STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** Based on observation, record review, and interview, the facility failed to follow the menu for 1 of 3 observed meals, as evidenced by the failure to follow the recipes for the main entree of Beef Quesadilla and the alternate entree of Savory Baked Chicken Thigh. This resulted in a food complaint by 2 of 10 sampled residents, Resident #7 and a resident who requested to be anonymous. The Certified Dietary Manager (CDM) also added mashed potatoes and gravy to the alternate meal without following their documented process.The findings included:1) Review of the policy Menus and Adequate Nutrition with a Copyright of 2025, documented in part, Policy Explanation and Compliance Guidelines: . 4. Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Review of the policy Altering Food Recipes dated 07/08/22, documented in part, Policy: All recipe alterations must be approved by the facility's Registered Dietitian (RD) before implementation. Documentation of changes is required for regulatory compliance and quality assurance. Review of the lunch menu for 02/04/26 documented the main meal consisted of a beef quesadilla, Spanish rice, corn, wheat bread, and a sugar cookie. The alternate meal was documented as a savory baked chicken thigh and roasted carrots. An observation of the tray line was made on 02/04/26 beginning at 11:35 AM. The food taken to the steam table for service included beef quesadillas, chicken thighs, mashed potatoes, and gravy. Staff D, cook, plated four main entrée meals with the quesadilla and eight alternate meals with the chicken thigh, carrots, and mashed potatoes with gravy. During an interview on 02/04/26 after the meal service at approximately 1:15 PM, when asked what ingredients she used in the quesadilla, Staff D stated, I used regular ground beef and peppers only. Review of the Beef Quesadilla recipe included the addition of shredded mild cheddar cheese, green chilies, onions, and taco seasoning to beef fajita strips. The cook confirmed she did not use the beef fajita strips or additional ingredients as per the recipe. During the continued interview, the recipe for the savory baked chicken thighs was reviewed by Staff D, cook. The recipe instructed the cook to brush the chicken with mustard and coat with biscuit mix, then to sprinkle paprika and parmesan cheese over the chicken thighs. When asked if she followed this recipe, the cook stated she did not use the biscuit mix or parmesan cheese for the chicken topping. When asked about the process for menu substitution or recipe alteration, Staff H, cook, stated they (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	would sometimes try to find a recipe in their recipe binder that had the ingredients they already had on hand, and make that recipe instead. When asked why the mashed potatoes were added to that day's menu, the CDM stated because the alternate meal only had chicken and carrots, she felt the meal needed a starch. The CDM stated she spoke with the RD who agreed. The staff were asked for any documentation for that day's substitutions, and none was provided. 2) Review of the record revealed Resident #7 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] document the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. During an interview on 02/02/26 at 11:35 AM, when asked how the food at the facility was, Resident #7, stated the food was just bad, they can't cook, and it doesn't taste good. 3) Clinical record review for a resident who requested to remain anonymous revealed that the resident was admitted to the facility on [DATE] with diagnoses that included depression. The admission MDS assessment, with a reference date of 01/21/26, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident had moderate cognitive impairment. On 02/02/26 at 10:16 AM, an interview was conducted with the resident. He was alert, oriented, and coherent. When asked about the facility's food, he complained that the facility should improve the food, stating that it is not good. He reported that there is little variety in the meals, and the same foods are served frequently. He also noted that the scrambled eggs are served cold every morning. Today, he received toast with no butter or jelly. On 02/03/26 at 9:09 AM, the Resident again voiced that the scrambled eggs were served cold. On 02/04/26 at 8:21 AM, the resident was observed lying in bed with his breakfast tray in front of him. When the surveyor asked, Were the eggs served hot? he replied, No. He stated that he ate the eggs and the sausage, but two pieces of French toast and some oatmeal remained on his plate. When asked if he did not have much of an appetite, he said, It's the food here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, sanitary conditions, and the prevention of foodborne illnesses. This had the potential to affect 18 residents who ate food by mouth. The census at the time of survey was 18. The findings included:An observation of the kitchen was conducted on 02/02/26 beginning