STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106062	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentley Care Center	875 Retreat Drive Naples, FL 34110

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review the facility failed to treat each resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her life, recognizing each resident's individuality for 2 of 21 sampled residents (Residents #26 and #18) The findings included: 1. Record review for Resident #26 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Pneumonia Unspecified Organism and Unspecified Severe Protein-Calorie Malnutrition. Review of the Minimum Data Set for Resident #26 dated 10/30/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. On 11/18/24 from 11:50 AM until 12:20 PM an observation was made of Resident #26 sitting up in her bed. Staff D Registered Nurse (RN) came into the resident's room to take her vital signs (Temperature, pulse, blood pressure, respiration). She called the resident honey twice upon entering the room and addressing the resident. Staff D RN then offered to wrap the resident's legs with ace wrap and while doing so said to the resident, careful of your hands honey. Then called the resident honey again when she was done wrapping the resident's legs. Staff D RN called the resident honey after she was done answering the resident's questions by saying okay honey. During an interview conducted on 11/19/24 at 2:30 PM with Resident #26 who was asked about the Staff D RN calling her honey several time the previous day, the resident put her head down and said, I don't like that and I wish they wouldn't do it, but I don't want to say anything. The resident then went on to add that is not the worst, she said when the Nurse Practitioner comes to see her, he gets real close to her face which she does not like and then he always pats her on the head like a small child. She said I don't think he realizes it is very patronizing and I am sure he is just trying to be tender but I don't like it. Again she stated she does not want to say anything. During an interview conducted on 11/19/24 at 10:45 AM with Staff C Licensed Practical Nurse (LPN) who was asked about calling residents honey or sweetie she said they don't like you calling them those types of names, it is to much like a friend or coming onto them. We are here to help the residents, and it may be considered a dignity issue. She said, They are not kids, and I am not their spouse. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Urinary Tract Infection Site Not Specified, Neuromuscular Dysfunction of Bladder Unspecified, Presence of other Specified Devices Note: Indwelling Catheter. Review of the Minimum Data Set for Resident #18 dated 11/12/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. On 11/20/24 10:55 AM an observation of catheter care provided by Staff H Certified Nursing Assistant (CNA) for Resident #18, Staff H CNA put on gloves and gown, gathered supplies, approached the resident asked the resident their name and stated let me check your name band sweetie. During an interview conducted on 11/20/24 at 11:18 AM with Staff H CNA who stated she has worked at the facility for [AGE] years. When asked if residents are ever referred to as sweetie or honey, she said that it is my mistake, I love all my patients like family I even call some mama and [NAME].

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Keep residents' personal and medical records private and confidential. 39026 Based on observation and interview, the facility failed to maintain resident privacy by posting signs with private medical information on the entrance doors to their rooms. This affected 12 residents in the final sample (Residents #4, #9, #14, #16, #17, #22, #26, #38, #43, #53, #55, and #211) with the potential to affect 27 additional residents in the facility with signs on their doors. The findings included: During the initial tour of the facility on 11/18/24 at 9:15 AM, the surveyor observed signs on resident rooms on the second and third floor of the facility. 39 rooms had signs posted that indicated fall risk, general caution, caution oxygen, swallow caution, sight impaired, hearing impaired, and/or no additional liquids. Resident #4's posted sign on the entrance to her room stated Fall risk, Hearing impaired, Swallow caution and General caution. Resident #9's posted sign stated Fall risk. Resident #14's posted sign stated Fall risk, General caution. Resident #16's posted sign stated Fall risk, Caution oxygen. Resident #17's posted sign stated Fall risk. Resident #22's posted sign stated Fall risk, Sight impaired, General caution. Resident #26's posted sign stated Caution oxygen, Swallow caution. Resident #38's posted sign stated Fall risk, General caution. Resident #43's posted sign stated Fall risk, Hearing impaired, General Caution. Resident #53's posted sign stated Fall risk. Resident #55's posted sign stated No additional liquids. Resident #211's posed sign stated Fall risk, Caution oxygen. An interview was conducted with the Director of Nurses (DON) on 11/20/24 at 8:47 AM. She stated when she started working at the facility she didn't think the signs should be there. She is unaware who is pulling out the signs. It could be a certified nursing assistant or a nurse but she is the risk manager and she is not doing that. She stated that some signs don't even match the resident. She agreed that they should not be there.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observation, interview, and record review the facility failed to ensure services provided (Administration of Intravenous [IV] medication) meet professional standard of quality for 1 of 12 Licensed Practical Nurses (LPNs) employed by the facility for 1 of 1 resident with Peripherally Inserted Central Catheter affecting Resident #264. The findings included: Review of the Florida Board of Nursing located at the web address: https://floridasnursing.gov/administration-of-intravenous-therapy-by-licensed-practical-nurses/ Included in part the following: CHAPTER 64B9-12 ADMINISTRATION OF INTRAVENOUS THERAPY BY LICENSED PRACTICAL NURSES 64B9-12.005 Competency and Knowledge Requirements Necessary to Qualify the LPN to Administer IV Therapy. (1) The course necessary to qualify a licensed practical nurse or graduate practical nurse to administer IV therapy shall be not less than a thirty (30) hour post-graduation level course teaching aspects of IV therapy. The didactic intravenous therapy education must contain the following components: (a) Policies and procedures of both the Nurse Practice Act and the employing agency in regard to intravenous therapy. This includes legalities of both the Licensed Practical Nurse role and the administration of safe care. Principles of charting are also included. (b) Psychological preparation and support for the patient receiving IV therapy as well as the appropriate family members/significant others. (c) Site and function of the peripheral veins used for veinpuncture. (d) Procedure for veinpuncture, including physical and psychological preparation, site selection, skin preparation, palpation of veins, and collection of equipment. (e) Relationship between intravenous therapy and the body's homeostatic and regulatory functions, with attention to the clinical manifestations of fluid and electrolyte imbalance. (f) Signs and symptoms of local and systemic complications in the delivery of fluids and medications and the preventive and treatment measures for these complications. (g) Identification of various types of equipment used in administering intravenous therapy with content related to criteria for use of each and means of troubleshooting for malfunction. (h) Formulas used to calculate fluid and drug administration rate. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(i) Methods of administering drugs intravenously and advantages and disadvantages of each. (j) Principles of compatibility and incompatibility of drugs and solutions. (k) Nursing management of the patient receiving drug therapy, including principles of chemotherapy, protocols, actions, and side effects. (l) Nursing management of the patient receiving blood and blood components, following institutional protocol. Include indications and contraindications for use; identification of adverse reactions. (m) Nursing management of the patient receiving parenteral nutrition, including principles of metabolism, potential complications, and physical and psychological measures to ensure the desired therapeutic effect. (n) Principles of infection control in IV therapy, including aseptic technique and prevention and treatment of iatrogenic infection. (o) Nursing management of special IV therapy procedures that are commonly used in the clinical setting, such as heparin lock, central lines, and arterial lines. (p) Glossary of common terminology pertinent to IV fluid therapy. (q) Performance check list by which to evaluate clinical application of knowledge and skills. (2) Clinical Competence. The course must be followed by supervised clinical practice in intravenous therapy to demonstrate clinical competence. Verification of clinical competence shall be the responsibility of each institution employing a licensed practical