STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106047	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review and interview, the facility failed to provide a weekly menu to a resident on contact precautions for Clostridium Difficile (C. Diff) for 1 of 1 sampled resident reviewed for contact precautions for C. Diff (Resident #6). The findings include:Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that included Malignant Neoplasm of Temporal Lobe, Malignant Neoplasm of Parietal Lobe, and Enterocolitis due to C. Diff. (C. diff infection is a serious bacterial infection that primarily affects the colon, often causing severe diarrhea and inflammation. C. Diff is highly contagious. A resident who has C. Diff is on contact precautions, which means whoever enters the room must wear a gown and gloves). His Brief Interview for Mental Status (BIMS) score was 11 on the admission Minimum Data Set (MDS) dated [DATE]. This indicated the resident had mild cognitive impairment. Further record review revealed on 07/01/2025, the resident weighed 174.4 pounds. On 08/11/2025, the resident weighed 154.6 pounds, which is a -11.35% Loss.An observation of the breakfast meal at 8:30 AM on 08/13/25 revealed the resident did not eat the scrambled eggs, ham, cereal or toast. He drank the apple juice. An interview was conducted with the resident immediately after the meal observation. The surveyor asked the resident why he did not eat breakfast. The resident stated he was served eggs every morning and he was sick of eggs. He stated the ham was tough. He wished he could get something else to eat. The surveyor asked the resident if he was choosing his meal preferences. He stated that he has not seen a menu in a long time.An interview was conducted with the Diet Technician on 08/13/25 at 8:47 AM. She stated the Dietary Director does the meal preferences.An interview was conducted with the Dietary Director on 08/13/25 at 10:35 AM. She was asked about preferences for Resident #6. She stated that she had no preferences for Resident #6, just that he dislikes fish. She was unaware that he did not want eggs. She has an alternate menu for pancakes, french toast or bagels but she did not get the alternate menu to him because he is on isolation, and he won't answer the phone. She does not want to have him touch a menu and have it brought back to the kitchen. An interview was conducted with Resident #6 on 08/14/25 at 8:50 AM. The resident was observed discontinued off contact precautions and on Enhanced Barrier Precautions. The resident was asked if he ate breakfast today and he stated he did, and it was pancakes. An interview was conducted with the Diet Technician immediately after speaking with the resident. She stated she had brought him (Resident #6) a menu when he first came to the facility (06/30/25). She was asked if the menu was good until now and she stated it was good for a week. She was asked if she brought the menu to him weekly and she stated that is not her responsibility, it is the Dietary Director's responsibility. She stated the Dietary Director did not want to take the paper menu into the kitchen because the resident was on contact precautions. The Administrator heard this conversation and acknowledged the findings.

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow physician orders for oxygen therapy care and management for 2 of 4 sampled residents (Resident #23 and Resident #40), and failed to follow its own policy to ensure the respiratory care and services are in accordance with professional standards of practice by: failing to properly disinfect and store nebulizing masks for 2 of 4 sampled residents (Resident #45 and Resident #100); failed to have an order for a required tracheostomy tube size, and failed to maintain sterility during tracheostomy care for 1 of 2 sampled residents (Resident #1). The facility also failed to provide a readily available tracheostomy inner canula for immediate care for 2 of 2 observations and for 1 out of 2 sampled residents reviewed for tracheostomy care (Resident #9). The findings included:Review of facility's policy titled, Oxygen Administration (Infection Control, Safety, & Storage, undated, revealed the following: Oxygen should be written for specific liter flow required by the resident. Change oxygen supplies (e. g. cannula, tubing, humidifier) weekly, and when visibly soiled. Equipment should be labeled with resident name and dated when set up or changed out. Review of the facility's Tracheostomy Care Policy, with the latest review date of [DATE], revealed the following: The facility will provide and perform tracheostomy care in accordance with physician orders and current standards of care.Use sterile cotton tipped applicator and a sterile gauze pad to clean the stoma site. A review of the facility's policy titled, Tracheostomy tube cannula and stoma care, undated, revealed the following: If a product is expired, is defective, or has compromised integrity, remove it from patient use. Make sure that extra tracheostomy tubes and obturator, as well as the handheld resuscitation bag with an attached oxygen source are readily available for easy access in case of an emergency. Open the tracheostomy care kit using sterile technique.Using sterile technique, pour sterile normal saline solution, sterile water or other cleaning solution, into one of the sterile solution containers. Record review revealed Resident #23 was admitted on [DATE] with diagnoses that included Fracture of Nasal Bones, Fracture of the Orbital Floor, Gastroesophageal Reflux Disease without Esophagitis and Hyperlipidemia. