36057 3. On 09/23/24 at 9:55 AM, during the initial tour to the facility, observation revealed in room [ROOM NUMBER] that the air conditioner's (A/C) vent / slats were observed with multiple black color moist matter. The A/C unit was next to a resident bed, turned on and the resident was in bed asleep. Photographic Evidence Obtained. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 09/23/24 at 10:08 AM, during the initial tour to the facility, observation revealed in room [ROOM NUMBER] the A/C vent / slats and it's filters had multiple black color moist matter observed on the vents and crusted black matter on the filters. The A/C unit was turned on, next to a resident bed, and the resident was in bed asleep. Photographic Evidence Obtained.

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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** 40153 Based on observations, interviews and record review, the facility failed to monitor weights and provide adequate nutritional interventions in a timely manner for 1 of 3 sampled residents reviewed for nutrition, Resident #17. The findings included: Record review revealed Resident #17 was readmitted to the facility on [DATE] with diagnoses to include Generalized Anxiety Disorder, Parkinsons Disease, and Dementia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Section GG of the MDS for eating showed Resident #17 needed substantial / maximum assistance with eating. In an observation conducted on 09/25/24 at 8:39 AM, Resident #17 was in her room eating breakfast. The tray consisted of oatmeal, juice, banana, and a muffin. Resident #17 was observed attempting to drink the oatmeal in the cup. No staff was noted at the time of this observation. A continued observation at 9:00 AM revealed staff sitting near Resident #17 assisting her with her breakfast meal. The breakfast tray was observed to be consumed 100%. Review of the Physician's orders showed an order for Ensure (nutritional supplement) 3 times a day dated 12/04/23. Review of the Weights log showed the following weight for Resident #17: On 05/02/24, a weight of 128 pounds. On 06/05/24, a weight of 125 pounds. On 07/02/24 a weight of 123 pounds. On 08/01/24, a weight of 122 pounds On 09/03/24, a weight of 121 pounds. This showed a weight loss trend from 128 pounds to 121 pounds, as above. Review of the nutrition progress note, dated 07/03/24, revealed the following: The Resident lost 2 pounds in one month. Oral intake of meals ranges from 50% to 75% of all meals. In this note, Staff L, Certified Dietary Manager, discontinued the Magic cup (nutritional supplements) twice a day, which provided an additional 580 calories and 18 grams of protein. Review of the dietary progress note dated 09/03/24 showed the following: current weight of 121 pounds with a 3.2% weight loss. Oral intake fluctuates between 50% to 75% of meals that are assisted. To continue encouraging high caloric foods and monitor weights. In this note, no additional nutritional recommendations were made or changes to the current nutritional supplements (Ensure). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested a new weight on 09/25/24 at 10:00 AM, which showed a new weight for Resident #17 of 118 pounds. This showed an additional weight loss of 10 pounds from 05/02/24 to 09/25/24. Record review under the tasks section of the electronic charting, documented by the Certified Nursing Assistants (CNAs), revealed that for the last 14 days, Resident #17 ate 54% to 77% of her meals. An interview was conducted on 09/25/24 at 10:35 AM with Staff D, Registered Nurse, who stated when there is an order for Ensure nutritional supplements three times a day, it is usually given at 10:00 AM, 2:00 PM, and 6:00 PM. When asked what time the Ensure was given to Resident #17 this morning, she said that she refused it this morning. She further said that Resident #17 gets the Ensure twice a day at 10:00 AM and 6:00 PM. Review of the Medication Administration Audit Report showed the following: On 09/11/24, an Ensure was supposed to be given at 2:00 PM and was given at 4:02 PM. On 09/14/24, an Ensure was supposed to given at 10:00 AM and was given at 12:16 PM. On 09/15/24, an Ensure was supposed to be given at 6:00 PM and was given at 7:45 PM. On 09/16/24, an Ensure was supposed to be given at 6:00 PM and was given at 7:59 PM. On 09/17/24, an Ensure was supposed to given at 6:00 PM and was given at 8:31 PM. On 09/21/24, an Ensure was supposed to be given at 2:00 PM and was given at 4:37 PM. On 09/22/24, an Ensure was supposed to be given at 10:00 AM and was given at 11:58 AM. A phone interview was conducted on 09/25/24 at 11:00 AM with the facility's Clinical Dietitian, who stated that Staff L, the Certified Dietary Manager, oversees the nutritional monitoring and documenting on the long-term care residents. She is in charge of attending the care plan meetings and reviewing any weight changes. The facility's Clinical Dietitian watches the weight trends to prevent residents from loosing weight. She would review the intake of meals and ensure the residents are receiving the nutritional supplements as ordered. An interview was conducted on 09/25/24 at 11:20 AM with Staff L, who stated she removed the Magic Cup nutritional supplement for Resident #17 on 07/03/24 because she wanted to improve her oral intake with food and not fill her up with nutritional supplements. When asked why she removed the nutritional supplements for Resident #17 in spite of the resident losing 5 pounds from 05/02/24, she did not know.

