STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106091	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Wellington Rehabilitation Center The	10330 Nuvista Avenue Wellington, FL 33414

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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	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** 25404 Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents were spoken to and cared for in a dignified manner (Residents #18, #39, and #33). The findings included: 1) Review of the record revealed Resident #18 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current orders revealed the resident had an admission order dated 08/30/24 for the use of barrier cream, a protective cream, every shift and as needed. A secondary order was written on 09/01/24 to clean the buttock with normal saline and apply zinc oxide every shift. This order was typically used when a resident has excoriation to the buttock. During an interview on 09/24/24 at 10:33 AM, when asked if she was treated with dignity and respect, Resident #18 stated with some of the staff it's like they don't care. Resident #18 explained her bottom was raw from a week in the hospital and a week at the facility. Resident #18 stated, The other night it hurt when she, a Certified Nursing Assistant (CNA) was cleaning me up. She had me almost in tears, and I told her it hurt, and she just kept doing the same thing. I don't think she was intentionally trying to hurt me, but she just wasn't listening or caring. When asked if she had told anyone about her concerns, she stated, No one comes around to see how we are doing. When asked if they do daily rounds to see you and see how you are doing, Resident #18 stated, No, I don't think they have time for that. Resident #18 stated she can hear staff talking to the resident across the hall, to include staff statements like, I'm busy. You'll have to wait. You don't need that right now. I'm not getting you that now. During the continued interviewed, when asked about therapy, Resident #18 stated one of the therapists speaks down to me. When asked what she meant by that, the resident stated, I don't know if she thinks I don't understand, but she tries to force me to do something when she wants it done. The resident gave the example that she could be in the middle of eating and the therapist will see the red exercise band hooked on the side of her bed and say, let's do it now, referring to the exercises, even though she was still eating. Resident #18 stated, She just talks and thinks right over me. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the record revealed Resident #39 was admitted to the facility on [DATE]. Review of the current MDS dated [DATE] documented the resident had a BIMS score of 15 and was dependent upon staff for toileting. During an interview on 09/25/24 at 3:59 PM, Resident #39 explained that morning, after being taken to the bathroom, she was having trouble cleaning herself. She called for assistance and the CNA was very abrupt with her. The resident explained she was standing up and needed help. The CNA asked her multiple times, what do you need with a tone in her voice. The resident stated then the CNA kept telling her Move your leg two or three times, while the resident was saying I'm trying to but can't. The resident stated, It's just not respectful. During this same interview, Resident #39 stated therapy dropped her off in her room that afternoon, placing her next to the bed. The resident stated a little later she needed to use the bathroom, and the call light was on the other side of her bed out of reach. The resident stated she had to start screaming to get anyone in the room to assist her. Resident #39 stated staff will often come in and shut the light off and say they will be back. After 45 minutes or so she would have to call them back. The resident stated she had been left in a soiled diaper for over an hour. 51137 3) Review of Record revealed Resident #33 was admitted to the facility 08/26/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #33 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 09/23/24 at 2:47 PM, Resident #33 was observed to be visibly upset. When asked about her care, the resident stated the care could be better. She stated there were some disrespectful staff that took care of her. She explained they roll their eyes when she asked for help. When asked how that made her feel, the resident stated, It is upsetting. During an Interview on 09/27/24 at 11:05 AM, when Resident #33's concerns were addressed with the Administrator and Social Service Assistant, they agreed the resident was not treated in a dignified manner.

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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** 32078 Based on observation, interviews and record reviews, the facility failed to ensure adequate staff communication with 2 of 2 sampled residents who were unable to speak English (Resident #29 and #394). The findings included: 1) A review of the Electronic Health Record documented Resident #29 was admitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder, Need for Assistance with Personal Care, and Difficulty in Walking, A review of the 5 day Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #29 has a BIMS (Brief Interview for Mental Status) score of 7 out of 15 (cognitively impaired). It also documented in Section A of the MDS that the resident is of Hispanic origin and her preferred language is Spanish. It also documents her desire to have an interpreter to communicate with a doctor or health care staff. On 09/23/24 at 11:01 AM, an attempt was made to interview Resident #29, but she was unable to understand English. Her [family member] who was in the room at the time and states that she visits frequently, complained, [Resident #29] only speaks Spanish and there are no care staff available who speak Spanish. There is no way for [Resident #29] to communicate her needs to the staff, or for the staff to communicate with [Resident #29]. There should be something they can use to communicate. There are apps on the phones that will translate, but I haven't seen any care staff using them to communicate with [Resident #29]. 51137 2) A review of the record revealed Resident #394 was admitted to the facility on [DATE]. A review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #394 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS section A Identification Information documented the resident was of Hispanic, Latino or Spanish origin. The MDS documents the resident's preferred language as Spanish and her need/want of an interpreter to communicate with a doctor or health care staff. Two observations on 09/25/24 at 9:30 AM and 09/25/24 at 11:40 AM were made of staff interacting with Resident #394 in English. During an interview on 09/23/24 at 12:00 PM conducted in Spanish, when asked how she communicated with staff, Resident #394 stated she cannot communicate with staff and had not been offered any communication system such as the use of a language line. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/24 at 11:12 AM, when asked how the care of Resident #394 was, the family member stated there is no diversity here. Before the resident's admission to the facility, she was told there were Spanish personnel at the facility. During the last care plan meeting the family member was told that nurses were trilingual, she stated this was not true because they're not able to communicate with the resident. When asked if staff use a language line or any type of communication system, she stated they do not. During an interview on 09/27/24 at 9:51 AM, when asked how many Spanish speaking nurses and Certified Nursing Assistants (CNA) were available in the facility, the Staffing Coordinator stated they had one Spanish speaking CNA during the day shift and one during night shift. She stated they had two Spanish speaking nurses during the day. During an interview on 09/27/24 at 9:57 AM, when asked how staff communicated with Spanish speaking residents, the MDS Coordinator stated they call nurses, CNAs, or Spanish speaking staff to translate for residents. During an interview on 09/27/24 at 10:52 AM, when asked what staff should do when there is no Spanish speaking staff available, the Administrator and Social Service Assistant stated they should use the language line. The Surveyor was provided with evidence of the language line instructions of how to access an interpreter the facility staff is expected to utilize. (Photographic evidence obtained).