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview for Mental Status (BIMS), revealed a score of 5 indicating Resident #23 had severe cognitive impairment. Section O, subcategory, C1. under oxygen therapy revealed a no' response, indicating Resident #23 was not receiving oxygen therapy. An electronic record review of physician orders dated [DATE] revealed the following: Oxygen at 2 liters per minute continuously per nasal cannula, document every shift.Change oxygen tubing and nebulizer circuit, every night shift, every Sunday, label when changed. Oxygen saturation rates, every shift. A review of the Medication Administration Record (MAR) for [DATE], revealed oxygen at 2 Liters per minute, continuously, per nasal cannula, to document every shift. These orders were carried out as indicated by check marks, and Nurses' initials during AM and PM shifts, on the dated columns. During an observation conducted on [DATE] at approximately 11:26 AM, the oxygen calibration ball observed on the oxygen concentrator cylinder, was level at 3.5 Liters per minute, indicating the physician order was not followed. During another observation conducted on [DATE] at 11:02 AM, the oxygen calibration ball was at 2.5 liters per minute level, indicating the physician order was not followed. In an interview conducted with Staff D, Licensed Practical Nurse (LPN) on [DATE] at 10:34 AM, when she was asked regarding oxygen therapy, she stated the doctor's orders must be followed. 2) Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Anxiety. A review of the annual Minimum Data Set (MDS) assessment, dated [DATE] under Section C of the Brief Interview for Mental Status (BIMS), revealed a score of 13, indicating Resident #40 was cognitively intact. A review of physician orders dated [DATE] revealed oxygen at 2 liters per minute per nasal cannula as needed, for shortness of breath (SOB). An additional review of a physician order dated [DATE], revealed to change oxygen tubing, and nebulizer circuit every night shift, and every Sunday. Review of the [DATE] Treatment Administration Record (TAR) revealed that the oxygen tubing and the nebulizer circuit were changed on the night shift hours on [DATE] and [DATE], as indicated by check marks and Nurse's numbers and initials. During an observation conducted on [DATE] at 10:51 AM, the oxygen tubing connected to the oxygen concentrator for Resident #40, was marked with black ink revealing the date of [DATE] on a white sticker wrapped around the tubing, indicating the doctor's order was not carried out. Additional observations revealed the presence of a clear tubing contained inside a plastic bag with a blue sticker label wrapped around it, but with nothing written on it. The bag where the

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to follow the professional standards of practice and doctor's order regarding taking blood pressure (BP) on the dialysis access site for 1 of 1 sampled resident (Resident #5) reviewed for dialysis. The findings included:Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease, Acute Post Hemorrhagic Anemia, and Respiratory Tuberculosis. A review of the most recent Minimum Data Set (MDS) assessment, dated 06/08/25, under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 13 indicating Resident #5 had intact cognition. A review of physician orders dated 06/12/25, documented to not take BP on right arm with fistula/shunt. A further review of BP documentation on Point Click Care (PCC- electronic health record for Nursing Homes), revealed that Resident #5's BP measurements were taken on the right arm during the following dates and times: On 05/14/25 at 10:05 [NAME] 05/16/25 at 10:11 PMOn 06/07/25 at 11:01 [NAME] 06/07/25 at 11:02 PMOn 06/08/25 at 10:21 PMOn 06/11/25 at 9:12 [NAME] 06/12/25 at 9:13 [NAME] 06/25/25 at 11:30 AM On 06/30/25 at 10:10 AM On 07/05/25 at 10:35 PMOn 07/06/25 at 10:20 PMOn 07/19/25 at 9:37 PMOn 07/20/25 at 10:02 PMOn 07/21/25 at 10:13 AM On 07/25/25 at 10:01 PMOn 07/29/25 at 10:34 [NAME] 08/02/25 at 9:31 PM On 08/06/25 at 10:03 AM In an interview conducted with Resident #5 on 08/12/25 at 12:45 PM, he stated that sometimes, facility staff takes his BP on the arm of the dialysis site. In an interview conducted with Staff N, Registered Nurse (RN) on 08/13/25 at 4:36 PM, when she was asked about nursing care of a resident on dialysis, she responded to check for bruit and pulses on the dialysis access site but take the BP on the opposite arm because Staff must not use the dialysis site arm. Staff document in PCC what arm was used during BP monitoring. She added that Nurses document l for left arm and r for right arm, whether the resident was lying or sitting and the time the BP was taken