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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** 50895 Based on interviews, record reviews, and policy reviews, the facility failed to ensure that 1 of 1 sampled resident reviewed for dialysis, Resident #300, received care and services for the provision of hemodialysis consistent with the professional standards of practice, as evidenced by lack of ongoing communication and collaboration with the dialysis facility regarding the provision of dialysis care and services. The findings included: Review of the facility's Dialysis Policy Statement, effective 04/25/18, documented, in part, The Social Services Coordinator / designee will arrange for transporting to and from an off-site certified dialysis facility for dialysis treatments. It also documented that The care of the resident receiving dialysis services reflects ongoing communication, coordination and collaboration between the community and the dialysis staff. This communication process is established between the community and the dialysis facility to be used 24-hours a day. Communication is documented in the progress notes. Photographic Evidence Obtained. Review of the Agreement for Services between the facility and the dialysis center signed 06/05/18, documented under Section 20 Nursing Facility, (a) Use of Outside Resources: the Nursing Facility must have those services furnished to its [sig] residents by a person or agency outside the Nursing Facility under an agreement described in 42 CFR s 483.75. According to this provision, the Nursing Facility assumes responsibility for (i) obtaining services that meet professional standards and principles that apply to professional providing services in the Nursing Facility; and (ii) the timeliness of the services. Notwithstanding the foregoing, Contractor remains liable for its own acts and omissions and the acts and omissions of any person providing services pursuant to this Agreement and 42 CFR s 483.75 shall not be construed to limit such liability. Photographic Evidence Obtained. The Agreement for Services also included Schedule A Services that listed transportation arrangements under the coordination of the resident's plan of care. It specified The Contractor and Nursing Facility will coordinate the plan of care of dialysis residents. Such coordination shall include but not be limited to: iii) transportation arrangements. It documented, The medical management of the dialysis resident will be under the direction of the resident's attending physician. Record review revealed Resident #300 was admitted to the facility on [DATE], and discharged to the hospital on 09/23/24 to receive dialysis treatment for End Stage Renal Disease (ESRD). Prior to his admission to the facility, Resident #300 had surgery for a fractured right hip that resulted from a fall. The resident's diagnoses included Dependence on Renal Dialysis, Heart Failure, Nondisplaced Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Acute Kidney Failure, and Major Depressive Disorder. Review of the resident's Brief Interview for Mental Status (BIMS) assessment performed on 09/17/24, documented a BIMS score of 14 indicating Resident #300 was cognitively intact. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #300 on 09/23/24 at 12:45 PM. The surveyor observed the resident in bed and upset because he missed his appointment earlier for dialysis. He explained he did not go because the transportation arrived with the wrong equipment. He said that he fell and broke his hip, and that he was in a lot of pain. He added that the transportation company came with a chair, and that he needed a stretcher for the transportation because of the pain in his hip. Resident #300 also stated the transportation company was supposed to come back today with the appropriate equipment. Review of Resident #300's medical record showed a physician's order dated 09/17/24 for dialysis on Tuesdays, Thursdays, and Saturdays. During Resident #300's first week at the facility, this included Tuesday 09/17/24, Thursday 09/19/24, and Saturday 09/21/24. Review of the dialysis communication forms revealed no evidence that dialysis occurred on Tuesday 09/17/24 and on Thursday 09/19/24. There was no dialysis communication form provided for Saturday, 09/21/24. A phone interview was conducted on 09/24/24 at 10:05 AM, the Dialysis Outpatient Representative who stated that on Saturday, 09/21/24, Resident #300 didn't show up at