nurse based on institutional protocol. Such verification shall be given through a signed statement of a licensed registered nurse. (3) Central Venous Lines (CVL) and Peripherally Inserted Central Catherer (PICC) Lines. The Board recognizes that through appropriate education and training, a Licensed Practical Nurse is capable of performing intravenous therapy via central and PICC lines under the direction of a registered nurse or other health care practitioner as defined in subsection 64B9-12.002, F.A.C. Appropriate education and training requires a minimum of four (4) hours of instruction. The requisite four (4) hours of instruction may be included as part of the thirty (30) hours required for intravenous therapy education specified in subsection (4) of this rule. The education and training required in this subsection shall include, at a minimum, didactic and clinical practicum instruction in the following areas: (a) Central venous anatomy and physiology; (b) CVL and PICC site assessment; (c) CVL and PICC dressing and cap changes; (d) CVL and PICC flushing; (e) CVL and PICC medication and fluid administration; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(f) CVL and PICC blood drawing; and, (g) CVL and PICC complications and remedial measures. Upon completion of the intravenous therapy training via central and PICC lines, the Licensed Practical Nurse shall be assessed on both theoretical knowledge and practice, as well as clinical practice and competence. The clinical practice assessment must be witnessed by a Registered Nurse who shall file a proficiency statement regarding the Licensed Practical Nurse's ability to perform intravenous therapy via central lines. The proficiency statement shall be kept in the Licensed Practical Nurse's personnel file. During a review of Staff B Licensed Practical Nurse (LPN) personnel file it was determined there was no IV Certification for the LPN. The job description for Staff B LPN dated 05/20/18 included under section titled Pricipal Accountabilities/Essential Job Functions: Performs clinical and technical aspects of care in accordance with established policies, protocols, standards of care and practice, regulatory mandates and within limits of the respective State Nurse Practice Act. Record review for Resident #264 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Acute and Subacute Infective Endocarditis, Bacteremia, Sepsis due to Methicillin Susceptible Staphylococcus Aureus, Nonrheumatic Aortic (Valve) Stenosis, Bacterial Infection Unspecified. Review of the Minimum Data Set for Resident #264 dated 11/08/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. On 11/19/24 at 8:40 AM an observation of medication pass with Staff B LPN for Resident #264 for the medication Cefazolin 2mg/100ml IV over 30 minutes. The nurse performed hand hygiene, gathered supplies, applied a gown and gloves, assessed the PICC access site, spiked medication with tubing, inserted tubing into pump, primed tubing with pump, flushed the PICC access after wiping with alcohol, connected tubing, programed pump and infusion started. The nurse removed gown and gloves and performed hand hygiene. During an interview conducted on 11/20/24 at 10:30 AM with the Director of Nursing (DON) who was asked if Staff B LPN had IV Certification, she said she should have it in her personnel file. The DON was asked for a copy of the IV certification for Staff B LPN (None was provided). During an interview conducted on 11/20/24 at 2:30 PM the Administrator was asked for the IV certification for Staff B LPN and stated they were not able to provide the IV certification. The Administrator said when they asked Staff B LPN to provide a copy of her IV certification, Staff B LPN gave her resignation effective immediately. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 11/21/24 at 9:28 AM the Director of Human Resources stated he has worked for the organization for about 3.5 years. When asked who would be in charge of ensuring credentials for staff such as LPNs, he stated upon screening during interview process they make sure all licenses are current. When asked about specialized certification to perform a specific function on their job, such as IV Certification he stated, In accordance with the first bullet point of job description for staff they perform clinical and technical aspects of care in accordance with established policies, protocols, standards of care and practice, regulatory mandates and within limits of the respective State Nurse Practice Act. The Director of Human Resources provided a copy of Staff B LPN signed job description dated 05/20/18. The Director of Human Resources went on to say we would expect the staff member to follow standard care of practice and regulatory mandates and limits of the respective state nurse practice act and would expect every employee to perform their job functions/duties within their scope of practice and licensure and certification, and if they had a conflict within that regard, the expectation is to put resident care as priority and alert appropriate personnel with their concern. The employee has many ways to alert the appropriate personnel; they could alert a supervisor, the administrator or compliance hotline, identifiable or anonymously. The Director of Human Resources acknowledged there was no IV certification in the Staff B LPN's personnel file.

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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** 01948 Based on observation, interview, and record review it was determined that the facility failed to assess and provide adaptive eating utensils and drinking cups to maintain independence in eating ability for 1 (Resident #43) of six residents reviewed for nutrition. The findings included: Observation of the lunch meal on 11/18/24 at 12:30 PM noted Resident #43 eating in the second floor Main Dining Room and was served a served a Regular diet. Continuous observation noted the resident to have shaking and tremors when attempting to eat independently. Specifically the resident would spill food from use of regular silverware, and would press the glass cup against his nose and face to decrease hand shaking/tremors. A review of the clinical record of Resident #43 on 11/18/20/24 noted an admitted [DATE] with diagnoses that included Parkinson's Disease with Dyskinesia (involuntary movements), and Dementia. Further review noted a physician order dated 12/20/23 for a Regular diet and Ensure Lactose Reduced 8 ounces every day. Current Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status Score of 4 (Cognitive Impairment) and required set up with eating. Current care plan dated 10/17/24 documented risk for malnutrition due to Parkinson's Disease with Dyskinesia (no intervention for adaptive eating or drinking equipment). Review of weights noted a nine pound weight loss from 183 pounds on 10/15/24 to 173 pounds on 11/06/24. Review of nutrition progress note dated 03/20/24 documented Resident #43 with diagnoses of Parkinson's Disease with Tremors. On 11/19/24 the surveyor met with the facility's administrator and discussed the resident's issues with shaking and tremors and the lack of use of adaptive eating and drinking equipment. The administrator stated that Resident #43 would be screened by Occupational Therapy and the finding would be presented and discussed with the surveyor. Observation of the lunch meal conducted on 11/20/24 at 12:30 PM noted that the Occupational Therapist was screening the Resident #43 in the Second Floor Dining Room. In an interview during the screening the therapist stated that she was screening for the use of weighted utensils, however a weighted knife was not included in the screening. When asked why a weighted knife was not being screened for use as well adaptive drinking cups such as Sippy or [NAME] Cup, the therapist responded that she was only screening for the adaptive equipment (weighted silverware). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the screening observation it was noted that a sandwich was the main entree along with French Fries, Salad, and Ice Cream. During the screening it was noted that the resident utilized the weighted silverware to eat independently the French Fries, Salad, and Ice Cream. It was noted that the resident was drinking cold beverages from glass containers and pressing the glass against his nose and mouth which was a safety concern. Also noted that the hot coffee was served in a china cup posing a danger of burn from spilling hot coffee onto the clothing protector. Following the screening the therapist requested a copy of the resident's 11/20/24 screening. On 11/20/24 a copy of Resident #43's Occupational Therapy Screen Form dated 11/20/24 was provided. Review of the screening noted the following documentation : Screen completed in dining room. Able to eat sandwich. Presented with weighted utensils and instructed on use. Recommend use of straws for liquids and Sippy Cup, and use of weighted utensils versus regular utensils. Following the screening the findings were discussed with the administrator and confirmed that Resident #43 required adaptive eating and drinking equipment to maintain safety and maintain independence self feeding.