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident's medication regimen for psychotropic (antipsychotic) medication was monitored appropriately, as evidenced of the lack of written documentation of behavior monitoring for 1 of 5 sampled (Resident #3) residents reviewed for Unnecessary medications. The findings included:Review of the facility policy provided by the Assistant Director of Nursing titled Psychotropic Medication Use revised on 09/15/24 documents .psychotropics medications are drugs that affect .behavior and include .antipsychotics.facility staff should monitor the resident's behavior pursuant to facility policy using behavioral monitoring chart.for residents receiving psychotropic medication.facility staff should monitor behavioral triggers, episodes and symptoms.Review of Resident #3's clinical record documents an admission to the facility on [DATE] with a readmission on [DATE]. Resident #3's diagnoses included Anoxic Brain, Cognitive Communication Deficit, Bipolar Disorder, and Seizures.Review of Resident #3's record documents an active physician order dated 07/03/25 for Seroquel Oral Tablet 25 milligrams (mg), give 12.5 mg by mouth two times a day for Bipolar Disorder; Seroquel Oral Tablet 25 MG give 1 tablet by mouth at bedtime for Bipolar Disorder dated 07/02/25 and discontinued on 07/22/25. Seroquel Oral Tablet 25 MG give 1.5 tablet by mouth at bedtime for Bipolar Disorder dated 07/22/25.Review of Resident #3's July and August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed a lack of written documentation of behavior monitored for the resident's Seroquel, an antipsychotic medication. Review of Resident #3's Minimum Data Set (MDS) admission assessment dated [DATE] documents a Brief Interview Mental Status (BIMS) score of 3 indicating severe cognition impairment. The assessment documents the resident received antipsychotic medication seven (7) days prior of the completion of the assessment. On 08/13/25 at 11:45 AM, a side-by-side review of Resident #3's July and August 2025 MAR and TAR was conducted with the Assistant Director of Nursing (ADON) who stated the resident went out to the hospital and the Seroquel behavior monitoring was not reimplemented. The ADON confirmed Resident #3 clinical record did not contain documentation of behavior monitoring related to Seroquel.On 08/14/25 at 3:30 PM, an interview was conducted with Staff K, Licensed Practical Nurse (LPN) who stated if they have a resident on Seroquel they have to complete behavior monitoring, and it is documented on the resident's MAR or TAR.On 08/14/25 at 3:33 PM, an interview was conducted with Staff N, Registered Nurse (RN) who stated if they have a resident on Seroquel they do monitor side effects and behavior, and it is documented on the TAR.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide double portions for 2 of 2 sampled residents (Resident #6 and #107) reviewed for dining observations, and for 1 of 1 tray line observations in the kitchen. This has the potential to affect 8 residents with double portions orders. The facility failed to provide fortified foods during observations in the kitchen, that has the potential to affect 12 residents who are to be served fortified foods. The findings include: 1. During an observation conducted in the main kitchen on 08/13/2025 at 12:00 PM, on three occasions, a Dietary Aid was seen reading the double portion meal ticket to the Cook, Staff A. During the observations, Staff S did not understand what double portion meant. This surveyor had to intervene, as the plate was already placed on the tray with single portions and ready to go on the cart. At the time of intervention, the CDM (Certified Dietary Manager) had to explain to Staff A that double portion meant two scoops of each food item to be served. 2. During an observation conducted in the main kitchen on 08/13/2025 at 12:10 PM with most of the trays in the carts ready to go on the floor, this surveyor asked the Certified Dietary Director to identify the fortified mashed potatoes and that's when they realized that no fortified mashed potato servings were cooked today. At that moment, the Certified Dietary Director then asked a dietary aid to make the fortified mashed potatoes. In an interview conducted on 08/13/2025 at 4:05 PM, the Certified Dietary Director stated that she didn't have an explanation for the cook not understanding the definition of double portions. She further stated that regarding fortified foods, she always identifies the fortified food when she is taking the temperatures, but because she didn't take the temperature today, she did not realize that it wasn't on the tray line. In an interview conducted on 08/13/2025 at 2:20 PM, the Registered Dietitian (RD) stated that she has been working in this facility for 5 years and comes to the facility twice a week (Tuesday and Thursday). She explained that it's very important for a resident to receive fortified food because it's a nutritional intervention. She also explained that the kitchen follows a recipe from corporate for fortified foods. For example, for breakfast they add butter and sugar to the oatmeal which makes it fortified; for lunch they add milk and creamer to the mashed potatoes. RD stated that oatmeal and mashed potatoes are the only fortified foods they offer. Regarding the double portions, the RD stated that a plate with double portions should have double entrée: double protein, double carbohydrates and double Vegetable. For example, the lunch for today should have two slices of meatloaf, two scoops of mashed potato, two scoops of spinach and the dessert and the drink should be one. The RD acknowledges that for a double protein a cheeseburger should have 2 patties. In an interview conducted on 08/14/2025 at 11:00 AM, with the Cook, Staff A, she stated that she has been working in this facility for 5-6 months and she is being trained in the kitchen by the manager. Regarding the double portions, Staff A explained that before the incident, she was under the impression that double portion meant double protein. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 08/11/25 at 12:17 PM, during dining observations at the facility's [NAME] 1 unit, Resident #107 was observed sitting in the dining room and had main dish portions on a small scoop plate. The resident meal ticket documented “Double Portions…scoop plate”. Further observation revealed the plate had one scoop of mashed potatoes, vegetables and meat. The portions were not double as per the meal ticket. On 08/13/25 at 12:20 PM, observation revealed Staff I, Certified Nursing Assistant (CNA) feeding Resident #107. Subsequently, an interview was conducted with Staff I who was asked if Resident #107 had double portions on her plate. Staff I was not able to state if the resident had double portion meal. Resident #107 meal portions were not double. On 08/13/25 at 2:16 PM, a joint interview with the facility Consultant Registered Dietitian (RD) and the survey team were conducted. The RD stated a resident with a double portions order should have double protein, carbohydrate and double vegetables. The RD stated a resident with a scoop plate should have two plates to accommodate double portions and added she believed they did not have any residents on a scoop plate. On 08/14/25 at 11:24 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated she had a resident who the family asked for double food portions but was discontinued because of a weight gain. She stated she did not have any resident on double food portions. The ADON was asked who checks the resident's tray to ensure they receive the correct meal and replied that the CNA, the nurses, and herself will check the meal tray to make sure they get the right tray: staff are supposed to know what the resident is to get on the tray. The ADON stated Resident #107 was a set-up before for meals but needs to be fed now. On 08/14/25 at 12:05 PM, an interview was conducted with Staff O, CNA who stated that for a double portion meal, the resident will have two scoops of the food. Staff O was apprised Resident #107 did not receive two scoops of the food on 08/11/25 and on 08/13/25. On 08/14/25 at 12:01 PM, during an interview, the ADON was asked how she can tell if the resident who has a fortified food diet is receiving it as ordered and replied that a resident on a fortified food diet gets a magic cup. On 08/14/25 at 12:07 PM, an interview was conducted with Staff O, CNA who was asked what fortified food is and stated a magic cup and for breakfast they get prepared oatmeal. On 08/14/25 at 12:10 PM, an interview was conducted with Staff K, LPN who was asked what fortified food is and stated the resident on fortified food will get a magic cup. 4. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that included Malignant Neoplasm of Temporal Lobe, Malignant Neoplasm of Parietal Lobe, and Enterocolitis due to Clostridium Difficile, (C. Diff). (C. Diff is a serious bacterial infection that primarily affects the colon, often causing severe diarrhea and inflammation). His brief interview for Mental Status (BIMS) score was 11 on the admission Minimum Data Set (MDS) assessment dated [DATE]. This indicated the resident had mild cognitive impairment. Record review revealed on 07/01/2025, the resident weighed 174.4 pounds. On 08/11/2025, the resident weighed 154.6 pounds, which is a -11.35% loss. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/25 the Dietician recommended double portions for weight loss for Resident #6. An observation of lunch was conducted on 08/13/25 at 12;30 PM. The resident's meal ticket documented “Double Portion”. Further observations revealed lunch was delivered with a magic cup, apple juice, 1 meatloaf slice, 2 servings of mashed potatoes, a scoop of spinach and one piece of pie. On 08/13/25 at 2:16 PM, a joint interview with the facility's consultant Registered Dietitian (RD) and the survey team surveyors were conducted. The RD stated a resident with a double portion order should have double protein, carbohydrate and double vegetables. A double portion for Resident #6 for lunch on 08/13/25 should have been 2 slices of meatloaf, 2 scoops of mashed potatoes, 2 scoops of spinach and 1 piece of pie. An interview was conducted on 08/13/25 at 3:56 PM with the Dietary Director. She stated Resident # 6 should have received 2 slices of meatloaf for lunch for double portions. An interview was conducted with Resident #6 on 08/14/25 at 8:50 AM. Resident #6 was asked if he ate breakfast today and he stated he did, and it was pancakes. The resident did not receive the fortified oatmeal.