the dialysis center due to transportation issues. She added he was supposed to go to the dialysis center on Monday, 09/23/24, to make up for the missed appointment, but when he arrived, he was unable to be transferred to the treatment chair because he needed two people to transfer him. The Dialysis Outpatient Representative said he required a stretcher because of his hip surgery. She stated the facility knew Resident #300 needed to come to his dialysis treatments with a stretcher since they did not have the resources to accommodate other transportation methods. An in-person interview with the facility's Concierge, conducted on 09/24/24 at 2:53 PM, revealed that she was aware that Resident #300 was scheduled for dialysis three times each week and that he did not receive dialysis on Tuesday, 09/17/24, because he could not be transferred to the treatment chair. The Concierge said she called the Staff Director of Sales in the admissions department and explained the problem with the transportation. After the Staff Director of Sales was notified, she arranged for transportation to the dialysis center, on the following day. This transportation included a stretcher for an appointment on Wednesday, 09/18/24, to make up for the missed session. A dialysis communication form documented evidence that the dialysis treatment occurred on 09/18/24. In a phone interview on 09/24/24 at 3:17 PM, the facility's Staff Director of Sales said that when Resident #300 was first admitted , they thought he could go to dialysis by wheelchair. After she was notified that the dialysis center was unable to transfer the resident to the treatment chair on 09/17/24, she set up an appointment for the following day with a different transportation company. Resident #300 was transported to the dialysis center and was dialyzed on 09/18/24. According to the Staff Director of Sales, she arranged for a transportation company to go to the facility on Saturday, 09/21/24, to conduct a site survey to determine if this resident would qualify for emergency services. She was told that they thought his services would qualify, and that they needed a form to be signed by the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staff Director of Sales said that a representative from the transportation company brought a paper to the dialysis center to be signed. She was made aware that the resident was not transported to the dialysis center on Saturday, 09/21/24. When the Staff Director of Sales followed up with the dialysis center, she was informed that Resident #300 needed to arrive by 11:00 AM to receive dialysis. The Staff Director of Sales asked the dialysis center representative if he should go to the hospital to get dialysis, and she said she was told that he could wait until Monday morning. The Staff Director of Sales set up transportation for Monday morning and expected the transportation company to arrive with a stretcher. On Monday morning, instead of arriving with a stretcher, the transportation company arrived with a Broda chair (which is like a transportable recliner chair). The transportation company transported the resident in the Broda chair and after they arrived at the dialysis center, they were told that the dialysis center could not transfer the resident from the Broda chair to the dialysis treatment chair. The Staff Director of Sales said she requested a new chair time for the dialysis treatment and that she arranged for another transportation company to bring the resident to a later dialysis appointment on Monday 09/23/24. When the Staff Director of Sales was asked why Resident #300 didn't go to the later appointment at the dialysis center, she said that a Covid-19 test was performed on Resident #300 and the results were positive. The Staff Director of Sales said that Resident #300 was not able to go to dialysis because he tested positive for Covid-19. She added that they sent him out to the hospital because they knew he would miss the dialysis treatment. In a phone interview, on 09/24/24 at 3:46 PM, the Dialysis Outpatient Representative was asked what the usual protocol for a missed dialysis treatment was. She said that when a patient cannot make it to the dialysis center on one day, they are rescheduled for an appointment on the next day. She explained that three days would have been too many days for him to wait for the next day for dialysis treatment. She added that it all depends on the patient and at times it is a nurse's call.