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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 record review, review of facility's policy and procedure, resident and staff interviews, the facility failed to ensure nutritional assessments were completed accurately with appropriate interventions in place for 3 of 6 residents reviewed for nutrition (Residents #55, #6 and #26). The findings included: A review of the policy titled, Weight Management Protocol, revised in March 2021, showed that Resident intake of ordered snacks and ordered supplements is monitored. If intake is less than 50% in a 24-hour period for 3 days, the healthcare provider, with prescriptive authority and Dietitian, will be notified. It further showed educated diet and the importance of intake. A review of the Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist by the Academy of Nutrition and Dietetics showed the following: Roles of Registered Dietitian Nutritionists (RDNs), whose practice involves nutrition care, Medical Nutrition Therapy, and nutrition-related services use knowledge, skills, evidence-based information and research, critical thinking, and clinical judgment to address health promotion and wellness, and prevention, delay, or management of acute or chronic diseases and conditions. It further showed that the RDN identifies evidence-based screening criteria/tools according to the patient/client population (adult or pediatric), collaborates for incorporation into the health record system when others complete screening, and reviews reported nutrition screening data or incorporates screening into nutrition assessment. 1. A chart review revealed that Resident #55 was admitted on [DATE] with diagnoses of acute kidney failure and anemia and was on hemodialysis. The 5-day Minimum Data Set (MDS) dated [DATE] revealed that Resident #55 had a Brief Interview of Mental Status (BIMS) score of 15, which was cognitively intact. A review of the Physician's orders showed the following: An order for dialysis on Tuesdays, Thursdays, and Saturdays, which was dated 09/24/24. An order for fluid restriction was 1260 milliliters (ml) a day with 660 ml for nursing and 600 ml allocated for dietary, which was dated 10/4/24. A review of the Initial Nutrition assessment dated [DATE] which was completed by the facility's Certified Dietary Manager (CDM) showed the following: Estimated required nutritional needs were estimated at 1671 calories, 61 grams of protein and 2138 ml of fluids daily. It further revealed that Resident #55 was triggered at risk for malnutrition and that she was going to be educated on dietary restrictions. The initial nutritional assessment was not reviewed or signed as completed by the Consultant Dietitian. A follow-up progress note dated 09/25/24 (completed by the CDM) revealed that the CDM reached out to the dialysis center and left a message but did not get a callback. A follow-up note dated 10/2/24 (completed by the CDM) revealed that Resident #55 was on 1260 ml fluid restrictions, with 600 ml allocated for dietary intake. On this note, the CDM did not adjust the daily fluid needs of 2138 ml on 09/22/24 to reflect the fluid restrictions. It further showed that Resident #55 was not educated on the fluid's restrictions. The CDM did not attempt to reach out again to the dialysis Dietitian to discuss a nutritional plan of care for Resident #55. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 11/19/24 at 2:23 PM with the facility's CDM, she stated that she estimated the daily nutritional needs of Resident #55 based on their height, weight, and age. When asked about the daily fluid needs estimated on 09/22/24, she said that she made a mistake and that it should have been around 1690 ml fluids a day and not 2138 ml. When asked why she did not update the Resident's fluid needs to reflect the fluid restrictions as per the doctor's order, she did not have an answer. 2. In an interview conducted on 11/18/24 at 11:35 AM with Resident #6 she said that her appetite was not what it used to be and that she was eating about 50% of her meals and only drank one boost supplement which is as much as she can tolerate at this time. The chart review revealed that Resident #6 was admitted on [DATE] with diagnoses of dysphagia (impaired swallowing) and cerebral infarction. The Mini Nutritional Assessment completed on 09/29/24 revealed that Resident #6 was scored as malnourished. The Initial Nutritional Assessment completed on 09/29/24 by the CDM showed the following: Intake of meals noted at 25% to 75% and a history of 20 pounds weight loss in 6 months. In this assessment the CDM calculated Resident #6's estimated calories needs at 1671, 6 grams of protein and 2022 fluids a day. A review of the Physician's order showed an order for Boost (nutritional supplement) twice a day which was dated 10/01/24. The care plan dated 09/29/24 revealed that the patient would be monitored and recorded food intake and provided with Boost supplements twice a day. The goal for Resident #6 was to have no signs of malnutrition and dehydration, stop weight loss, and improve meal intake. A review of the Medication Administration Record from 10/1/24 to 10/31/24 revealed that Resident #6 was given the Boost supplement twice a day, but the percentage consumed was not documented each day. Further review of the Certified Dietary Assistants under Vital in the electronic system showed that from 10/19/24 to 11/18/24, missing data was noted for Breakfast, Lunch, and Dinner on multiple days. In an interview conducted on 11/19/24 at 2:23 PM the facility's CDM stated that she reviewed the Certified Dietary Assistants for intake of meals and will sometimes speak to the nursing staff regarding Resident #6's intake of meals. When asked why the percent intake of the Boost was not documented, she stated that it is not always recorded and that she would speak to nursing staff regarding the daily intake of the supplements. 41837 3. Record review for Resident #26 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Pneumonia Unspecified Organism and Unspecified Severe Protein-Calorie Malnutrition. Review of the Minimum Data Set for Resident #26 dated 10/30/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Mini Nutrition Assessment for Resident #26 dated 10/24/24 documented that the CDM assessed the resident with following estimated needs scored 5 indicating malnutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nutritional Assessment for Resident #26 dated 10/24/24 revealed the CDM who completed the initial assessment estimated the following: kal 1238, protein 35 gr fluids 1060 ml. Review of the Physician's orders revealed an order for Resident #26 dated 10/24/24 Offer snack and hydration three times daily Three Times A Day 09:00 AM - 11:00 AM, 02:00 PM - 04:00 PM, 07:00 PM - 09:00 PM Review of bedtime snack for Resident #26 from 10/23/24 to 11/20/24 documented under vitals section a bedtime snack was only given to the resident once on 10/28/24 at 5:54 PM. Review of the Care Plan for Resident #26 dated 10/24/24 with a problem of the resident is malnourished diagnosis of COPD (Chronic Obstructive Pulmonary Disease), CKD (Chronic Kidney Disease) dysphagia, weight loss. The goal was for resident to consume meals with least restrictive diet as able, working with speech therapy, stop weight loss, maintain above 77 pounds and gain 1-2 pounds per week through next review. The approaches included in part the following: Diet Regular, ground meat, no raw fruits/vegetables, thin liquids. Encourage po (oral) intakes of meals/fluids and snacks as appropriate. Honor food preferences as able per resident's wishes. Monitor and document intake of meals and fluids. Monitor and record weight weekly. Monitor lab work as ordered. Provide 8oz strawberry Ensure twice daily 10:00 AM and 2:00 PM. Provide a selective diet menu following the prescribed regime. During an interview conducted on 11/18/24 at 11:50 AM Resident #26 stated she was concerned because she did not eat a lot of food and it was a long time between meals. She said dinner comes between 5:30 PM to 6:00 PM and breakfast does not come until 7:00 AM to 7:30 AM. When asked if they offer her a bedtime or evening snack, she said no. If she asks for a snack they will bring it to her and she has asked once in a while. (continued on next page)

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	106062	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentley Care Center	875 Retreat Drive Naples, FL 34110