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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 observations, interviews and record reviews, the facility failed to provide the correct diet consistency for pureed diets, for 5 of 5 sampled residents (Resident #20, Resident #45, Resident #108, Resident #33 and Resident #15) observed on pureed diets. This has the potential to affect 10 residents receiving pureed diets. The findings include: 1. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses of Degenerative Disease of Nervous System and Encounter for palliative care. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) revealed that Resident #20 was unable to conduct the interview. A review of Resident #20's orders dated 06/19/25 documented the following: Regular diet, Puree texture, Nectar/Mildly consistency, nectar fluids by teaspoon. In an observation conducted on 08/11/25 at 1:15 PM revealed Resident #20's meal ticket diet consistency read puree regular and nectar fluid. Further observation revealed Resident #20's tray consisted of a lumpy beige pureed food, grainy light brown pureed food and a yellow and brown pureed food with a red sauce. 2. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnosis of Parkinson's Disease without Dyskinesia and Bronchitis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 4, which indicates severe cognitive impairment. A review of orders dated 07/21/25 indicated the following: Regular diet, Puree texture, Honey/Moderately consistency, Fortified Foods with all Meals. In an observation conducted on 08/11/25 at 1:30 PM, observation revealed Resident #45's meal ticket diet included consistency as puree, regular, honey/moderately consistency. Resident #45's tray consisted of a lumpy beige pureed food, a grainy light brown pureed food and a yellow and brown pureed food with a red sauce. In an observation conducted on 08/12/25 at 12:42 PM, observation revealed Resident #45's meal ticket diet consistency is puree, regular, honey/moderately consistency. Further observations revealed Resident #45's meal tray consisted of grainy brown pureed-like food, and orange pureed-like food, a light yellow pureed-like scoop of food and a light brown topped with gravy pureed like food. 3. Record review revealed Resident #108 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Encephalopathy and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 3, which indicates severe cognitive impairment. A review of the orders dated 07/22/25 revealed the following: Regular diet, Puree texture, Nectar/Mildly consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation conducted on 08/11/2025 at 1:30 PM this surveyor observed that Resident #108 meal ticket diet consistency was puree, regular, double portions, nectar. Further observations revealed Resident #108's tray consisted of a lumpy beige pureed food, a grainy light brown pureed food and a yellow and brown pureed food with a red sauce. In an interview conducted on 08/13/2025 at 2:20 PM, the Registered Dietitian (RD) stated that a pureed texture is not supposed to be runny nor too thick. Some food may be lumpy, grainy-like depending on the food like bread and pancake but mostly should be smooth. I don't check the tray line for the pureed food because I do more clinical work. She further explained that she hasn't checked the tray line this past week. The RD acknowledged the findings. In an interview conducted on 08/13/2025 at 4:10 PM, Certified Dietary Director stated that pureed food should look like an ice cream scoop but not exactly because it's too dry, so a semi melted ice cream. The Dietary Director acknowledged the findings and said she will find a solution to make sure the pureed foods are very smooth. In an interview conducted on 08/14/2025 at 11:00 AM with the cook, Staff A, she stated that she makes the pureed food in the food processor machine. For the bread you must leave it in the food processor machine a lot. Since I started working here, they always told me all pureed are in the food processor machine. In an interview conducted on 08/14/2025 at 11:30 AM, the Speech and Language Pathologist stated that she has been working for the facility for almost 6 years. She further explained that pureed food should be blended, not runny, cohesive, different than chopped, lumps would be fine like a tapioca pudding would be fine, not grainy with solid parts, mostly smooth, nothing that would need to be chewed. The Speech and Language Pathologist showed the pictures and said it was okay to be a little lumpy. 4. On 08/11/25 at 12:38 PM during dining observations at the facility's [NAME] 1 unit, Resident #33's meal ticket read Puree, Regular diet. Observation revealed the food texture was lumpy and not pureed as ordered. The resident was not interview able and was not able to feed herself. Resident #33's diagnoses included Unspecified Protein-Calorie malnutrition, Dysphagia-Oropharyngeal Phase, Unspecified Dementia, and Cognitive Communication Deficit. 