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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. 36057 Based on record review, observation and interviews the facility failed to properly destroy a controlled substance patch for 1 of 1 sampled resident reviewed during the controlled substance record review, Resident #8, and failed to ensure controlled substance medications reconciliation was accurate for 2 of 5 sampled residents, Resident #8 and #37. The findings included: Review of the facility's policy, undated, titled, Narcotic Reconciliation, provided by the Director of Nursing (DON) documented, in part, the licensed nurse is responsible to sign the administration of the controlled medication on the Medication Administration Record and the Controlled Substance Declining Inventory Record at the time of the administration to the resident . 1. Review of Resident #8's clinical record documented an admission on 02/11/22 and a readmission on 04/18/24. The resident's diagnoses included Chronic Pain, Heart Failure and Osteoarthritis. Review of Resident #8's clinical record documented an active physician order dated 04/22/24 for Buprenorphine Transdermal Patch (controlled substance) weekly 5 microgram per hour (mcg/hr.), apply 1 patch transdermally in the morning every Tuesday for Non Acute Pain and remove per schedule. Review of Resident #8's September 2024 Medication Administration record (MAR) documented, Buprenorphine Transdermal Patch weekly 5 mcg/hr., apply 1 patch transdermally in the morning every Tuesday for Non-Acute Pain and remove per schedule start date 04/23/24. Further review revealed Staff H, Registered Nurse (RN), signed off that Buprenorphine patch was removed on 09/24/24 at 5:59 AM and applied on 09/24/24 at 6:00 AM. On 09/24/24 at 11:33 AM, a joint side by side review of Medication Cart #1 was conducted with the Assistant Director of Nursing (ADON) and Staff F, Registered Nurse (RN). The review revealed an opened Buprenorphine Transdermal System, a single package, that was opened with the patch dated 09/10/24 and was located on the top drawer of the cart. Staff F stated the patch belonged to Resident #8 and it was supposed to be discarded and signed by two nurses. A side-by-side review of Resident #8's Controlled Drug Declining Inventory Sheet for the resident's drug Buprenorphine was conducted with the ADON and Staff F, RN. The inventory sheet documented an entry that a patch for Buprenorphine was removed from the controlled box on 09/10/24 at 6:00 AM. The inventory sheet also documented above patch was destroyed by nurse (A) and witness (B) who signed and dated to the left. Further review revealed another entry signed off by Staff H, RN. The entry was not dated, and the patch was not destroyed and witness by (B) as per the inventory sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 12:28 PM, an interview was conducted with the Director of Nursing (DON) who stated that on 09/17/24, the night nurse went to Resident #8's room and asked the resident if she wanted the Buprenorphine patch and the resident refused it. The DON was apprised that the night nurse left the removed patch dated 09/10/24 in the medication cart and did not discard it as per inventory sheet. The DON stated the resident's patch was administered on 09/24/24 at 6:00 AM. The DON was asked to arrange for an interview with Staff H, RN. On 09/24/24 at 1:45 PM, a joint interview was conducted with the DON and Staff H, RN. Staff H stated he works the 3:00 PM to 11:00 PM or 11:00 PM to 7:00 AM shift. Staff H stated that on 09/24/24, he removed Resident #8's Buprenorphine patch dated 09/10/24 and applied a new one on her right forearm and added that two nurses should sign when dropping the old patch into the drug buster. Staff H stated the other nurse was busy and he was waiting 'to waste'. He stated, my mistake, I forgot. Staff H was apprised that he did not date the controlled substance inventory sheet either. 2. Review of Resident #37's clinical record documented an admission on 12/14/23 with a readmission on 08/08/24. The resident's diagnoses included Displaced Fracture of Base of Neck of Right Femur, Acute Kidney Failure and Dementia. Review of Resident #37's clinical record documented a discontinued physician order dated 08/02/24 for Oxycodone-Acetaminophen tablet 5-325 mg every 8 hours as needed for pain. On 09/24/24 at 12:12 PM, a side-by-side review of Resident #37's Controlled Drug Declining Inventory Sheet for Oxycodone-Acetaminophen (controlled substance) tablet 5-325 mg every 8 hours as needed for 2 days, received on 07/17/24, was conducted with Staff G, RN and the ADON. The review revealed two tablets of Oxycodone-Acetaminophen 5-325 mg in the controlled box. The inventory sheet documented that on 08/30/24 at 8:00 PM, one tablet was removed from the controlled substance box. Further review revealed that the Oxycodone-Acetaminophen 5-325 mg tablet removed from the box on 08/30/24 was not documented as administered on Resident's #37's August 2024 MAR. There was not a written physician order to administer Oxycodone-Acetaminophen 5-325 mg on 08/30/24. On 09/25/24 at 9:45 AM, during an interview, the DON confirmed Resident #37's Oxycodone-Acetaminophen 5-325 mg was discontinued on 08/02/24 and the tablet had been removed on 08/30/24 without a physician order and it was not documented on the MAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review the facility failed to ensure medication error rates was below 5 percent; a total of 29 opportunities were observed with 3 medication errors identified which yield a medication error rate of 10.34 percent, affecting 2 of 5 sampled residents reviewed for medication administration, Resident #249 and Resident #250. The findings included: Review of the facility's policy, titled, Medication Administration General Guidelines, dated 01/2023, included the following: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR immediately following the medication being given. 