STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105875	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Skilled Nursing Facility LLC	2090 N Congress Ave West Palm Beach, FL 33401

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation and interview, the facility failed to ensure a functional wheelchair for 1 of 1 sampled resident, Resident #17, whose wheelchair lock had been broken since admission to the facility. The findings included: Review of the record revealed Resident #17 was admitted to the facility on [DATE], with Occupational Therapy services initiated on 05/01/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating mild cognitive deficits. This same MDS documented that the resident used a wheelchair for mobility. Review of the Physical Therapy (PT) Evaluation and Plan of Treatment dated 05/04/25 documented the patient will improve ability to safely and efficiently transfer to and from a bed to a wheelchair. Daily PT Treatment Encounter Notes dated 05/04/25, 05/05/25 and 05/09/25, all included skilled interventions focused on transfer training to increase functional task performance. This task would necessitate the use of a safe wheelchair that was able to be locked. During an observation on 05/13/25 beginning at 12:28 PM, Resident #17 was in the main dining room, sitting in his wheelchair, attempting to eat lunch. As he was eating, his wheelchair moved back away from the table, and the resident had to reach further for his meal, spilling food during the attempts to eat. At 12:57 PM staff repositioned him at the table and provided additional food. As he again began to eat, his unlocked wheelchair again rolled backward away from the table. During a subsequent meal observation on 05/14/25 beginning at 12:47 PM, Resident #17 was again in the main dining room. While trying to eat, the resident's wheelchair again rolled away from the table. After two times that the resident inadvertently moved back, staff locked the right side of his wheelchair. At that point, the right side of the wheelchair remained close to the table while the resident ate, but the left side rolled backward and away from the table, placing the resident at a 45 to 90 degree angle away from the table's edge. When asked why staff don't lock both sides of the chair, the Director of Nursing (DON) stated he unlocks it himself. The DON was told the resident had not been seen attempting to lock or unlock his wheelchair that week. Upon closer observation of the resident's wheelchair, the left lock was noted to be broken, did not contact the wheel, and unable to function as a brake. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/25 at 1:13 PM, Resident #17 had been taken back to his room. Therapy staff were in his room and stated another therapist, Staff A, Certified Occupational Therapist Assistant (COTA), was his usual therapist. During an interview on 05/14/25 at 1:23 PM, Staff A, COTA, confirmed she had been working with Resident #17 since his admission to the facility. When asked about the resident's wheelchair and the inability to use the left lock, the COTA stated she had noticed the broken lock upon admission, but maintenance was not available. The COTA further stated, I can fix wheelchairs, but I have to do my case load first.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review, interview, and policy review, the facility failed to assess for and or assist to formulate advance directives upon admission for 1 of 1 sampled resident, Resident #17. The findings included: Review of the policy Residents' Rights Regarding Treatment and Advance Directives implemented 05/01/25, documented, in part, 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Review of the policy Social Services implemented 05/01/25, documented, in part, 3. The social worker, or social service designee, will complete an initial and quarterly assessment of each resident, identifying any need for medically-related social services of the resident. Any need for medically-related social services will be documented in the medical record. 4. Services to meet the resident's needs may include: a. Advocating for residents and assisting them in assertion of their rights within the facility. m. Assisting residents with advance care planning, including but not limited to completion of advance directives. Review of the record revealed Resident #17 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating mild cognitive deficits. Further review of the record lacked any evidence of advance directives, any assessment for advance directives or assessment by social services, or any evidence of assistance to formulate advance directives. During an attempted resident interview on 05/12/25 at 1:26 PM, Resident #17 could answer simple questions about his care and services but was unable to answer questions about advance directives. The record documented the resident was his own representative. During an interview on 05/14/25 at 11:30 