5. On 08/11/25 at 12:40 PM, during dining observations at the facility's [NAME] 1 unit, Resident #15 meal ticket read/documents Puree, regular diet: observation revealed the food texture was lumpy and not puree as ordered. The resident was not unreviewable and was not able to feed herself. Resident #15 diagnoses included Dysphagia-Oropharyngeal Phase, Cognitive Communication Deficit and Alzheimer's. On 8/13/25 at 2:16 PM, a joint interview with the facility consultant RD and the survey team surveyors was conducted. The RD stated that for Puree texture food she makes sure is not running, not too thick, some food may be lumpy and should be smooth. During an interview, a side-by-side review of Resident #15's photographic evidence of puree food served on 08/11/25 was shown to the RD who confirmed the food was lumpy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106047	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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 observations, interviews and record reviews, the facility failed to provide food that meets residents' preferences, for 3 out of 22 sampled residents observed during dining. (Resident #21, Resident #55, Resident #62).The findings included:1. A record review showed that Resident #21 was admitted on [DATE] with diagnosis of unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing and fracture of unspecified part of neck of right femur. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 14, which indicates no cognitive impairment.In an observation conducted on 08/11/2025 at 1:15 PM this surveyor observed that Resident #21 meal ticket consisted of Broccoli & Cauliflower under the Allergies and Dislikes section. Resident #21 tray consisted of a mix of vegetables including cauliflower and broccoli. Residents #21 ate everything on the plate except the mixed vegetables. Resident #21 stated that she is tired of explaining that she doesn't eat broccoli or cauliflower, but she always gets them on her tray.2. A record review showed that Resident #55 was admitted on [DATE] and readmitted on [DATE] with diagnosis of anemia and hereditary and idiopathic neuropathy. The Medicare -5 Day Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairment.In an observation conducted on 08/11/2025 at 1:18 PM, this surveyor observed that Resident #55 meal ticket consisted of Double Protein in Preferences and Resident #55 tray consisted of a single patty cheeseburger with lettuce and tomato.In an observation conducted on 08/12/2025 at 12:45PM, this surveyor observed that Resident #55 meal ticket consisted of Double Protein in Preferences and Resident #55 tray consisted of a single patty cheeseburger with lettuce and tomato.3. A record review showed that Resident #62 was admitted on [DATE] with diagnosis of cachexia and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairment.In an interview conducted on 08/11/2025 at 12:36PM, Resident #62 stated that she did not order mashed potato with meat sauce but spaghetti with meat sauce. Resident #62 was very mad and further explained that it's not the first time. In an observation conducted on 08/11/2025 at 12:35 PM, this surveyor observed that Resident #62 tray consisted of mashed potato and meat sauce. Resident #63 showed this surveyor a sheet of paper where she writes what she wants to eat every day for lunch and dinner.In an interview conducted on 08/13/2025 at 2:20 PM, Registered Dietitian stated that a plate with double portions should have a double entree: double protein, double carbohydrate, double vegetable. Like lunch today should have been two slices of meatloaf, two scoops of mashed potato, two scoops of spinach and the dessert and the drink should only be one. RD acknowledged that for a cheeseburger they should have 2 patties.In an interview conducted on 08/13/2025 at 4:00 PM, Certified Dietary Director stated that she has been working for this facility for almost two years. She further explained that the person doing the tray is supposed to read the ticket to the cook. The only way I can make sure that the meal ticket matches the tray is by making sure that the meal ticket is as accurate as they can be. And it also starts with getting the information's from the patients. The Certified Dietary Director acknowledged the findings and admitted that she could of sent the alternative to Resident #21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106047	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106047	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center at Inverrary	4300 Rock Island Road Lauderhill, FL 33319