1. Record review for Resident #250 revealed she was readmitted to the facility on [DATE] with the following diagnoses: Fracture of Sacrum, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Stage 3, and Paroxysmal Atrial Fibrillation. Review of Section C of the Minimum Data Set (MDS) dated [DATE] Admissions MDS revealed Resident #250 had a Brief Interview for Mental Status (BIMS) score of 10, indicating she was moderately cognitively impaired. On 09/24/24 at 9:25 AM, a medication administration observation was conducted with Staff F, Registered Nurse (RN), for Resident #250. Staff F was observed preparing Resident #250's medications to include 8 oral medications: Allopurinol 100mg 2x daily Colchicine 0.6mg tab daily Gabapentin 300 mg cap 2x daily Pilocarpine 5mg 2x daily Prednisone 2.5mg, give 7.5mg daily (3 tabs) daily (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Docusate Sodium cap 100mg 2x daily Magnesium Gluconate 250mg daily Vitamin B-12 500 mcg daily. Reconciliation of Resident #250's physician's orders and medications administered above revealed Resident #250 was scheduled to receive the above medication at 10:00 AM, plus 2 other medications: Ferrous Sulfate Oral Tab 45 mg daily and Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 mcg/ACT, 1 puff inhale daily. These 2 medications were omitted in the medication administration observation at 9:25 AM. During an interview conducted on 09/24/24 at 10:45 AM with Staff F, she stated she has been working at the facility for almost 2 years. She stated she administered the Trelegy Ellipta and the Ferrous sulfate prior to the medication administration observation with the surveyor. When asked to see the medications, Staff F remembered that the Ferrous Sulfate 45mg was not in the medication cart or the medication storage room, therefore she did not administer it. She noted that she did administer Trelegy prior to the medication administration observation at 9:25 AM. Review of the Medication audit report (time stamp) revealed Staff F documented that Resident #250 received the 8 oral medications between 9:53 and 9:54 AM including the Trelegy (9:54 AM) and not prior to the start of the medication administration observation at 9:25 AM as Staff F stated. In addition, Staff F signed for the Ferrous sulfate 45mg and then changed it at 10:47 AM after the surveyor brought it to her attention. Review of the nursing progress notes dated 09/24/24 at 12:24 PM revealed Resident #250's physician was contacted and an order received for a one-time dose of Slow Fe 45mg, which was administered at 12:47 PM. In addition, there was no further documentation of the Trelegy Ellipta administration. An interview was conducted on 09/24/24 at 2:59 PM with Resident #250's private aide. She stated she does not recall seeing the nurse give the resident the Trelegy Ellipta inhaler today, however, the nurse could of given the inhaler prior to her coming in at 7:30 AM. She also stated that she stepped out around 11:30 AM to pick up something from downstairs and the nurse could have administered the inhaler then. 36057 2. Review of Resident #249's clinical record documented an admission on 09/19/24 with a diagnosis to include Sepsis, Extended Spectrum Beta Lactamase (ESBL) Resistance (a bacteria), Escherichia (E) Coli (a bacteria) and Urinary Tract Infection (UTI). On 09/24/24 at 9:54 AM, medication administration observation for Resident #249 performed by Staff G, RN started. The RN prepared the followings meds: Aspirin 81 mg(milligram) one tablet Multivitamin without minerals one tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol Tartrate 50 mg one tablet On 09/24/24 at 10:22 AM, Staff G stated she had finished the medication administration for the time for Resident #249. Review of Resident #249's clinical record documented an active physician order dated 09/20/24 for Multivitamin-Minerals Oral Tablet (Multiple Vitamins with Minerals) give 1 tablet by mouth one time a day for supplement. Review of Resident #249's September 2024 Medication Administration Record (MAR) documented Multivitamin-Minerals Oral Tablet (Multiple Vitamins with Minerals) give 1 tablet by mouth one time a day for supplement, start date 09/20/24 at 10:00 AM. On 09/24/24 at 12:12 PM, a side-by-side review of Medication Cart #2 and the Multivitamins bottle in the cart was conducted with Staff G, RN and the Assistant Director of Nursing (ADON). The cart had one opened bottle of Multivitamins without minerals. Staff G stated that was the only Multivitamin bottle she had in Medication Cart #2 and added she had not seen a bottle of Multivitamins bottle with minerals and did not give Multivitamin with mineral to Resident #249. On 09/24/24 at 12:39 PM, a side-by-side review of Multivitamins supply located at the facility's Central supply room was conducted with the Central Supply Clerk (CSC) and the ADON. The CSC stated the most popular over the counter Multivitamins she ordered was the one used by Staff G, Multivitamins without minerals.