AM, when asked who was responsible for assessing for and or assisting with advance directives, the Director of Nursing (DON) stated Admissions was responsible for that, although nursing ensures the code status of each new admission to the facility. During an interview on 05/14/25 at 11:19 AM, when asked the process for advance directives, the Business Office Manager (BOM), who was also responsible for admissions and social services, explained they would normally get the advance directives information from the hospital or Assisted Living Facility upon admission. The BOM stated if the information was not provided by either of those sources, she would reach out to the resident, power of attorney, or legal representative. When asked specifically about Resident #17, the BOM stated she was not part of his admission as she was newly hired but referred to the electronic medical record. The BOM stated she did not see anything in the medical record but would reach out to her regional director. During a subsequent interview on 05/14/25 at 2:45 PM, the BOM stated Resident #17 was his own representative and they did not have anything related to advance directives for the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on interview and record review, the facility failed to ensure interdisciplinary team (IDT) participation and care plan meetings for 5 of 5 residents reviewed, specifically Resident #3, 6, 18, 16, and 11. The findings: 1) The clinical record review indicated that Resident #3 was admitted to the facility on [DATE] and again on 03/25/25, with diagnoses that included progressive neurological conditions. It was noted that the 5-day Minimum Data Set (MDS) assessment was completed on 03/30/25; however, there was no evidence of care plan meetings held to review the care plan with the Interdisciplinary Team (IDT). On 05/15/25 at 10:02 AM, an interview was conducted with the Director of Nursing (DON) regarding the care plan review process with the IDT. She stated that she could not locate the sign-in sheet for the review. However, she presented an invitation letter dated 03/20/25 for review. She mentioned that care plan meetings are typically held every Thursday, but she could not find any evidence of these meetings. The DON also noted that the MDS coordinator works remotely, and the activities director, who possesses the relevant documents, had been off for two weeks and was not responding to her phone calls. As a result, she could not find any documentation of the care plan meetings or their reviews. 25404 2) Review of the record revealed Resident #6 was admitted to the facility on [DATE]. Further review of the record revealed the most current MDS assessment was completed on 02/17/25. Further review of the record lacked any evidence of a care plan meeting with IDT participation since the completion of that MDS. 3) Review of the record revealed Resident #18 was admitted to the facility on [DATE], with a recent readmission to the facility on [DATE]. Review of the record revealed the current MDS assessment was completed on 04/05/25. Further review of the record revealed the most current care plan meeting with IDT participation was completed on 01/30/25. The record lacked any evidence of a care plan meeting since the completion of the MDS assessment from 04/05/25. The Director of Nursing had been asked during the survey to locate and provide evidence of the care plan meeting participation. The DON explained it was located on paper in a binder. As of the exit conference, the DON had been unable to provide evidence of any current care plan meetings. 52127 4) Review of the record revealed Resident #11 was admitted to the facility on [DATE]. Further review of the record revealed the most current MDS assessment was completed on 03/30/25. Further review of the record lacked any evidence of a care plan meeting with the Interdisciplinary Team participation since the completion of that MDS. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Review of the record revealed Resident #16 was admitted to the facility on [DATE]. Review of the record revealed the current MDS assessment was completed on 03/12/25. Further review of the record lacked any evidence of a care plan meeting with IDT participation since the completion of that MDS.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, record review, and policy review, the facility failed to implement timely interventions and or adaptive equipment to ensure eating independence for 1 of 4 sampled residents, Resident #17, reviewed for Activities of Daily Living (ADLs). The findings included: Review of the policy Adaptive Feeding Equipment, dated 05/01/25, documented, in part, 1. Residents who are identified as needing feeding assistance should be referred to the occupational therapy department as a potential candidate for a feeding evaluation. 3. The therapist should document findings from the evaluation, and make recommendations as to a treatment plan, including the use of adaptive feeding equipment. 