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow their own policy for Clostridium Difficile Infection (CDI) regarding meal tray removal for 1 sampled resident (Resident #6) and failed to follow their policy for disinfection of machine and equipment after residents' use during 2 observations.The findings included:A record review of a policy titled, Clostridium Difficile (CDI) with the latest revision date of 02/22/21, it revealed meal trays should be bagged prior to removal from the room and are then placed on the tray cart (p.2, no.7).An additional record review of a policy titled, Cleaning and Disinfection of Non-Critical Patient Care Equipment, with the latest revision date of 08/22/22, revealed the following: Equipment will be cleaned and disinfected prior to storage (p. 2, no.1). Non-critical items require cleaning followed by either low or intermediate-level disinfection following manufacturers' instructions (Procedure no.1.) Disinfection should be performed with an Environmental Protection Agency (EPA)- registered disinfectant labeled for use in healthcare settings (Procedure no.2). A record review revealed Resident #6 was admitted on [DATE] with diagnoses that included Benign Prostatic Hypertrophy, Hypertension, Diverticulosis, and Hypothyroidism. A positive test result dated, 07/18/25 for Toxigenic B, C. Difficile, put Resident #6 under contact precautions. A review of Minimum Data Set (MDS) assessment, under Section C of the Brief Interview for Mental Status (BIMS), revealed a score of 11, indicating Resident #6 had mild cognitive impairment. During an observation conducted by another surveyor on 08/13/25 at 08:30 AM and at 12:50 PM, it was revealed that staff Certified Nursing Assistants (CNAs), do not contain or bag Resident #6's meal tray when they removed them from the room. In an interview conducted with the Infection Preventionist Registered Nure (IPRN) on 08/13/25 at 3:38 PM, she was asked how she educated Nurses, CNAS and other direct care staff regarding disease transmission and infection control practices, responded she provided in services about contact-based precautions, and Enhanced Barrier Precautions (EBP). When she was asked about the type of utensils and dining supplies used by Resident #6, she responded that this resident uses plastic utensils for eating, but she is not sure. When she was asked if facility staff members were in-serviced regarding containing or bagging supplies such as meal tray when leaving Resident #6's room, she responded, I provided in services for contact-based precautions . When she was asked if she had observed any meal tray removal by direct care staff from Resident #6's room, she responded she had not performed observation of staff bagging the meal tray. When she was asked if observation of facility staff member regarding infection control practices is included in her responsibility as Infection Preventionist RN, she did not respond. When asked how long Resident #6 had been in facility, she responded, since June 2025. When asked why she had not performed observation and education of direct care staff CNAs and Nurses regarding meal tray removal from Resident #6's room, she responded she had not performed these tasks because she was assigned with different tasks for the past few months. In a continuing interview conducted with the Infection Preventionist RN on 08/13/25 at 3:48 PM, when she was asked if she educated kitchen staff about infection control practices and transmission of CDI, she responded that the education is provided by the Certified Dietary Manager (CDM). During an observation conducted on 08/11/25 at 12:58 PM, there were 2 staff members helping a resident move from bed to chair using a machine, inside a resident's room. The machine had a label of Golvo 7007 ES. When the staff members were done with the bed to chair transfer, Staff I, Certified Nursing Assistant (CNA) left the room with the machine. She parked and plugged the machine in front of the Nurses' station on 08/11/25 at approximately 1:12 PM. She left the machine and stated she would wash her hands. When this surveyor asked if she was done with the machine, she responded, Yes. Staff I, CNA did not disinfect the machine after resident's usage. During another observation conducted with Staff F, Certified Nursing Assistant (CNA) on 08/14/25 at 8:57 AM, who was seen rolling a vital signs machine cart out of the resident's room. Staff F, CNA, who has been working in the facility for one year, was seen without gloves. She stopped across the Nurses' station on the second floor and was ready to leave the vital signs machine cart after parking it. She was asked by this surveyor about the care and cleaning of machine and equipment after resident's usage. She responded that she cleaned the vital signs machine cart inside the resident's room using hand sanitizer. When she was asked to repeat, she responded, I used two little hand sanitizer wipes to clean the vital signs machine cart. When she was asked if she could show this surveyor the hand sanitizer wipes, that she just used to clean the vital signs machine cart, she responded, I don't have one anymore, but I will get more from the Nourishment room. She went inside the Nourishment room and started searching for