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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 correct diet consistency for the Pureed diet during 1 of 3 dining observations for Resident #20 and Resident #6. This had the potential to affect 5 of 48 residents on a Pureed diet. The findings included: Review of the Purred Diet-NDD Level 1 taken from the 2014 Nutrition Care Manual, Academy of Nutrition and Dietetics, showed the following: pureed foods must be smooth and thick enough to mound on the plate. No coarse textures, chunks, lumps, or particles are allowed in the food. Record review revealed Resident #20 was admitted on [DATE] with a diagnosis of Dysphagia, Repeated Falls, and Weakness. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 02, indicting severe cognitive impairment. Review of the physician's orders showed an order, dated 07/24/20, for a Regular diet, Pureed texture, and Nectar consistency for dysphagia. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder and Parkinsons Disease. Review of the physician's orders, dated 11/12/23, showed an order for a Concentrated Carbohydrate diet, Pureed texture, and Honey consistency. The MDS assessment dated [DATE] revealed a BIMS score of 02, indicating severe cognitive impairment. Review of the menu cycle for 09/24/24 showed the following for the lunch meal: Cream of Mushroom shop, Fried Chicken, Steamed rice, and Stir-Fried Vegetables. In an observation conducted on 09/24/24 at 12:15 PM, Resident #6 was observed in the dining room eating her lunch meal. The meal ticket was noted to have L1 Puree Concentrated Carbohydrates and a Honey Thickened diet. Resident #6 was observed eating a Cream of Mushroom soup, which was observed to be lumpy and thick with an oatmeal-like consistency. Photographic Evidence Obtained. Resident #6 was observed coughing while attempting to drink the soup. Resident #20 was observed sitting at the same table, eating her lunch. Her meal ticket was noted to be on a Pureed diet with nectar-thickened liquids. Resident #20 was eating her Cream of Mushroom soup which was noted with the same consistency as Resident #6. In an interview conducted on 09/24/24 at 1:06 PM with Staff B, the Executive Chef stated that Cream of Mushroom soup was placed in an Emersion blender, and a thickener was added to it. When asked how much of the thickener was placed into the soup portion of the pureed diet, he said, We just eyeball it. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 09/25/24 at 11:23 AM with the facility's Speech Pathologist who stated the Cream of Mushroom soup is considered food and needs to be made into three consistencies: Regular, Pureed, and Mechanical soft. For the Pureed consistency, the soup needs to be smooth with no lumps. When looking at Pureed foods, you should not be able to see pieces and should see one uniform texture. When shown a picture of the Cream of Mushroom soup taken earlier by the surveyor, she said that it was not smooth enough to be considered Pureed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40153 Based on interviews, observations, and record, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, which could potentially affect 48 residents in the facility. The findings included: 1. In a tour of the main kitchen conducted on 09/23/24 at 9:15 AM, accompanied by the Kitchen Manager, the following issues were observed: a. Three large round garbage bins were opened without lids in the food production area. Thirty minutes later, at 9:45 AM, this was still observed. b. A small Styrofoam cup, with an employee's name written on it, was noted in the food production area. c. The Traulsen reach-in refrigerators was noted with dirt and debris on the bottom. d. The commercial charcoal grills were noted with an old sticky-like black dried substance attached. Staff A, Cook, stated the grill is supposed to be cleaned the night before and that it is usually clean when he arrives for his shift in the morning. When asked when it was last cleaned, he did not know. e. A rectangular silver tray with some debris and dirt inside it was noted underneath the tray line. f. The walk-in refrigerator had two boxes (10.5 pounds) each, with ready to cook boneless, skinless chicken breast filets. No date was noted on the boxes indicating the time and date that the boxes were placed in the walk-in refrigerator. Further observation revealed that the chicken filets were sitting in a pool of red fluid. The boneless, skinless chicken breast filets were also in an open plastic bag and not sealed appropriately. In this observation, Staff A was asked when the two boxes were placed in the walk-in refrigerator, and he did not know. g. The reach-in refrigerator contained a 16-ounce round container of clam base, dated 09/13/24, which was ten days ago. Staff A reported that the 16-ounce container of clam base should have been used and discarded after 3 days. h.The walk-in refrigerator had a box of 8 servings (2.5 pounds each) of oven roasted chicken halves with no dated on the box indicating when the box was placed in the walk-in refrigerator. i. A large metal container was noted with multiple pieces of raw fish that were in the walk-in refrigerator. Further observation revealed the container was placed there on 09/16/24 which was 7 days later. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. Four large boxes of frozen Swai fillets were noted in the walk-in refrigerator. The fillet boxes did not have a date on them indicating when they were placed in the refrigerator. In this observation, Staff B, Executive Chef, said that the boxes were placed in the walk-in refrigerator on Saturday. He acknowledged that the date that the boxes were placed in the walk-in refrigerator should have been marked on the boxes. k.A large box of frozen Swai fillets was in the walk-in refrigerator. The fillet box did not have a date on the box indicating when the boxes were placed in the walk-in refrigerator, and it was opened and not sealed. l. The floor in the dry storage area noted with debris and dirt on the floor. Continued observation showed a live insect on the wall in the dry storage area. 2. In an observation conducted on 09/23/24 at 10:30 AM on the 2nd floor satellite kitchen, an opened round garbage container with no lid was noted. At 10:45 AM, the round garbage container was still opened with no lid. 3. In an observation conducted on 09/25/24 at 11:56 AM on the 2ndfloor Satellite Kitchen, the following were noted: a. Using a facility-calibrated thermometer, Staff C, Dietary Aid, measured the internal temperature of a small square metal container with blue cheese. The temperature was 44.2 degrees Fahrenheit (F), not the recommended 40 degrees and below Fahrenheit. b. Using a facility-calibrated thermometer, Staff C, Dietary Aid, measured the internal temperature of 12 individuals' Ham and Cheese Sandwiches. The internal temperature was 45.8 degrees Fahrenheit, not the recommended 40 degrees and below Fahrenheit. In an interview conducted on 09/26/24 at 2:00 PM with the facility's Administrator, he acknowledged all findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to ensure they had implemented an infection control program that ensured a resident with a bacterial Urinary Tract Infection (UTI) was placed on contact precautions for 1 of 3 sampled residents reviewed for Transmission Based Precautions (TBP), Resident #249; and failed to perform hand washing between gloves change during wound care observation for 1 of 1 sampled resident reviewed for pressure ulcers, Resident #34. The findings included: Review of the facility's policy, titled, Infection Prevention and Control Program for Skilled Communities -Transmission-Based Precautions, revised on 07/2024, provided by the Director of Nursing (DON), documented, in part, Transmission-based precautions are used for residents with documented .infection . with highly transmissible pathogens for which additional precautions are needed to prevent transmission . Contact Precautions-use contact precautions for residents with known .infections that are at an increased risk of being transmitted by direct contact with the residents or the resident's environment .use the following guidelines to manage the care of resident's on contact precautions: PPE [personal protective equipment] - use gloves and gown when in contact with the resident or the resident's environment. Put on PPE prior entering the resident's room . 1. Review of Resident #249's clinical record documented an admission on 09/19/24 with a diagnosis that included Sepsis, Extended Spectrum Beta Lactamase (ESBL) Resistance [a bacteria], Escherichia (E) Coli (a bacteria) [E-Coli] and Urinary Tract Infection (UTI). Review of Resident #249's hospital discharge instructions listed a diagnosis of Bacterial UTI and Sepsis, discharge to Skilled Nursing Facility (SNF) on 09/19/24. Review of Resident #249's clinical record documented an active physician order dated 09/20/24 for Meropenem Solution (an antibiotic) 1 GM (Gram) intravenously (IV) every 12 hours for ESBL/ E.Coli - UTI until 09/26/24. Review of Resident #249's September 2024 Medication Administration Record (MAR) documented Meropenem Solution 1 GM (Gram) intravenously every 12 hours for ESBL/ E.Coli-UTI, as administered for the first time on 09/20/24 at 10:00 AM. Review of the facility's resident's census list provided by the Director of Nursing (DON) on 09/23/24 documented ISO above Resident #249's name. On 09/23/24 at 8:49 AM, an interview was conducted with the DON who stated that ISO means isolation, and stated that Resident #249 was on isolation. On 09/23/24 at 9:41 AM, during an initial tour, observation revealed Resident #249 in her room being helped to walk to the bathroom by the Assistant Director of Nursing (ADON). The ADON was holding the resident by her arm. Observation revealed the ADON was not wearing PPE (gown or gloves). Further observations revealed the resident's room did not have signage or any indications that Resident #249 was on Isolation or Contact Precautions due to a bacterial infection. There were no PPE supplies readily available for the staff to care for Resident #249. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 8:45 AM, observation revealed Resident #249 door with a Contact Precautions signage on the door and PPE supplies cart outside the room. On 09/24/24 at 9:52 AM, an interview was conducted with Staff G, Registered Nurse (RN), assigned to Resident #249, who stated the resident had ESBL in the urine and was placed on contact precautions on 09/24/24. Staff G stated the resident was on intravenous antibiotic for the ESBL infection since admission. On 09/24/24 at 10:04 AM, an interview was conducted with Resident #249 who stated she has had an UTI four (4) times and added she told the hospital to treat her before she was sent home. The resident added she was told she had the UTI and was sent to the nursing home for antibiotic and will not go back home until clear. On 09/24 24 at 11:33 AM, an interview was conducted with the ADON / Infection Preventionist (IP) who stated they missed placing Resident #249 on contact precautions for ESBL on admission on 09/19/24. The ADON added that contact precautions were started last night on 09/24/24. The ADON was apprised of the surveyor observation of taking the resident to bathroom without her wearing a gown or gloves on 09/23/24 morning, and that the census indicated the resident was on isolation but there was not a sign or PPE supplies in the room. The ADON confirmed findings. 2. Review of the facility's undated document provided by the DON, titled, Shadowing and Skills - Team Member Hand Hygiene, documented, in part, Standard: all steps in the procedure must be completely and properly performed by the team member .skill procedure - handwashing .state when handwashing is required after removing gloves . Review of Resident #34's clinical record documented an admission on 03/04/23 with no readmissions. The resident diagnoses included Lymphedema, Dementia, Benign Prostatic Hyperplasia, Difficulty in Walking, and Muscle Weakness. Review of Resident #34's Minimum Data Set (MDS) annual assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 3, indicating that the resident had severe cognitive impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff to complete the activities of daily living (ADLs) including turning and repositioning. Review of Resident #34's physician order dated 09/17/24 documented Santyl Ointment 250 unit/gram (Collagenase), apply to Left ischium topically every night shift, cleanse with normal saline, apply Santyl then alginate calcium with skin prep around periwound and cover with gauze island daily. On 09/26/24 at 1:49 PM, wound care observation for Resident #34 performed by Staff F, RN and assisted by Staff D, RN started. Staff F removed the resident's wound's previous dressing, removed her pair of gloves and without performing hand hygiene, opened the room door, retrieved the treatment cart's key from her pocket and opened the treatment cart to retrieve wound care supplies. Staff F returned to Resident #43's beside, placed the wound care supplies on top of the table and donned gloves without performing hand hygiene prior to care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff F cleaned the surrounding wound skin with skin prep pads, removed her pair of gloves and without performing hand hygiene donned a pair of gloves and was not able to open the normal saline vial to clean the wound with. Observation revealed Staff F removed her pair of gloves, opened the room door, pulled the treatment cart keys from her pocket, opened the cart and retrieved more normal saline vials from the cart. Staff F returned to the resident's bedside, donned gloves without performing hand hygiene, and cleaned the resident's wound, removed her pair of gloves and again without performing hand hygiene donned another pair of gloves. Staff F then applied the Santyl ointment with a tongue depressor, removed her gloves and donned gloves again without performing hand hygiene, applied a Calcium alginate dressing, and with her gloved hand, Staff F reached for a marker in her pocket to label the dressing. At the end of the observation, a joint interview was conducted with Staff D and Staff F, who both stated that they are supposed to do hand hygiene / washing between gloves changing. Staff F confirmed she did hand hygiene only once. Staff D confirmed that Staff F did not perform hand hygiene between gloves changes.