5 The dietary department should be notified of residents needing adaptive feeding equipment; the equipment is stored and maintained in the dietary department. Review of the record revealed Resident #17 was admitted to the facility on [DATE], with Occupational Therapy services initiated on 05/01/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating mild cognitive deficits. This MDS also documented the resident could eat with set up assistance from staff. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 05/01/25 documented the resident needed the setup assistance from staff for eating. This evaluation documented the reason for skilled OT was to maximize independence with ADLs. Review of the daily OT encounters lacked any documentation related to eating. Review of physician orders documented an OT evaluation as of 04/29/25, with a clarification OT order on 05/01/25 to provide skilled OT services, in part, for self-care. An order dated 05/13/25 documented the need for an OT evaluation for adaptive equipment. A progress note dated 05/13/25 by the Registered Dietician documented the resident was observed at lunch with excessive food spillage. An observation on 05/12/25 at 1:26 PM revealed Resident #17 in bed, having finished lunch with his tray nearby and an excessive amount of food spillage on the tray and about the bed. The resident's shirt had a large wet stain covering most of the front of the shirt. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/13/25 beginning at 12:28 PM, Resident #17 was noted in the main dining room, attempting to eat with a spoon, and only utilizing his right hand, which was very shaky. Regular utensils and a regular plate was noted. While attempting to eat the uncut piece of chicken, the Resident was unable to get any of the meat onto the spoon. While trying to get the chicken, the whole piece was pushed off the plate onto the table. Resident #17 then attempted to eat the noodles that were on the regular plate, and they were also inadvertently pushed onto the table and the floor. The resident was only able to eat a bite or two. Resident #17 moved himself away from the table while in his unlocked wheelchair. Staff then provided the mechanical soft chicken to the resident, placing the chicken on his plate, and he ate a couple of bites. Staff E, Registered Nurse (RN) instructed the Certified Nursing Assistants in the dining room to cut up the resident's food the next time. An observation of the meal ticket documented the resident was to receive a regular meal with thin liquids. Resident #17 attempted to eat the dessert out of a bowl but spilt the food and bowl onto the floor. The resident then started eating the noodles off of the table with his fingers. Staff then cleaned up the area and provided Resident #17 with a bowl of noodles and meat, and repositioned him at the table to eat. At 12:52 PM, Resident #17 appeared frustrated and wheeled himself just outside of the main dining room into the nearby hallway. When asked if he was ok or if he was still hungry, Resident #17 stated, I'm still hungry. When told he could go back into the dining room and ask for more food, he started to go back into the dining room. Staff E, RN, overheard part of the conversation and stated, He doesn't like anyone to help him. Maybe I can get him something else. At 12:57 PM, Resident #17 was provided a peanut butter and jelly sandwich, cut in four pieces, and the resident was able to eat it, although his hand continued to shake. As the resident was eating, his unlocked wheelchair rolled backward again, and no staff attempted to lock the wheelchair to assist the resident in staying close to the table to eat. Resident #17 ate the entire sandwich and asked for another. Upon finishing his lunch, the resident's shirt was noted with food ruminants and liquid stains from his earlier attempts to eat. During a second meal observation on 05/14/25 at 12:47 PM, Resident #17 was again in the main dining room. The resident was observed again trying to eat independently. He continued to spill food on the table and the floor. Photographic Evidence Obtained. While trying to eat, the resident's wheelchair again rolled away from the table. After two times that the resident inadvertently moved back, staff locked the right side of his wheelchair. The left side of the wheelchair continued to move away from the table, leaving the resident at a 45 to 90 degree angle from the table edge. The Director of Nursing (DON) stated they were going to get him a plate guard since he does not want help eating. During an interview on 05/14/25 beginning at 1:23 PM, Staff A, Certified Occupational Therapy Assistant (COTA), accompanied by the Director of Rehab, stated she was the occupation therapist who had been routinely working with Resident #17. When asked what she was working on with the resident, the COTA stated she was working on his posture as he leans to right. The COTA stated the resident had tremors, but he was, functional to self-feed, but messy as he had some cognitive issues and tremors. When asked if she had tried anything for the spillage of food, the COTA stated that she had not as she was only working on positioning. When asked again about his ability to eat, Staff A, COTA, stated, He can eat but is messy. But who isn't? The COTA further volunteered that she had observed him prior to that week, in his room, sitting on the edge of the bed eating, again stating he was messy, but she was working on his posture and trunk strengthening. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During this continued interview, when asked if she had noted the new order dated 05/13/25 to assess for adaptive equipment, Staff A stated she tried to see him that morning, but he had already finished. The COTA stated he had eaten all of his oatmeal, and that she had noted some bread on the floor. The COTA stated, He can live without it (the bread). When asked about an observation of the lunch meal that day, the COTA stated she was taking her lunch at the time of the resident's lunch that day. When asked how she was going to assess for adaptive equipment if she wasn't available to observe lunch, the COTA explained she was assisting a discharged resident's family during her lunch hour. When asked if her responsibility was to the current residents, she stated, Yes, but I helped the discharged resident during my lunch time. When asked if she could have taken her lunch before or after the resident's scheduled lunch in order to observe Resident #17, Staff A stated, I guess so . it (the discharged resident) took longer than I expected. During [NAME] interview on 05/14/25 at approximately 2:00 PM, the Director of Rehab provided the OT Evaluation, and stated she had completed the evaluation for Resident #17. The Director of Rehab stated Resident #17 was not eating at the time of the evaluation. The Director of Rehab explained she was able to determine he could eat because he had range of motion in his upper extremities. The Director of Rehab stated she had not seen or heard of any issues with eating, until earlier that day during the interview with Staff A, COTA. During an interview on 05/14/25 at 3:20 PM, when asked if the facility had any adaptive equipment, the Dietary Manager stated, Not one piece. I've been here a year and have been asking for it because some of our residents need it, like (name of R#17). During an observation and interview on 05/15/25 at 9:27 AM, Staff B, COTA, was noted with Resident #17, to assess the resident for adaptive equipment. The resident was observed to cooperate and the COTA was providing the hand-over-hand assistance. The COTA stated, He definitely could benefit from a scoop plate or plate guard as he did better with the oatmeal in a bowl. The COTA also stated he could benefit from finger foods. Review of the Treatment Encounter Note by Staff B, dated 05/15/25, documented, in part, Patient would benefit from use of plate guards, sippie cup, and weighted utensils to maximize with feeding. Patient requires assistance when feeding.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, and record review, the facility failed to ensure proper nail care 1 of 4 sampled residents, Resident #6, reviewed for Activities of Daily Living (ADLs). The findings included: Review of the record revealed Resident #6 was admitted to the facility on [DATE] and admitted to Hospice services as of 05/06/23. Resident #6 had a diagnosis of having had a stroke that affected her left side. Review of the current Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. This MDS also documented the resident was substantially to totally dependent upon staff for all ADLs, except for eating. A current care plan initiated on 03/20/22, and revised 05/12/25, documented Resident #6 had an ADL self-care performance deficit functional decline. This care plan instructed staff to check the nail length of the resident, and to trim and clean the resident's fingernails on bath days and as necessary. Review of the bathing and showering schedule documented Resident #6 was to receive a shower on Tuesdays, Thursdays, and Saturday during the 3 PM to 11 PM shift. Review of the Certified Nursing Assistant's (CNAs) documentation, the progress notes, and additional care plans, all lacked any documentation related to nail care, or refusals of ADLS care, for Resident #6. During an observation on 05/12/25 at 12:10 PM, the right-hand fingernails of Resident #6 were longer than the fingernails of her left hand, extending beyond the end of the fingernail nearly a centimeter in length. Observation of the right hand revealed visible debris under the nails. The left hand was clean and trimmed. When asked if she eats with her right hand, Resident #6 stated, I've learned to eat with my left hand because my food tray is always put on my left side. Resident #6 at first stated