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 11/21/24 at 12:42 PM with the Certified Dietary Manager (CDM) who was asked about Resident #26, the CDM stated her observations were documented in the assessments (the Mini Nutritional Assessment and the Nutritional Assessment) both dated 10/24/24. The resident had a BMI (Body Mass Index) of 13 and the screening indicated the resident had a score of 5 which indicated malnutrition. The CDM stated the resident was 78 pounds and was a high risk resident. The CDM said she estimated to meet the resident's needs as follows: 1238 calories, 35 grams of protein, and 1060 milliliters for fluids. The CDM stated she uses the [NAME] nutrition tool to estimate the needs of the resident by entering the resident's height, weight and age. The CDM stated she uses a formulary that was given to her by the Registered Dietician for the facility and she just plugs in the resident's height, weight and age and it will give the values for the estimated calories, protein, fluids. When asked if she should go by ideal body weight, the CDM stated I may have gone by what the resident stated to her ideal body weight was which was underweight. When asked if there was any additional nutritional assessment for resident, the CDM stated no but there should have been. When asked if she discussed the resident's preferences, she stated if she did, it would be in the care plan and the menu system they have. The CDM was asked if she had done any follow up for the resident, she stated she did, but did not document it anywhere. She stated the resident had told her appetite had improved and was due to being on pureed diet. She acknowledged she did not follow up on snack intake or supplement consumption and was only told in care meeting Resident #26's intake was better. The CDM stated she does not check up to see if supplements or snacks were received or consumed. When asked if a percentage for supplements are documented in the resident's chart, she said they may be it would depend on the order. She will look at the medical record for percentage consumed, and if it is not documented, she will ask the resident and ask nursing staff about supplements consumed. The CDM stated for Resident #26 the reg portion diet 1800 to 2000 calories and the resident is only consuming 25%, she was asked what is 25% of 1800, she stated it would be 450 (this is the estimated calories the resident is consuming from her diet). When asked how many calories are in each supplement, she said 280 and she receives 2 supplements a day which would be 560 calories. When asked, the CDM acknowledged the dietary consumption of 450 calories and if the resident is consuming the full amount of the supplements would come out to be a total of 1010 calories which is far less than the lowest estimated needs of 1800 calories. The CDM acknowledged this was less than what she had estimated for the resident. When asked what snacks are provided for residents yogurt, cookies, pudding, banana, fruit, coffee, soda, she said specific snacks are not provided to specific resident and she does not follow to make sure they do not have a snack roster. The CDM said she was the only person to monitor weights, and the resident had gained 2 pounds. The CDM said she will communicate weekly with RD but not about specific residents, she just communicates about generalities. During an interview conducted on 11/21/24 at 1:20 PM with Staff F Registered Nurse who stated the CNAs (Certified Nursing Assistants) passed the snacks to the residents. During an interview conducted on 11/21/24 at 1:25 PM with Staff G CNA who stated she has worked at the facility for 4 months. When asked about passing snacks to residents, she stated she does not pass snacks, the other CNAs do that. During an interview conducted on 11/21/24 1:30 PM Staff E CNA who stated she has worked at the facility for [AGE] years. When asked about passing snacks, she stated she passes snack for some resident but not all of them on her floor, other CNAs also pass snacks. She helps her resident open their snack and will document if they get the snack.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interview and record review the facility failed to transcribe the physician's order agreeing to pharmacy recommendation for psychotropic medication for 1 of 5 sampled residents for unnecessary medication affecting Resident #22. The findings included: Record review for Resident #22 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Dementia, Anxiety and Depression. Review of the Minimum Data Set for Resident #22 dated 06/12/24 documented in Section C a Brief Interview of Mental Status score of 0 indicating severe cognitive impairment. Review of the Consultant Pharmacist Recommendations to Physician for Resident #22 dated 09/29/24 included the following: Recommend discontinue PRN (as needed) use of Chlordiazepoxide HCl. Physician Response: Evaluation for the appropriateness of use of Chlordiazepoxide PRN has been completed. Non-pharmacological interventions have failed multiple times. Continuing PRN use of Chlordiazepoxide prescribed for Anxiety for 90 days as the benefit outweigh the risk. Signed by the Physician on 10/01/24. Review of the Physician's Orders for Resident #22 revealed an order dated 09/17/24 for Chlordiazepoxide HCl capsule; 10 mg; amt: 1 capsule; oral at bedtime PRN (as needed) and was open ended with no stop date. This indicated the order signed by the Physician on 10/01/24 on the Consultant Pharmacist Recommendations was not transcribed to the resident's record. During an interview conducted on 11/21/24 at 11:14 AM with the Director of Nursing (DON) who was asked about unnecessary medications for residents, the DON stated they have a gradual dose reduction (GDR) meeting held monthly with herself, 2 Social Workers, the Psychiatric Advanced Practice Registered Nurse (APRN), and the Unit Manager. Sometimes the Administrator and/or the resident's family member will also attend. They discuss the various medications and the pharmacy recommendations. The attending physician is aware of meetings but refers for the facility to discuss recommendations with the Psych APRN during the GDR meeting. After the GDR meeting the DON will inform the Physician of recommended changes and will take a telephone order from the Physician and she will enter the order into the resident's record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observations, interviews, and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days for 2 of 5 sampled residents for unnecessary medication (Residents #22 and #53). The findings included: The facility's policy titled Psychotropic Medication Use revised July 2022, revealed For psychotropic medications that are not antipsychotics: if the prescriber or attending physician believes it is appropriate to extend PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 1. Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses that included Cerebral atherosclerosis exacerbation and Vascular dementia. A chart review revealed a Physician order for Ativan (lorazepam) 0.5 milligrams (mg) give 1 tablet as needed every 6 hours with no stop date. Special Instructions: Monitor for side effects such as Nausea, unable to sleep, dry mouth, constipation. Evaluation for the appropriateness of use of Ativan PRN has been completed. Non-Pharmacological interventions have failed multiple times. Continue PRN use of Ativan, as the benefit outweighs the risk. The start date for this order was 11/07/24 and the last pharmacy review was done 10/29/24. This order was not evaluated by the consultant pharmacist. An interview was conducted with the consultant pharmacist on 11/20/24 at 11:30 AM. She stated prn psychotropics need a stop date per the regulation and she has had the discussion with the facility to have a stop date for these medications. The person should be evaluated in 14 days after the prn was ordered and then ordered for additional days. A subsequent interview was conducted with the consultant pharmacist with the Director of Nursing (DON) present on 11/20/24 at 12:10 PM. She stated the facility just spoke with the physician and the prn Ativan was discontinued due to non-use. 41837 2. Record review for Resident #22 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Dementia, Anxiety and Depression. Review of the Minimum Data Set for Resident #22 dated 06/12/24 documented in Section C a Brief Interview of Mental Status score of 0 indicating severe cognitive impairment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #22 revealed an order dated 09/17/24 for Chlordiazepoxide HCl (a psychotropic medication) capsule; 10 mg; amt: 1 capsule; oral at bedtime PRN (as needed) and was open ended with no stop date. Review of the Consultant Pharmacist Recommendations to Physician for Resident #22 dated 09/29/24 