at 10:00 AM with the Certified Dietary Manager (CDM). The following findings were noted and confirmed by the CDM:a) The beverage dispenser had a brown thick liquid substance in the tray.b) A brown liquid spillage and loose dry macaroni noodles were noted on the clear plastic cover of a box in the dry storage area, that contained three cans of chicken and dumplings.c) There was an opened bag of macaroni noodles in the dry storage area.d) Food crumbs were noted along the side of the clean plastic cups stored on a three shelf rolling cart. e) There was debris and food crumbs on the floor at the side of the ovens.f) There was debris and food crumbs on the floor around the feet of all stainless-steel tables.g) All stainless-steel tables had a non-smooth surface along legs and shelving edge, making it unable to be properly cleaned.h) The can opener had a black substance near the cutting edge.i) There was a residue on the metal shelf by the scale and silverware holder.j) The microwave door and framing was chipped.k) A dirty used kitchen rag was left on a rolling cart shelf next to a tray of clean glasses.l) A grease-like substance was found on the outside of a box of carrots in the walk-in refrigerator.m) There were crumbs and food debris in the knife holder. Photographic evidence obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain the dumpster area in a clean and sanitary condition as evidenced by the failure to dispose of garbage and refuse properly. This failure had the potential to attract pests.The findings included:An observation of the dumpster area was made with the Certified Dietary Manager (CDM) and the Environmental Service Director on 02/05/26 at 10:51 AM. There were two dumpsters located at the back of the building with a wooden fence around them. On the ground in front of the fence, and inside the fence in front of each dumpster was spilled debris and food. Photographic evidence obtained. The Environmental Service Director stated, I'll get someone to clean this up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to service food at a safe and palatable temperature for 2 of 3 sampled residents who were served milk during the lunch meal on 02/04/26, Residents #3 and #16, and as evidenced by kitchen processes resulting in resident complaints of cold food by Resident #7, #2, and #10.The findings included:1) A tray line observation was made on 02/04/26 beginning at 11:35 AM. Upon arrival in the kitchen two small open carts and two large open tray carts were noted with the resident's food trays and meal tickets set up on the four different carts. Staff E, Dietary Aide, explained one of the large carts was for the skilled nursing facility (SNF) and the other for the assisted living facility (ALF). Staff D, cook, explained one of the small carts was for the pureed meals and the other for the mechanically altered meals. The cook further explained she preferred to do all the pureed meals first, followed by the mechanically altered meals, and then the regular meals. The Dietary Aide was prepping all of the trays for both the SNF (a 24-bed facility that had 18 residents) and the ALF (a 17-bed facility that had 14 residents), at the same time by placing all the drinks and cold food items on every tray, including milk. On 02/04/26 at 11:40 AM, Staff D, cook, began to take the food from both the stove top and oven and put it on the tray line, and completed the process at 11:50 AM. The cook began to take temperatures of the food at 11:55 AM, and stated she had to reheat the pureed chicken, which was originally at 134 degrees F. (Fahrenheit) and reheated to 168 degrees F., the mashed potatoes, which was originally at 155 degrees F. and reheated to 163 degrees F., and the gravy which was originally at 150 degrees F. and reheated to 171 degrees F. Staff D, cook, began to plate the food at 12:20 PM. The cook took some warmed plates from the upright food warmer, placing the warmed plates on an insulated bottom and covered with an insulated top after plating each meal. There was also a second stack of plates that had not been in the warmer, but had been on a shelf in the kitchen, and used some of those plates as well during the service. The facility did not use any metal insert or any type of cover for the cart. The facility did not have a closed, insulated cart for trays, but used open metal tray carts. Only four residents ate in the dining room, and the remaining 12 residents ate in their rooms. The cook plated the four pureed meals and placed them on the first small cart. The meals were verified by the Certified Dietary Manager (CDM) who told the Dietary Aide they were ready to go. The CMD was asked to replace the milk on the tray for Resident #16 and obtain a temperature of that milk that would have been sent to the resident. The temperature of the milk that would have gone to the resident was 50 degrees F. A safe holding temperature for cold foods is 41 degrees F or below. The cook then plated the six mechanically altered meals on the second small cart. The