she took care of her own fingernails, but then stated she gets help. The resident also stated a girl from Hospice painted her nails a while ago. Observation of the nails appeared as if most of the nail polish had worn off. On 05/13/25 at approximately 2:00 PM, and on 05/15/25 at 10:30 AM, the condition of the resident's nails remained the same. During an interview on 05/15/25 at approximately 10:45 AM, when asked who cares for the fingernails of Resident #6, Staff D, Licensed Practical Nurse (LPN) stated that Hospice provided bathing for Resident #6. When asked if facility staff provided bathing, the LPN stated they did as well. When asked again about the provision of nail care, the LPN stated she had seen activities do nail care every other weekend. When shown the care plan for cleaning and trimming nails on the resident's bath day, the LPN agreed the CNAs should be doing the nail care. The LPN observed the fingernails of Resident #6 and agreed with the concerns.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 52127 Based on observations and interviews, the facility failed to ensure daily staffing information included the number of nursing staff for 4 of 4 days and that it was posted for the correct date on 1 of 4 days. The findings included: During observations on 05/12/25, 05/13/25 and 05/15/25, the daily staffing information did not include the actual number of nursing staff and on 05/14/25 at 10:32 AM, the staffing information was from the previous day, 05/13/25 instead of 05/14/25. Photographic evidence obtained. During an interview on 05/15/25 at 2:41 PM, the owner of the building stated that the nurse on the 11:00 PM to 7:00 AM shift fills out the nurse staffing form and posts it on the wall near the entry door. The owner was advised that the form does not contain all the required information, and she agreed to address it with her staff to correct it.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, review of menus, and policy review, the facility failed to ensure the menu was developed for a mechanical soft diet, affecting 5 of 21 current residents, to include sampled Residents #15, #6, #17, #177, and #16. The findings included: Review of the policy Therapeutic Diets and Texture Modification dated 01/01/25, documented, in part, Policy Purpose: To ensure all residents receive appropriate nutrition that meets their medical, functional, and cultural needs through individualized therapeutic and texture-modified diets as ordered by a physician or registered dietitian. 6. Menu Planning: Menus are developed to accommodate various therapeutic diets and modified textures. On 05/12/25 at 11:00 AM, the Dietary Manager was asked to provide the menu for the current week, along with the extensions (supplemental information for different diet types). The Administrator provided the menu for the regular diet, along with a menu for the pureed diet, that documented to use the regular menu but to puree the food. During a second request on 05/13/25 at 2:36 PM, the Administrator was again requested to provide all of the menu extensions, to include the mechanical soft diet. The Administrator referred the surveyor to the Registered Dietitian (RD). During this continued interview, the RD stated she was hired in February of 2025, and upon signing off on the menus in March, she asked for the extensions and was told they used the same menus as the Assisted Living Facility, which did not include any extensions. The RD stated she immediately identified the issue, at which time management met and started getting proposals for a new dietary service. The Administrator provided a proposal from DiningRD through [NAME] Foods. The RD stated they don't yet have extensions as the company was going to provide a new menu with the extensions. The RD was asked to provide what the kitchen staff were currently using to make and prepare the mechanical soft meal. The RD stated she thought they were taking the regular menu and making the items to the correct texture or consistency, but she would check further. The RD also stated she believed the kitchen staff were encouraged to utilize Food for 50, a book that contained recipes for large groups of people. During the lunch meal observation on 05/14/25 beginning at 12:01 PM, the Dietary Manager confirmed the entree for the meal was a soft taco. Review of the menu documented the resident was to get two 3-ounce beef soft tacos. When asked for the recipe for the tacos, the Dietary Manager provided a recipe from the book Food for 50, that documented the use of hard taco shells. The Dietary Manager explained she uses the recipes in the book as a guide, but then modifies them for the residents, as she sees fit for the population in the facility. During the lunch service, those residents who consumed mechanical soft meals were served a soft roll in place of the observed soft tortilla. The Dietary Manager stated those residents on a mechanical soft diet could not tolerate the tortilla. When asked about the mechanical soft diet recipe, the Kitchen Manager stated she does not have recipes, but she does provide the correct consistency, from her experience. (continued on next page)