included the following: Recommend discontinue PRN use of Chlordiazepoxide per the following guideline: In accordance with State and Federal Guidelines, revised regulation 483.45 Euro F Tag 758, Psychotropic Drugs PRN, orders for psychotropic drugs are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the prn order to be extended beyond 14 days. Then he or she should document the rationale in the resident's medical record and indicate the duration for the PRN order. Physician Response: Evaluation for the appropriateness of use of Chlordiazepoxide PRN has been completed. Non-pharmacological interventions have failed multiple times. Continuing PRN use of Chlordiazepoxide prescribed for Anxiety for 90 days as the benefit outweigh the risk. Signed by the Physician on 10/01/24. Review of the Listing of Residents Reviewed with no recommendations dated 10/31/24 documented Resident #22 was reviewed during the consultant pharmacist's visit, but did not require any recommendations. This should have had a recommendation of the Chlordiazepoxide HCl (a psychotropic medication) was continued to be prescribed PRN for more than 14 days and did not have an end date. During an interview conducted on 11/21/24 at 11:14 AM with the Director of Nursing (DON) who was asked about unnecessary medications for residents, the DON stated they have a gradual dose reduction (GDR) meeting held monthly with herself, 2 Social Workers, the Psych ARNP, and the Unit Manager. Sometimes the Administrator and/or the resident's family member will also attend. They discuss the various medications and the pharmacy recommendations. The attending physician is aware of meetings but refers for the facility to discuss recommendations with the Psych APRN during the GDR meeting. After the GDR meeting the DON will inform the Physician of recommended changes and will take a telephone order from the Physician and she will enter the order into the resident's record. The DON and the Consulting Pharmacist identified Chlordiazepoxide HCl (a psychotropic medication) for Resident #22 continued to be PRN with no stop date and should have been identified as such on the Consultant Pharmacist Review completed on 10/31/24.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on interviews and record reviews, the facility failed to ensure that clinical nutritional assessments were completed within the scope of practice and failed to ensure appropriate competencies in accordance with standards of practice for 5 of 6 residents reviewed for nutrition (Residents #55, #6, #14, #43, and #26). This had the potential to affect 67 residents on the facility's current census. The findings included: A review of the Certified Dietary Manager (CDM) scope of practice dated March 2022 showed the following: Gather Nutrition Data. Interview and identify client-specific nutritional needs/problems. Review nutrition screening data and calculate nutrient intake. Document in the medical record. Identify food customs and nutrition preferences based on race, culture, religion, and food intolerances. Utilize standard nutrition care procedures following ethical and confidentiality principles and practices. Participate in care conferences and review the effectiveness of nutrition care. Provide nutrition education. A Review of the Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist by the Academy of Nutrition and Dietetics showed the following: The Registered Dietitian is responsible for reviewing reported nutrition screening data or conducting nutrition screening, if applicable; completing nutrition assessments; determining the nutrition diagnosis or diagnoses; developing care plans; implementing the nutrition intervention; evaluating the patient's/client's response; and supervising the activities of professional, technical, and support personnel assisting with the patient's/client's nutrition care. They also assign duties that are consistent with the individual scope of practice. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Record review showed that Resident #55 was admitted to the facility on [DATE] with diagnoses of acute kidney failure and anemia and is on hemodialysis. The initial nutrition assessment was conducted on 09/22/24 and was completed by the facility's CDM. In this assessment, the CDM estimated the daily estimated (calories, protein, fluids) to meet Resident's #55 nutritional needs. The assessment was signed and completed by the CDM with no oversight or review by the Consultant Dietitian. 2. Record review revealed that Resident #6 was admitted on [DATE] with diagnoses of dysphagia and cerebral infarction. The initial nutrition assessment was conducted on 09/29/24 and was completed by the facility's CDM. In this assessment, the CDM estimated daily (calories, protein, fluids) to meet Resident's #55 nutritional needs. The assessment was signed and completed by the CDM with no oversight or review by the Consultant Dietitian. 3. Record review revealed that Resident #14 was admitted on [DATE] with diagnoses of dementia and protein-calorie malnutrition. The initial nutrition assessment was conducted on 02/14/24 and was completed by the facility's CDM. In this assessment, the CDM estimated the daily estimated (calories, protein, fluids) to meet Resident's #14 nutritional needs. The assessment was signed and completed by the CDM with no oversight or review by the Consultant Dietitian. 4. Record review revealed that Resident #43 was admitted on [DATE] with diagnoses of dementia and major depressive disorder. The initial nutrition assessment was conducted on 12/21/23 and was completed by the facility's CDM. In this assessment, the CDM estimated the daily estimated (calories, protein, fluids) to meet Resident's #43 nutritional needs. The assessment was signed and completed by the CDM with no oversight or review by the Consultant Dietitian. In an interview conducted on 11/19/24 at 2:23 with the facility's CDM, she stated that she had been working there since 2001. She oversees the main kitchen and is responsible for completing all the initial nutrition assessments for all residents, including nutrition high-risk residents. When asked about the initial nutrition assessment, she said that she collects the nutritional data from residents (height, weight, intake of foods, food preferences, and weight history). She further stated that she calculates the residents' estimated daily calories, protein, and fluids. When asked what nutrition dietary guidelines and standards of practice for estimating the nutritional needs she is using to calculate the Resident's nutritional needs, she did not know. The CDM stated that she plugs the residents' height, weight, and age into a formulary that was given to her by the consultant dietitian to meet the residents' estimated nutritional needs. When asked what her scope of practice as a CDM is regarding nutritional assessment, she said that she did not know and that she has always done the initial nutritional assessments for all residents for as long as she can remember. The CDM said that the Consultant Dietitian told her that she was more than qualified to complete the initial nutrition assessments. According to her, the Consultant Dietitian might have reviewed her completed initial nutrition assessment, but she could not tell for sure. In a telephone interview conducted on 11/20/24 at 11:30 AM with the Consultant Dietitian, she stated that she was responsible for completing the quarterly nutrition assessment and the annual nutrition assessments. The CDM oversaw the completion of all the initial nutrition assessments because she was in the facility full-time and could see all residents. The Consultant Dietitian reported that the CDM was very knowledgeable and was competent to complete those initial assessments. She further stated that she does not review all the initial nutrition assessments that the CDM completes and that she was able to see that assessments when she completes the quarterly nutrition assessments. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	41837 5. Record review for Resident #26 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Pneumonia Unspecified Organism and Unspecified Severe Protein-Calorie Malnutrition. Review of the Minimum Data Set for Resident #26 dated 10/30/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Mini Nutrition Assessment for Resident #26 dated 10/24/24 documented that the CDM assessed the resident with following estimated needs scored 5 indicating malnutrition Review of the Nutritional Assessment for Resident #26 dated 10/24/24 revealed the CDM completed the initial assessment and estimated the following: kal 1238, protein 35 gr fluids 1060 ml.