CDM checked the meals as they were completed by the cook. The cook then plated the 12 regular meals for the residents who ate in their rooms. Upon completion of that service at 12:40 PM, the CDM confirmed the trays were ready to go. The CDM was asked to take the temperature of the milk on the tray for Resident #3, and it read 55 degrees F. When asked the process to ensure the milk was served at a safe cold temperature, the cook stated the milk was put in the freezer prior to service, and further stated, I guess I'll have to go back to putting the milk on ice while in the kitchen. When asked why they prep all the trays with the cold items at one time, the cook stated because it typically was just her and one aide, so she was unable (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to run a typical tray line that completes the tray with both hot and cold food at the same time and sends out a few at a time to maintain palatable and safe temperatures, since the one Dietary Aide also delivers the carts out to the staff to provide to the residents. 2) Review of the record revealed Resident #7 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. During an interview on 02/03/26 at 8:50 AM, Resident #7 was finishing her breakfast. When asked how it was, the resident stated her scrambled eggs were cold as usual. When asked if the food was usually cold or if it has been just that week during the cold snap, Resident #7 stated, not really, confirming the food was usually cold. When asked if she had asked staff to warm her food, the resident stated she didn't think they were allowed to do that. During an interview on 02/04/26 at approximately 9:30 AM, when asked how her breakfast was that morning, Resident #7 stated the eggs were ice cold. 2) Clinical record review revealed that Resident #2 was re-admitted to the facility on [DATE] with diagnoses that included medically complex conditions, atrial fibrillation, and septicemia. The annual Minimum Data Set (MDS) assessment with a reference date of 10/29/25 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The MDS further indicated that the resident reported feeling down, depressed, or hopeless, with no behavioral symptoms documented. On 02/02/26 at 11:05 AM, during an interview, Resident #2 reported that the facility's food was served cold and stated she disliked cold food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, menu review, and interview, the facility failed to ensure food was prepared to meet the needs for 3 of 3 sampled residents observed, as evidenced by the failure to provide and serve chopped meat to Resident #2 and #21, and failure to cut up meat to bite-sized pieces for Resident #5.The kitchen staff also failed to prepare ground meat on 02/02/26 as per the mechanical soft diet menu.This failure had the potential to affect 7 residents who were on physician ordered mechanical soft diets.The findings included:1) A lunch observation was made on 02/02/26 beginning at 11:49 AM in the main dining room. The posted menu for that day included a roast beef sandwich. Four residents were brought into the dining room and were accompanied by Staff I, Certified Nursing Assistant (CNA), throughout the meal. The lunch trays were served to the four residents, as noted below, and staff failed to compare the meal with the corresponding meal ticket. After the meal service on 02/02/26 at approximately 12:40 PM, Staff D, cook, confirmed she had not prepared any ground meat for the meal nor did she serve any cut up meat for the sandwiches.a) Review of the record revealed Resident #2 was admitted to the facility on [DATE]. Review of the physician order dated 10/27/25, documented the resident's diet texture was mechanical soft with chopped meats.During an observation on 02/02/26 at 12:12 PM, Resident #2 was served a roast beef sandwich on white bread with sliced roast beef. The roast beef was not chopped up in any manner. Photographic evidence obtained. Review of the resident's menu ticket documented the resident should be served a mechanical soft diet with chopped meats.b) Review of the record revealed Resident #21 was admitted to the facility on [DATE]. Review of current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 6, on a 0 to 15 scale, indicating moderate cognitive impairment. This MDS also documented the resident needed partial to moderate assistance with eating.Review of the physician order dated 10/31/25 documented the resident's diet texture was mechanical soft with chopped meats.During an observation on 02/02/26 at 12:16 PM, Resident #21 was served a roast beef sandwich on white bread with sliced roast beef. The roast beef was not chopped up in any manner. Photographic evidence obtained. Review of the resident's menu ticket documented the resident should be served a mechanical soft diet, but lacked the instructions to include chopped meats as per the physician order.c) Review of the record revealed Resident #5 was admitted to the facility on [DATE]. Review of the admission MDS assessment dated [DATE] documented that the resident had a BIMS score of 3, on a 0 to 15 scale, indicating the resident had severe cognitive impairment.Review of the meal ticket for Resident #5 documented to cut up meat to bite size pieces.During an observation on 02/02/26 at 12:14 PM, Resident #5 was served a roast beef sandwich on white bread with sliced roast beef. The meat was not cut up at all. Photographic evidence obtained.2) An observation of the lunch meal on 02/03/26 revealed Resident #5 in the main dining room. The resident's meal had been placed in front of her and staff had cut up the piece of meat, leaving two of the cut up pieces in large chunks, larger than bite sized. Photographic evidence obtained. Review of the resident's menu ticket documented to cut up meat to bite size pieces.3) A tray line observation was made on 02/04/26 beginning at 11:35 AM. Staff D, cook, started plating the meals at 12:20 PM.The cook plated the 7 mechanically altered meals and placed them on a small cart. The Certified Dietary Manager (CDM) checked the meals as they were completed by the cook. The CDM asked the cook to cut up the whole piece of chicken thigh into bite size pieces for Resident #5. The cook quested the CDM who stated, that is what the meal ticket says.During an interview on 02/04/26 at approximately 1:15 PM, while describing the tray line process, Staff D, cook, stated it was usually completed by only the dietary aide and herself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 2 of 10 sampled residents, as evidenced by the inaccurate assessment for range of motion ability, diagnoses, and terminal illness status for Resident #7, and for range of motion ability for Resident #6.The findings included:1) Review of the record revealed Resident #7 was admitted to the facility on [DATE]. Review of the medical diagnosis included quadriplegia (partial or total loss of sensory and motor function in all four limbs and the torso). Review of current orders documented the resident was admitted to Hospice services as of 01/31/25. Review of the Hospice admission information revealed a physician signed the Certificate of Terminal Illness (CTI). This CTI was renewed with each certification period from admission to the present time. Review of the current Annual MDS dated [DATE] documented Resident #7 had no impairment to the lower extremities and had a documented diagnosis of quadriplegia. Review of the Quarterly MDS dated [DATE] documented Resident #7 had no impairment to the lower extremities and had a documented diagnosis of quadriplegia. This MDS also documented that the resident was on Hospice services but did not have a terminal prognosis. Review of the Significant Change assessment for the addition of Hospice services, dated 01/29/25, two days prior to the admission to Hospice services, documented Resident #7 was on Hospice services but did not have a terminal prognosis. During a side-by-side review of the record and interview on 02/05/26 at 12:52 PM, when asked if Resident #7 was a quadriplegic, the Director of Nursing (DON) stated the resident could not stand or walk but was not a quadriplegic. When asked about the contradiction related to the initiation of Hospice services and the lack of a documented terminal illness on the three MDSs reviewed, the DON had no explanation and agreed with the findings. 2) Review of the medical record documented Resident #6 was admitted to the facility on [DATE]. Medical diagnoses included bilateral foot drop (inability to lift the front part of both feet). Review of the Quarterly MDS dated [DATE] documented Resident #6 had no impairment to the lower extremities and a documented diagnosis of difficulty walking. Review of the progress note dated 01/28/26 documented Resident #6 was able to walk with the therapist using bilateral extremity AFO (ankle foot orthoses) which are braces. During a side-by-side review of the record and interview with the DON on 02/05/26 at 1:00 PM, when asked about the discrepancy in the MDS documentation, the DON was unable to explain and agreed with the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely assess, monitor, document care, and notify the physician for a resident who exhibited cold-like symptoms for 1of 1 sampled resident, Resident #2, reviewed for change of condition. In addition, the facility failed to assess and document blood pressure prior to administering antihypertensive medication as required by the physician order for 1 of 5 sampled resident, Resident #2, reviewed during the unnecessary medication review task. The findings included: 1) Clinical record review revealed Resident #2 was re-admitted to the facility on [DATE] with diagnoses including medically complex conditions, Atrial Fibrillation, and Septicemia.The annual Minimum Data Set (MDS) assessment with a reference date of 10/29/25 documented a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The MDS noted the resident reported feeling down, depressed, or hopeless, with no behavioral symptoms documented.On 02/03/26 at 9:06 AM, Resident #2 was observed sitting in her room with untouched food on the tray. The resident was observed repeatedly wiping a continuously running nose. The resident stated she had a cold, her stomach was upset, and she did not have an appetite.On 02/03/26 at 11:47 AM, Resident #2 was observed being transported to the dining room for lunch. The resident stated she felt cold and felt as though she had a cold. Staff A (Certified Nursing Assistant) assisted the resident with a jacket and placed a throw over her legs. The dining room temperature, per the thermo-hygrometer, was 68.9 F at that time.On 02/03/26 at 12:10 PM, Resident #2 was observed sitting in the dining room and continued to state she was not feeling well and was not interested in eating.On 02/04/26 at 8:24 AM, Resident #2 was observed sitting in her wheelchair in her room with a runny nose, repeatedly wiping her nose. Her food was present and untouched. The resident stated she did not have an appetite, had a cold, and was not feeling well. Review of the clinical record at that time revealed no documentation that the physician had been notified, no evidence the resident had been assessed or treated for her symptoms, and no documentation that any diagnostic testing had been performed for respiratory infection.On 02/04/26 at 12:38 PM, Resident #2 was observed in the main dining room and stated she did not feel well and declined additional food stated I don't feel well. I don't need the double meat, but when I'm feeling good, I will take it and eat it.On 02/05/26 at 8:57 AM, Resident #2 was observed sitting in her wheelchair in her room. When asked how she was feeling, the resident stated she was not doing well, reported ongoing cold symptoms that had worsened, and described alternating sensations of feeling hot and cold. The resident reported she did not eat breakfast due to nausea and fear of vomiting. The resident was observed with audible nasal congestion. At that time, there remained no documentation that the physician had been notified, no evidence of assessment or treatment of the resident's symptoms, and no documentation of testing.On 02/05/26 at 9:05 AM, an interview was conducted with Staff B (Registered Nurse). When the surveyor asked Staff B if she had received report from the outgoing nurse of how Resident #2 was doing, Staff B stated she had received report from the outgoing nurse and reported no changes in the resident's condition and no new complaints. Staff B proceeded to review the resident's records and stated review of the resident's electronic medical record showed no new concerns documented.At 9:09 AM, the surveyor accompanied Staff B to speak with Resident #2. During the interaction, the resident reported sneezing, coughing, a runny nose, and stated she had used an entire box of tissues. The resident denied having allergies and reported experiencing alternating sensations of feeling hot and cold. The resident stated the symptoms had been present since the other day.On 02/05/26 at 9:55 AM, an interview was conducted with the Director of Nursing (DON). The surveyor asked if a resident exhibits cold like symptoms, what did she expect the nurses to do? The DON stated that when a resident exhibits cold-like symptoms, nurses are expected to assess the resident and notify the physician. The DON further stated that based on the infection surveillance criteria, diagnostic testing such as laboratory work and chest x-ray may be initiated. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor informed the DON that Resident #2 had been reporting symptoms since 02/03/26.On 02/05/26 at 11:51 AM, Resident #2 was observed in her room with curtains drawn to separate her from her roommate. When asked if she was receiving treatment for her symptoms, the resident stated yes, thank goodness, finally. During this time, a regional nurse consultant came and placed a contact precaution signage on the door.2) Additional clinical record review revealed a physician order dated 10/28/25 for Metoprolol Tartrate 25 mg, to be administered orally once daily for Hypertension, with instructions to hold the medication for systolic blood pressure less than 100 mmHg and diastolic blood pressure less than 55 mmHg.Review of January and February 2026 Medication Administration Records (MARs) and treatment administration records (TARs) revealed the resident's blood pressure was not consistently monitored and documented prior to administration of Metoprolol, despite the physician-ordered parameters.Documented blood pressure readings included:01/03/26 at 8:18 AM: 144/6001/12/26 at 9:24 AM: 108/6501/17/26 at 8:06 PM: 124/7101/21/26 at 10:47 AM: 114/5201/26/26 at 9:38 AM: 141/6001/27/26 at 9:12 AM: 123/77Review of the MAR dated 01/21/26 indicated the resident's diastolic blood pressure was 52 mmHg; however, Metoprolol was administered and signed as given, despite the physician order indicating the medication should have been held.On 02/05/26 at 9:55 AM, during an interview with the DON, she was informed of the lack of consistent blood