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	105875	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Skilled Nursing Facility LLC	2090 N Congress Ave West Palm Beach, FL 33401

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the lunch observation on 05/14/25 at approximately 12:45 PM, Resident #15 was served the mechanical soft meal of the taco meat and a roll. Upon receiving the meal, Resident #15 immediately stated, I wanted the taco. The Certified Nursing Assistant (CNA) who served her did not respond. A few moments later, Staff C, server, was in the dining room, and the resident again stated, I wanted the taco. The server simply and nicely stated, Mechanical soft can't have the taco. The resident stated, I guess it doesn't matter what I want. During a subsequent interview on 05/14/25 at 2:10 PM, when asked about the roll in place of the tortilla for the mechanical soft diets, the Kitchen Manager stated the nurses told her not to give the residents on the mechanical soft diets the tortilla, because they can choke on it. The Dietary Manager volunteered that at the previous facility she worked at, they did give a resident on the mechanical soft diet a soft tortilla. The Dietary Manager again confirmed she did not have any recipes for the mechanical soft diet. During a subsequent interview on 05/14/25 at 3:20 PM, when asked if they have had the menus with extensions during her year at the facility, the Dietary Manager stated, No. I've been in this business for [AGE] years and know what you are asking for. We haven't had those menu extensions or recipes since I've been here, but I've been providing the proper foods as best I can. During a phone interview on 05/15/25 at 12:09 PM, the RD agreed there was no menu for the mechanical soft diets, and agreed the facility did not have any standardized recipes to correspond to the daily menus. When asked if the soft tortilla would be appropriate for the residents on a mechanical soft diet, the RD would not say, but stated there were no menu extensions or recipes to determine the appropriate substitutions for alternate textures.

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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** 25404 Based on observation, interview, record review, and policy review, the facility failed to provide physician ordered liquid consistencies for 1 of 1 sampled resident, Resident #17, who was downgraded to nectar liquids. The findings included: Review of the policy Therapeutic Diets and Texture Modification dated 01/01/25 documented, in part, 2. Diet Orders: All diet and texture modifications must be physician-ordered. 4. Staff Responsibilities: Nursing staff must ensure correct diet trays are served. dietary staff must prepare and deliver food per ordered diet and texture. All team members must be trained to recognize and adhere to dietary orders. Review of the record revealed Resident #17 was admitted to the facility on [DATE]. Review of the orders revealed the resident was admitted on a regular diet with thin liquids. During an observation on 05/13/25 at 12:28 PM, Resident #17 was observed by staff drinking quickly with subsequent coughing. The Registered Dietician (RD) was noted speaking with the staff, and reported the nurse noted some coughing with the thin liquids, so she provided nectar thick liquids for his safety. A subsequent progress note and physician order documented the downgrade to nectar thick liquids, with a subsequent speech therapy consult. On 05/14/25 at 12:47 PM, Resident #17 was in the main dining room and served regular thin juice. When asked about the juice, Staff G, Certified Nursing Assistant (CNA) stated she served the thin juice because the menu ticket documented thin. Upon further review of the menu ticket, it was noted that both thin and nectar liquids were documented. Photographic Evidence Obtained. The CNA stated she did not see the nectar liquids. During an interview on 05/14/25 at 1:23 PM, Staff A, Certified Occupational Therapy Assistant (COTA) stated she had tried to observe the breakfast meal for Resident #17 that morning. The COTA stated the resident had finished, but did ask for some more juice, so she gave him OJ (orange juice). When asked if she provided him with regular OJ, the COTA stated she did. When asked if she was aware he was downgraded to nectar thick liquids the previous day, Staff A stated she was not and It would be nice if they would tell us that. During an observation on 05/15/25 at 9:27 AM, Staff B, COTA, was in the room of Resident #17, to evaluate the need for adaptive equipment. The COTA was assessing his ability to drink from a glass and assisted the resident with a glass of regular/thin juice. When asked if he was aware the resident had been downgraded to nectar thick liquids, the COTA stated he was not aware and continued to provide Resident #17 with the thin consistency juice.