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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** 40153 Based on interviews, observations and record review, the facility failed to ensure that the correct fluid restriction was provided as per physician's order for 1 of 1 resident reviewed for Dialysis (Resident #55). The findings included: A review of the facility ' s policy titled Encouraging and Restricting Fluids, revised in October 2010, showed the following: the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Follow specific instructions concerning fluid intake or restrictions. When a resident is placed on fluid restriction, remove the water pitcher and cup from the room. If the resident refuses to have the water pitcher removed, notify the supervisor and, in turn, the Physician. Record review revealed Resident #55 was admitted on [DATE] with diagnoses of acute kidney failure and anemia and was on hemodialysis. A review of the Physician's orders showed the following: An order for dialysis on Tuesdays, Thursdays, and Saturdays, which was dated 09/24/24. An order for fluid restriction is 1260 milliliters (ml) daily, with 660 ml for nursing and 600 ml allocated for dietary. The 5-day Minimum Data Set (MDS) dated [DATE] revealed that Resident #55 had a Brief Interview of Mental Status (BIMS) score of 15, which was cognitively intact. In an observation conducted on 11/18/24 at 10:35 AM, Resident #55 was not in the room, and a sign outside the door noted, No Liquids. Further observation revealed a full 32-ounce pitcher of water at the side with a cup on top of the pitcher. In an observation conducted on 11/18/24 at 12:00 AM, Resident #55 was not in the room, and a sign outside the door noted No Liquids. Further observation revealed a full 32-ounce pitcher of water at the side with a cup on top of the pitcher. In an interview conducted on 11/18/24 at 12:05 PM, Resident #55 said that she was on a fluid restriction but was not able to tell this Surveyor the amount of fluids restriction she needed to consume every day. In an observation conducted on 11/19/24 at 8:04 AM, Resident #55 was in her room with her breakfast tray. Closer observation showed a meal ticket with the following: Renal diet, fluid restriction 1260 milliliters (ml), 4 ounces of juice and 4 ounces of hot tea. The breakfast tray was noted with 4 ounces of juice and 10 ounces of hot tea which exceeded the number of fluids as ordered by the attending physician. Resident #55's care plan which was dated 09/22/24 revealed that she was on a fluid restriction of 600 ml with meals and no water pitcher in the room. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 11/20/24 at 11:15 AM with Staff A, Certified Nursing Assistants stated that she provided the water pitcher to the residents in the room. She needs to make sure that the resident is not on any fluid restrictions and that there is a sign posted on the door letting her know if a resident is on a specific fluid restriction. The nurse assigned to the residents will also update them at the beginning of the shift on any residents who are not supposed to receive extra fluids. An interview conducted on 11/20/24 at 11:25 AM with Staff B, Licensed Practical Nurse, stated that a sticker outside the door is posted alerting staff on any residents who are on a fluid restriction. She will also review the residents ' orders before the start of her shift to ensure the correct fluids are given during medication passes. Dietary is responsible for ensuring that the correct fluid amount is placed on the tray for each meal, and she did not know the specific breakdown for each meal that is allocated for Dietary.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01948 Based on observation, interview, and record review it was determined that the facility failed to store prepare, distribute, and serve food in accordance with professional standards for food service safety in the skilled nursing home kitchen, satellite serving kitchen, and the main campus kitchen, which potentially effected all of the 66 facility residents. The findings included: 1. During the initial kitchen/food service observation tour conducted on 11/18/24 at 9 AM and accompanied with the facility's Certified Dietary Manager (CDM). The following were noted: Observation of the walk-in refrigerator noted that the exterior fan covers (3) of the unit were soiled and dust ladened, and the surrounding ceiling area was also dust ladened. Observation of the walk-in refrigerator noted 4- 20 thawed whole turkeys. The CDM stated that the turkeys were defrosted last week and would be cooked next week for the holiday meal. The surveyor discussed with the CDM that the regulatory requirement was thawing of frozen meats for a prior to not exceed 72 hours and be prepared after that time. It was discussed that the thawed turkeys would remain in the walk-in approximately 10 days prior to cooking and should be discarded. The CDM stated she was unaware that staff were thawing foods too long in advance to cooking. During the observation of the food preparation surface it was noted a 1 -pound can of an open powdered thickener. Further observation of the can noted that the entire scoop and stem was embedded into the powder. The surveyor discussed with the CDM that the powder was contaminated. Observation of cooking skillets (5) noted that the interior Teflon surface was worn off, and the outside surface was covered in black carbon matter. The surveyor discussed with the CDM that small Teflon and carbon pieces were wearing off of the skillets during cooking resulting in potential food contamination. During the observation of the clean silverware sorting area, it was noted that there was an open bottle of water. The CDM stated that staff are allowed drink from water and other beverage containers within the kitchen area. The surveyor discussed that saliva from the drinking is being spread by staff resulting in contamination of clean food surfaces and clean silverware. A test of the sanitizing chemical level of the 3-compartment sink was requested by the surveyor. The CDM performed the chemical testing of the final rinse, and it was noted that the level was low and did not meet regulatory requirement of 150 PPM of Quaternary chemical. The surveyor discussed with the CDM that the 3-compartment sink not be utilized until the required chemical level is obtained. A test of the sanitizing chemical level of the cleaning cloth buckets (2) was requested by the surveyor. The CDM performed the chemical testing of the buckets, and it was noted that the level was low and did not meet regulatory requirement of 150 PPM of Quaternary chemical. The surveyor discussed the CDM that the buckets not be utilized until the required chemical level is obtained. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the dish machine hood noted that the interior surface was rust ladened and the wall area behind the dish machine was covered with dust and a black mold like type substance. Observation of 3-floor drains located in food preparation and serving areas were noted to have a thick layer of dried food matter and a build-up of a black mold type substance. Observation of the walk-in refrigerator noted that the floor area was soiled with dried food matter and trash. It was also noted that a food transportation cart stored within the unit was also soiled with dried food matter. 2. Observation of the lunch meal on the second floor satellite serving kitchen, temperatures of foods were taken utilizing the facility's calibrated digital thermometer located. The testing noted that cold food temperatures were not being held at the regulatory requirement of 41 degrees F., as per the following: Chicken Salad Sandwich (2) = 52 degrees F. Sliced Turkey Sandwich (2) = 51 degrees F. Following the temperature testing the findings were again reviewed and confirmed with the CDM. 3. During the initial kitchen/food service observation tour conducted on 11/18/24 at 9 AM, it was noted that the were 2 - large containers (10 gallons) of soup delivered to the kitchen. Interview with the Certified Dietary Manager at the time of the observation noted to state that fresh homemade soup is prepared daily (morning-7 days)) in the main Independent Campus Kitchen and delivered to the Skilled Nursing Facility for residents' lunch and dinner meals. On 11/19/24 at 2 PM an observation tour was conducted by the surveyors (2) and accompanied with the facility's Administrator. It was discussed prior to the tour the emphasis of the tour would be the areas that the soups are prepared, staff preparing, and soup ingredients are stored (freezers/refrigerators, storage rooms). The findings of the tour included the following: Preparation Area; The floor and walls of the area were heavily soiled and dust ladened, The conventions ovens were heavily soiled with black carbon from spills during cooking process and had not been cleaned for weeks. The exterior of the commercial steam jacket kettle was noted a heavy build of dried rotting