pressure monitoring prior to administration of antihypertensive medication with ordered parameters. The DON reviewed the records, acknowledged the findings, and stated the medication order format did not prompt nurses to document blood pressure readings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the policy and procedure, the facility failed to ensure supervision and implementation of interventions to prevent falls for 1 of 1 sampled resident, Resident #20, which resulted in the resident sustaining 3 falls within 5 weeks.The findings included: Review of the policy titled, Fall Prevention Program dated 07/2025, documented in part, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Review of the record indicated that Resident #20 was admitted to the facility on [DATE]. Medical history included Metabolic Encephalopathy (a disturbance in brain function that causes confusion), Essential Hypertension (high blood pressure), Muscle Weakness and Idiopathic Peripheral Neuropathy (nerve damage which causes pain, numbness and tingling to the lower extremities).Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8, on a scale of 0 to15, indicating the resident had moderate cognitive impairment. The MDS also documented Resident #20 had 2 or more falls since the last assessment with no injuries. Resident #20 required maximum assistance from the staff for toileting and was dependent on assistance from the staff with showering and dressing the lower body.Review of the care plan dated 01/12/26 documented that Resident #20 was a Fall risk related to having poor safety awareness due to impaired cognition or disregard for safety and the requirement of assistance with transfers and mobility. Resident #20 had Musculoskeletal symptom (s) which could affect balance or extremity strength. Resident #20 used a wheelchair to maintain mobility with staff assistance. The interventions included: Observe for safety, place resident in a visible area, the staff to make frequent checks on resident to ensure resident is not in need for anything. The staff will keep frequently used items in reach, and the staff will observe any changes in cognition or mobility and notify MD.Review of the practitioner's note dated 10/22/25 documented that Resident #20 was at an increased risk for falls related to symptoms and forgetfulness. However, a review of the record documented Fall Risk assessments for Resident #20 at a low risk for falls, scores 0 to 18. On 11/29/25 the score was 17, 01/08/26 the score 13 and 01/22/26 the score 15. Also, the fall risk assessments did not include the diagnoses of Metabolic Encephalopathy, Muscle Weakness and Idiopathic Peripheral Neuropathy, all of which could contribute to a fall.An interview with the Director of Nursing (DON) was conducted on 02/05/26 at 11:00 AM. When asked about the fall prevention program, the DON reported that when residents fall, there was a protocol that the nurses follow. This included documenting the incident in a statement and doing an incident report. The DON was asked about the fall incidents for Resident #20. The DON confirmed that Resident #20 fell 3 times within the past month, on 01/08/26 at 4;00 PM, 01/21/26 at 5:30 PM and 02/02/26 at 6:10 PM, all occurred when the resident was most alert, Further explained the resident was generally calm and quiet in the morning and most alert and active in the afternoon and evening. The resident also fell on [DATE]. During a side-by-side review of the record, the DON confirmed that the documentation in the record lacked details of the date, time, circumstances, assessment and interventions taken at the time of the fall. The DON stated that Resident #20 does not get family visits as the roommate, so the resident enjoyed the company and the attention of the staff. Resident #20 would use the wheelchair to propel towards the common area but would also slide out of the wheelchair to gain attention. The DON further elaborated that there was a recent staff turnover which impacted Resident #20 because she had developed a rapport with the previous staff. The DON added that the new staff required further orientation in paying close attention to Resident #20 to prevent sliding from the wheelchair and added that on 02/02/26, the date of last fall, the new Certified Nursing Assistant (CNA) did not know Resident #20 well enough to properly supervise.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to follow the physician's order for feeding tube flush and to obtain weekly weights for 1 of 1 sampled resident, Resident #6, which was required to maintain the resident's nutritional needs and prevent complications. The findings included: 1. Review of the policy and procedure titled, Care and Treatment of Feeding Tubes dated 12/2025, documented in part, Feeding tubes will be utilized according to the physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush.A review of the record documented Resident #6 was admitted to the facility on [DATE]. Medical diagnoses included Chronic Dysphagia (difficulty swallowing). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] the resident was fed by a feeding tube. a) Review of the physician's orders documented as of 08/01/25 that Resident #6 received nutrition via a feeding tube. An additional order dated 11/04/25 instructed staff to administer 200 ml (milliliters) of water to the feeding tube at 6:00 AM, 12:00 PM, 4:00 PM and 8:00 PM throughout the day. During observation of the water administration through the feeding tube on 02/04/26 at 11:55 AM, Staff F, Registered Nurse, flushed the resident's feeding tube with 60 ml of water. In a side-by-side review of the record and interview with Staff F, when asked how much water was used to flush the feeding tube, Staff F confirmed that 60 ml was used. Staff F reviewed the physician's order and then confirmed that the ordered amount of 200 ml was not administered. b) Review of the physician's orders dated 01/09/26 documented for the staff to obtain weekly weights every Monday for 4 weeks. During a side-by-side review of the record and interview on 02/05/26 at 1:00 PM, when asked about who was responsible for obtaining and documenting the residents' weights, the Director of Nursing (DON) stated that all staff are responsible for weight checks and the Registered Nurse (RN) documents in the electronic chart. When the DON was asked about who ensures that the task is completed, the DON indicated that there was an issue with coordination between Nursing and Dietary in getting the residents' weights documented. Review of the documented weights revealed the weights were obtained on 01/21/26, 01/12/26 01/5/26 and 12/5/25. The record lacked any documented weights on 02/02/26 or 01/26/26 as ordered. The DON reviewed the record and agreed that the facility did not carry out the order to obtain weekly weights for 4 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106097	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Lakes Senior Living Community	1006 33rd St Vero Beach, FL 32960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of foods as per resident preference for 2 of 4 sampled residents, as evidenced by the failure to ensure ice cream and mashed potatoes daily for Resident #16, and failure to ensure double portions for Resident #2.The findings included:1) Review of the record revealed Resident #16 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score was not done as the resident was rarely or never understood. This MDS also documented the resident was totally dependent upon staff for eating.Review of the current care plan initiated on 11/13/24 and revised on 08/26/25 documented the resident was at increased nutritional risk related to a mechanically altered diet and the need for assistance with all meals. Intervention to this care plan included to provided the diet as ordered.An observation on 02/02/26 at 12:10 PM revealed Resident #16 in the main dining room being fed by Staff I, Certified Nursing Assistant (CNA). The resident's divided plate had pureed meat and pureed carrots. The third divided section of the plate was empty. Photographic evidence obtained. Review of the menu ticket for Resident #16 documented, Preferences: chocolate ice cream daily and mashed potatoes daily. No mashed potatoes were noted on the resident's plate.An observation of the tray line on 02/02/26 at approximately 12:30 PM lacked any mashed potatoes. The lack of potatoes was confirmed by the Certified Dietary Manager (CDM) at that time.An observation of the lunch meal on 02/04/26 at 12:35 PM revealed Resident #16 had not received chocolate ice cream. When asked if the resident's tray was missing anything, Staff A, CNA, who was feeding the resident, confirmed the ice cream had not been served. 2) Review of the record revealed Resident #2 was admitted to the facility on [DATE]. Review of the Annual MDS assessment dated [DATE] documented the resident had a BIMS score of 13, on a 0 to 15 scale, indicating intact cognition. This MDS also documented the resident required set up assistance for eating.During the meal observation on 02/02/26 at 12:12 PM, Resident #2 was served a roast beef sandwich on white bread and with sliced roast beef. The sandwich had the same amount of roast beef and the other two sandwiches served at the same table. Photographic evidence obtained. Review of the menu ticket revealed the resident was on a mechanical soft diet with a double portion protein.An observation of the lunch meal on 02/03/26 at 12:38 PM revealed Resident #2 received a scoop of ground meat. Resident #2 stated I don't feel well today. I don't need double meat. But when I'm felling good I will take it and eat it.During an interview on 02/03/26 at 12:16 PM, Staff H, cook, was asked to put a double portion of ground meat on a plate. The cook stated, Oh did I mess up? An observation of the double portion provided by the cook was more than the portion provided to Resident #2. Photographic evidence obtained. When asked if she gave Resident #2 a double portion of meat, the cook stated, I could have put more.