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52127 Based on observation, interviews, policy review, and record review the facility failed to ensure recommended diet upgrade was followed and communicated to staff for 1 of 3 sampled residents, Resident #16. The findings included: Review of the policy titled, Therapeutic Diets and Texture Modification implemented 01/01/25, documented, in part, the facility shall provide a variety of therapeutic and modified-texture diets as necessary to promote resident safety and maintain optimal nutritional status. All diets must be ordered by the attending physician and reviewed by the Registered Dietitian (RD). Review of record revealed that Resident #16 was admitted to the facility on [DATE]. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 13, on a 0-15 scale, indicating the resident was cognitively intact. Review of quarterly nutrition progress note dated 03/20/25, in part, Resident #16 reported a dislike of pureed diet texture, and that staff had referred Speech Therapy for evaluation of diet texture for possible upgrade. During an interview on 05/12/25 2:59 PM, Resident #16 stated, I would like to eat real chicken that is not pureed, I know I do not have teeth, but I can still eat regular food. When Resident #16 was asked if he had addressed this with staff, R#16 reported that he had worked with a therapist on eating and thought he was allowed to eat a regular texture. On 05/13/25 at 9:28 AM when Resident #16 was asked if he liked his breakfast he replied, It was good, and that he had [NAME] Krispies with milk, sausage and scrambled eggs even though I prefer a fried egg. Resident #16's meal ticket that was on his tray and listed diet as No added salt, Mechanical Soft, Thin Liquids and Preferences as fried egg. Photographic evidence obtained. On 05/15/25 at 9:16 AM Resident #16 had his tray on the bedside table and was upset because they gave him a Pureed breakfast and he stated that he was not going to eat it. An observation of his tray revealed that his meal ticket was not on the tray and Staff G, Certified Nursing Assistant (CNA) was asked where it was and she left the room and brought the ticket in and it had diet listed as No Added Salt, Thin Liquid, Pureed and Preferences as fried egg. Photographic evidence obtained. Resident #16 asked Staff G if she could get him his regular breakfast and she stated that she knows he usually has a fried egg and oatmeal and that she is not sure why they sent him pureed food. Review of record revealed that Resident#16 had a Speech Therapy Evaluation on 03/23/25 that documented, in part, that the patient's goals were that he will consume the least restrictive diet, with recommendations for diet as Thin Liquids, Mechanical Soft/ground textures for Solids. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 9:26 AM the Dietary Manager was confirming with the Director of Nursing (DON) Resident #16's diet orders and the DON advised the Dietary Manager that Resident #16's orders are for a Pureed Diet and that she will request a Speech Language Pathologist (SLP) consultation for Resident #16. The DON was then advised that there was a Speech Therapy Evaluation on 03/23/25 and treatment sessions on 03/29/25, 03/30/25, 04/03/25, 04/04/25, 04/05/25, 04/06/25, 04/11/25, 04/12/25, and 04/13/25 with documentation for a mechanical soft diet. The DON replied, That is a problem since the SLP should be updating orders if they change a diet. On 05/15/25 at 9:44 AM when the DON was asked Why aren't the recommendations for the diet being done? The DON replied, Because the SLP did not communicate with us. When the DON was asked if the SLP was available for an interview she replied that the SLP is a per diem staff member and that she had been unable to contact her.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39167 Based on policy review, observation, interview, and record review, the facility failed to adhere to infection control practices by failing to update the water management plan to include the appropriate team, failing to maintain linens in clean condition, failing to keep the laundry sorting area clean, and failing to disinfect blood pressure monitoring equipment after use. The findings included: 1) The Infection Prevention and Control Program policy, dated 05/12/25, indicated that a water management program has been established as part of the overall infection prevention and control program. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. The Maintenance Director serves as the leader of the water management program. The facility will conduct an annual review of the infection prevention and control program, including associated programs, policies, and procedures, based upon the facility assessment, which includes any facility and community risk. Following review, the infection control program will be updated as necessary. The infection control program, including the water management plan, was reviewed on 05/14/25 at 9:23 AM. It was revealed that the facility had reviewed the program on January 02, 2025, but the water management plan had not been updated to reflect the current program management team members. The plan included a table of contents with the names of the program management team. Each team member was assigned specific roles and responsibilities. The program recorded three team members: the Executive Director (ED), the Maintenance Director, and the Director of Nursing (DON). However, the water management program included the previous ED's name as one of the team members, even though this individual no longer worked at the facility. The most recent ED had been employed at the facility for about three years, but her name was not included in the plan. The recorded ED was designated as the team manager of the water management plan, responsible for overall program compliance and reporting to other parties within or outside the organization. Additionally, this individual was tasked with providing executive oversite and was responsible for reporting suspected or confirmed cases of Legionnaires disease to the appropriate organizational stakeholders. The water management plan also recorded a name for the Maintenance Director, which did not match the name of the current Maintenance Director. It was determined that the individual listed as the Maintenance Director no longer worked at the facility. This person was assigned as the team lead, responsible for the overall implementation of the program design for the systems and the daily operation, maintenance, and monitoring duties of the program. Similarly, the water management plan included a name for the DON that did not correspond with the current DON's name. It was confirmed that this individual also no longer worked at the facility. The recorded DON had been assigned as team 1, responsible for the overall implementation of the program design for the systems and the daily operation, maintenance, and monitoring duties of the program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/25 at 9:59 AM, an interview was conducted with the Maintenance Director, who revealed that he had been working at the facility for six months. When asked about the water management program and how he oversees it, he mentioned that he only checks the water temperature to ensure that it is hot; nothing else. He added that he might have a book somewhere regarding the program. During a side-by-side review of the water management plan the Maintenance Director acknowledged the concerns. On 05/14/25 at 1:08 PM, an interview was held with the current Director of Nursing (DON), who revealed she has worked at the facility since January 2025 and served as the Infection Preventionist. When the surveyor asked her about her role and responsibilities in the water management program, she stated that she does not have a role in it and has not had a meeting regarding the program. She mentioned that the previous Nursing Home Administrator (NHA), who had been at the facility for three years, handled everything related to it before leaving last week. However, she continues to work remotely as a consultant. The surveyor then showed the DON the water management plan containing incorrect team names. The surveyor informed her that the infection control program and policies had been reviewed in January 2025, with her signature recorded on it. The surveyor asked why the water management plan had not been updated to reflect the current team members. The DON agreed that the names were incorrect and acknowledged that the plan should have been updated in January 2025 when the current management team reviewed it. 2) On 05/14/25 at 1:43 PM, a tour was conducted in the laundry area with the Maintenance Director. On top of the two commercial dryers were heavily soiled with dust. These dryers were located immediately across from the sorting area for clean linens, which posed a potential contamination risk to the linens. In the laundry, there were also two commercial washing machines; one was in disrepair, rusty, soiled, and the bottom part was falling apart. At 1:52 PM, a large linen cart with clean linens was observed in the hallway. The material covering the linen cart was heavily soiled as well. The Maintenance Director acknowledged these findings. At 2:02 PM, another interview was held with the DON, who was made aware of the infection control-related concerns. 3) On 05/13/25 at 9:21 AM, medication administration was observed with Staff E, a registered nurse. During this time, she utilized blood pressure monitoring equipment to assess a resident's vital signs. Following the completion of this assessment, it was noted that the equipment was returned to the medication cart without undergoing disinfection.