food and a metal bar located above the cooking area was also noted to have a heavy build-up of dried food matter which was falling in the main cooking surface. The kettle was noted of contain approximately 10 gallons of a thick black substance of which the Executive Chef stated was homemade beef base. The chef continued to state the meat trimmings and bones are cooked for 3 days however are shut off overnight for three nights. It was discussed with the Executive Chef that the regulatory holding temperature requires was a minimum 135 degrees F and that the kettle should not be turned off nightly in order to maintain the regulatory temperature. It was also noted that a wire brush that was being utilized to scrap food from the kettle was hanging on the side of the unit. Further observation of the brush noted heavy wear and that the wires were falling off and potentially contaminating foods and was a medical safety hazard to swallow small pieces of wire bristles. Photographic Evidence Obtained (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Walk-in Freezer: Observation of the walk-in freezer noted that the floor area was noted to have a thick layer of ice build-up. It was then noted that the there was a huge layer of ice coming from the freezer system. The layer of ice was noting to be covering cases of foods (10) and in some cases actually penetrating the food container (15) boxes. It was also noted that many foods (fish, meats, vegetables, etc.) were open to the freezer air and were freezer burned and contaminated. The surveyor asked the Executive Chef that all foods located within the unit be checked for freezer burn, contamination, and discarded. It was noted that boxes (15) of foods were frozen directly to the floor area and tops of these boxes open and penetrated by ice. Photographic Evidence Obtained Dry/Canned Storage Room: The floor, walls, vents (1), light fixtures were soiled and dust ladened. Foods and supplies were noted to not be stored on shelving that is a minimum 6 inches off the floor area to allow for proper cleaning. Supplies were noted to be stored on wooden shelving (pallet) that were heavily soiled and trash, dirt, and debris trapped under the wooden pallet. Freezer jackets (3) were noted to be hanging directly on food storage shelving. It was discussed with the Executive Chef that the freezer jackets contain are soiled and have body odors. Photographic Evidence Obtained Preparation Staff: During the tour it was noted that there were 3 male cook staff that had long facial hair (beards) that failed to have donned commercial beard/facial hair restraint as per the regulatory requirement. The surveyor discussed with the Executive Chef that the beard hair is falling directly into foods during food preparation and serving.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 01948 Based on observation, interview, and record review it was determined that the facility failed to dispose of garbage and refuse properly. The findings included: During the review of the facility's Policy Protocol - Waste, Recycling and Biohazard Management, the following were noted: Purpose - This policy establishes guidelines for disposal of regular trash, recycling material, hazardous and biohazard waste materials within the communities. Process - Comply with applicable laws and regulations and help protect employees, residents, and visitors from harm. #2: Hazardous and biohazard wastes are separated from common trash recycling to avoid creation of mixed wastes. #3: Trash, recycling hazardous and biohazard waste are discarded are discarded in the designated container(s). #4: The compactor , recycling storage containers and hazardous waste storage areas are kept clean and free of spilled waste and liquids to avoid rodents, insects, and odors. #8: Employees are trained on an annual basis by their immediate supervisor in the appropriate and safe handling and disposal of trash and biohazard waste. During the tour of the facility's main Garbage/Refuse Area conducted on 11/19/24 at 2 PM and accompanied with the facility's Administrator, Director of Housekeeping, and Housekeeping, it was noted that the area contained 2 commercial garbage/trash compactors and 1 open container for recyclables. During the tour the following were noted: The ground area around the 2 compactors and open container (in front ,between ,and behind) noted to be covered with raw garbage, trash, medical Personal Protective Equipments, medication containers, and medical waste products. It was noted to be difficult to walk around the containers due to the amount of waste on the ground area. Photographic Evidence Obtained The entire area was noted to have an offensive rotting garbage odor and the air was thick with flying insects. Photographic Evidence Obtained (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 2 compactors noted numerous bags of garbage/trash broken open and spilling contents prior to entering the compacting area. The compactor was thick with open garbage, trash, and flying insects. The administrator stated to the surveyor that the possible reason that bags were not properly compacted could be due to the dumpster's being overflowing and staff not properly ensuring that all bags of garbage/trash are properly compacted prior to leaving the refuse area. Photographic Evidence Obtained Observation of the commercial open container of which only recyclables are to stored was noted to have open garbage and trash bags. Photographic Evidence Obtained Following the tour of the refuse area on 11/19/24 the findings were again reviewed and confirmed by the surveyor with the administrator.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40153 Based on interviews and record review, the Administrator failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. The facility's Administrator failed to ensure that the Consultant Clinical Dietitian provided dietary services, supervision, and oversight in accordance with State and Federal Guidelines. The facility's Administrator failed to ensure that the current Certified Dietary Manager (CDM) was providing dietary services within her scope of practice for 6 of 6 residents reviewed for nutrition (Residents #17, #43, #14, #55, #6, and #26). This had the potential to affect 67 residents who were on the census at the facility. The findings included: A review of the Job Description of the facility's Administrator, revised on February 1, 2018, showed the following: The Care Center Administrator has full legal authority and responsibility for the operation of the Care Center, ensuring that it operates in compliance with all applicable State and Federal Regulations. In addition, the Administrator is responsible for the quality of care and services provided to residents and performs other duties as assigned. A review of the facility's Consultant Dietitian Agreement, dated 03/31/22, revealed the following: Schedule regular visits to the Care Center for no more than 16 to a maximum of 24 hours per month. Ensure compliance with all Federal, State, and Regulatory Statutes and Regulations. A chart review revealed that Residents #17, #43, #14, #55, #6, and #26 had initial nutrition assessments that were completed and signed by the CDM in the facility. Further review did not show that the consultant dietitian reviewed and signed the initial nutrition assessments after they had been completed by the CDM. In an interview conducted on 11/19/24 at 2:23 PM with the facility's Certified Dietary Manager (CDM) stated that she has been completing all the initial nutrition assessment for as long as she can remember and it was never questioned by the Administrator. In an interview conducted on 11/20/24 at 1:00 PM, the facility's Administrator stated that the Consultant Dietitian's visits were seasonal, that she lived out of state, and that she worked remotely. In a telephone interview conducted on 11/20/24 at 11:30 AM with the Consultant Dietitian, she said that she comes into the facility in person every 2 months for 1-2 days. She oversees the quarterly and yearly nutritional assessments. According to her, the CDM oversees all initial nutrition assessments, including high-risk nutritional residents. The Consultant Dietitian said that she does not review the initial nutrition assessments that are completed by the CDM upon admission. She only looks at the initial assessments when she completes the quarterly nutritional assessments. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview conducted on 11/21/24 at 9:14 AM with the Administrator, she stated that she must ensure that all daily operations in the facility meet both State and Federal guidelines. She said that she was not aware that the Consultant Dietitian needed to complete the initial nutritional assessment on all residents and that she was not aware that the CDM was completing those assessments. The Administrator reported that the scope of practice for the CDM did not come up in any of the care meetings, and she never thought to check that the correct oversight had been completed by the Consultant Dietitian.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review, the facility failed to maintain medical records for each resident that are complete and accurately documented for 1 of 1 resident sampled for transmission based precautions with peripherally inserted central catheter (PICC) affecting Resident #264. The findings included: Review of the facility's policy titled, Charting and Documentation with a revised date of July 2017 included in part the following: The following information is to be documented in the resident medical record: a) Objective observations, b) Medications Administered, c) Treatments or services performed, d) changes in the resident's condition. Record review for Resident #264 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Acute and Subacute Infective Endocarditis, Bacteremia, Sepsis due to Methicillin Susceptible Staphylococcus Aureus, Nonrheumatic Aortic (Valve) Stenosis, Bacterial Infection Unspecified. Review of the Minimum Data Set for Resident #264 dated 11/08/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #264 revealed the following orders: An order dated 11/06/24 for Cefazolin in 0.9% sodium chloride solution; 2 gram/100 mL; amt: 1; intravenous Special Instructions: DX: Endocarditis Every 8 Hours. An order dated 11/05/24 for IV site monitoring every shift: Right upper arm PICC line An order dated 11/06/24 for Right upper PICC Single Lumen: dressing change every week on Tuesdays 7P-7A discontinued on 11/18/24 An order dated 11/19/24 for Right upper PICC Single Lumen: dressing change every week on Tuesdays 7P-7A discontinued on 11/20/24 An order dated 11/05/24 IV site monitoring every shift PICC site Right Upper arm Twice A Day was discontinued 11/05/24 Review of the medication administration summary for Resident #264 from 11/06/24 to 11/17/24 revealed the right arm PICC dressing was documented as changed each day not as ordered to be changed every week on Tuesdays. Review of the medication administration summary for Resident #264 from 11/06/24 to 11/20/24 revealed the PICC IV site was monitored every shift (2 12-hour shifts per day) during this time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #264 from 11/06/24 to 11/17/24 did not indicate any reason for the PICC to be changed outside of the ordered weekly on Tuesdays. On 11/18/24 at 1:15 PM an observation was made of Resident #264's right arm with PICC dressing with clean dry and intact with no date. On 11/19/24 at 8:05 AM a second observation was made of Resident #264's right arm PICC dressing with no date. On 11/19/24 at 8:40 AM an observation of med pass with Staff B LPN for Resident #264 for the medication Cefazolin 2mg/100ml IV over 30 minutes. The nurse performed hand hygiene, gathered supplies, applied a gown and gloves, assessed the PICC access site, spiked medication with tubing, inserted tubing into pump, primed tubing with pump, flushed the PICC access after wiping with alcohol, connected tubing, programed pump and infusion started. nurse removed gown and gloves and performed hand hygiene. During an interview conducted on 11/18/24 at 1:20 PM with Resident #264 with his wife present, the resident was asked if he knew when the last time the dressing had been changed, he stated it was changed once or twice since he has been here but was not sure of the dates. The resident's wife said I am here every day for about 12 hours a day and the dressing was only changed once. During an interview conducted on 11/19/24 at 9:00 AM with Staff B LPN who was asked what was included when she looked at the PICC site initially, she stated to make sure it looks intact and to make sure there is no redness. When asked if she looked at the date, she said no. She acknowledged there was no date on the PICC dressing for Resident #264 and stated it should have been changed Sunday, she knows because she changed it the previous Sunday.

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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** 41837 Based on observation, interview, and record review the facility failed to implement appropriate infection prevention and control practices during medication administration for 1 of 5 residents observed for medication administration affecting Resident #265. The findings included: Review of the facility policy titled, Standard precautions - Infection Control with a revision date of September 2017 included in part the following: Process: 1. Gloves are worn whenever exposure to the following items is planned or anticipated, or an item is contaminated with the following, including but not limited to: Blood/blood products/body fluids Mucous Membranes Performing venipuncture or invasive procedure(s) Saliva Review of the facility best practice guidelines and principles titled, Medication Administration Documentation and Storage: with no date included in part the following: Appendix B Recommended Procedures for Administration Insulin Administration Procedures Injection Technique 1. Wash hands and wear gloves. 7. Remove gloves and wash hands Nasal Spray Administration Procedure 1. Wash hands thoroughly. Gloves are worn. Nasal Inhalers 12. Wash hands thoroughly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review for Resident #265 revealed the resident was admitted to the facility on [DATE]. Review of the Minimum Data Set for Resident #265 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. On 11/20/24 at 8:40 AM an observation of medication administration with Staff B Licensed Practical Nurse (LPN) for Resident #265 included the administration of medications in part as follows: Eliquis 5mg orally, Flonase Allergy Relief (fluticasone propionate) spray, suspension; 50 mcg/actuation; Instill 2 sprays into each nostril once per day, Florastor 250mg orally, Jardiance 10mg orally, Potassium chloride 10meq orally, Lisinopril 20mg orally, Nifedipine tablet extended release; 30 mg orally, Vyndamax (tafamidis) capsule; 61 mg orally, ezetimibe tablet 10 mg orally, modafinil 200mg orally, torsemide tablet; 5 mg orally, and Humalog U-100 Insulin (insulin lispro) cartridge; 100 unit/mL 2 units subcutaneous per sliding scale injected into abdomen. Staff B LPN performed hand hygiene before entering the resident's room, did not apply gloves to her hands, administered the nasal spray, did not perform hand hygiene and did not apply gloves, then administered the insulin by injection into the resident's abdomen, did not perform hand hygiene or apply gloves, then administered the resident her oral medications in applesauce with a spoon. Once Staff B LPN finished administering all medications, she then performed hand washing. During an interview conducted on 11/20/24 at 8:45 AM with Staff B LPN who stated she has worked at the facility for [AGE] years. When asked about performing hand hygiene and wearing gloves, the LPN stated she did not wear gloves when administering insulin subcutaneous because there was no blood involved. When asked why she did not perform hand hygiene or wear gloves between administering the nasal spray, injecting the insulin and spoon feeding the oral medications to the resident, the nurse had a puzzled look on her face and again stated to surveyor there was no blood involved. The LPN then asked the surveyor Is that wrong?

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 01948 Based on observation, and interview it was determined that 6 of 13 resident room bathrooms located on the East Wing of the second floor were disabled, inoperable, and out of reach in a resident emergency. The six identified rooms were noted to effect Resident's #2, #7, #17, #24, #31, and #41. The findings included: During the initial screenings conducted by the surveyor on 11/18/24 of resident rooms #225 through # 240, it was noted that 6 of the rooms had bathrooms of which the nurse emergency call bell was wrapped around the wall mounted hand rails resulting in the in the bell coming inoperable when pulled. It was also noted that due to the wrapping around the handrails that the end of the cord exceeded the 4 inch minimum requirement from the floor. It was also noted that the bathroom trash containers were placed in front of the pull cords blocking reaching of the cord during a potential emergency. The resident's potentially effected included the following: Resident #41 - Minimum assistance by staff with toileting. Resident #17 - Maximum assistance by staff with toileting. Resident #2 - Stand by assistance by staff with toileting. Resident #31 - Supervision by staff with toileting. Resident #7 - Dependent by staff with toileting. Resident #24 - Dependent by staff with toileting. On 11/18/24 following the resident screening the observations were shared with the administrator concerning the bathroom call light issues and reviewed the resident rooms. In addition the surveyor toured the effected rooms again with the facility's Director of Maintenance Services. The surveyor's observations were reviewed and confirmed with the Director of Maintenance Services.