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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** 32078 Based on record review and interview, the facility failed to ensure timely administration of two prescribed medications for 1 of 6 sampled residents reviewed for medications (Resident #50). The findings included: Record review revealed that Resident #50 was admitted on [DATE] with diagnoses which included Parkinson's Disease, Syncope and Collapse, Orthostatic Hypotension, and Hypertension. A review of Resident's 5-day Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a BIMS score of 15 out of 15 (cognitively intact). On 09/24/24 at 9:45 AM, during an interview with Resident #50, she stated that she has run out of her medications a couple of times for 1-2 days. She stated she didn't want to speak about it further but provided the surveyor with her samily members number and asked that he be interviewed for further details. On 09/24/24 at 11:49 AM, Resident #50's family member was interviewed via telephone and stated that he felt Resident #50 had declined due to not participating in therapy as much as she needed to because she was not being provided her medications in a timely manner. When she doesn't get her medications on time, it can affect her blood pressure, she becomes dizzy, and she doesn't want to get out of bed to attend therapy. On 09/27/24 at 3:17 PM, an interview was conducted with the Assistant Director of Rehab/Physical Therapy Assistant. He stated, [Resident #50] is currently receiving PT/OT and is scheduled for 5 days, but there have been some refusals due to dizziness. A review of Resident #50's Care Plan, initiated on 08/30/24, documents that the resident has an alteration in neurological status due to diagnosis of Parkinson's, and the resident's prescribed medications are to be given as ordered. A review of Resident #50's medication orders showed active orders for the following Parkinson's medications: Carbidopa-Levodopa Oral Tablet 25-100 MG Give 1 tablet by mouth three times a day for Parkinson (9 AM, 1 PM, and 5 PM); and Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG Give 1 tablet by mouth two times a day for Parkinson (6 AM and 9 PM). A review of the Medication Administration Record revealed the following for the administration of Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG (8 AM and 8 PM): 09/08/24 - medication was not recorded as being given at 8 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/14/24 - medication was given at 10:09 PM (1 hour and 9 minutes late); 09/16/24 - medication was given at 11:10 PM (2 hours and 10 minutes late); 09/25/24 - medication was given at 10:09 PM (1 hour and 9 minutes late). A review of the Medication Administration Record revealed the following for the administration of Carbidopa-Levodopa Oral Tablet 25-100 MG (9 AM/900, 1 PM/1300, and 5 PM/1700): 09/20/24 - medication was given at 10:49 AM (1 hour and 49 minutes late); 09/20/24 - medication was given at 2:25 PM (1 hour and 25 minutes late); 09/21/24 - medication was given at 10:07 AM (1 hour and 7 minutes late); 09/22/24 - medication was given at 10:26 AM (1 hour and 26 minutes late); 09/22/24 - medication was given at 10:09 PM (1 hour and 9 minutes late); 09/24/24 - medication was given at 6:14 PM (1 hour and 14 minutes late); 09/26/24 - medication was given at 11:53 AM (2 hours and 53 minutes late); 09/26/24 - medication was given at 3:19 PM (2 hour and 19 minutes late); 09/27/24 - medication was given at 11:21 AM (2 hours and 21 minutes late); 09/27/24 - medication was given at 3:02 PM (2 hours and 2 minutes late). On 09/27/24 at 4:37 PM, an interview was conducted with the Director of Nursing (DON). She confirmed that medications are to be given within 1 hour prior and 1 after the prescribed time of the medication, per physician order. The DON was provided evidence showing Resident #50's medications have not consistently been provided within the allowed time frames. The DON stated she would start an in-service for nursing staff regarding providing the residents with their medications in a timely manner.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078 Based on observation, interview and record review, the facility failed to ensure sufficient staffing as evidenced by failure to provide timely administration of medications for 1 of 6 sampled residents (Resident #50 .refer to F684); ineffective communication for 2 of 2 sampled residents (Residents #29 and 394 (refer to F676); and numerous resident / family complaints from 13 of 31 sampled residents / representatives (Residents #394, #393, #192, #39, #66, #33, #4, #29, #193, #63, #1, #194, and #395). The findings included: 1) On 09/24/24 at 11:49 AM, Resident #50's family member was interviewed via telephone and stated that he felt [Resident #50] had declined due to not participating in therapy as much as she needed to because she was not being provided her medications in a timely manner. When she doesn't get her medications on time, it can affect her blood pressure, she becomes dizzy, and she doesn't want to get out of bed to attend therapy. A review of Resident #50's medication orders showed active orders for the following Parkinson's medications: Carbidopa-Levodopa Oral Tablet 25-100 MG Give 1 tablet by mouth three times a day for Parkinson (9 AM, 1 PM, and 5 PM); and Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG Give 1 tablet by mouth two times a day for Parkinson (6 AM and 9 PM). A review of the Medication Administration Record revealed the following for the administration of Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG (8 AM and 8 PM): 09/08/24 - medication was not recorded as being given at 8 AM. 09/14/24 - medication was given at 10:09 PM (1 hour and 9 minutes late); 09/16/24 - medication was given at 11:10 PM (2 hours and 10 minutes late); 09/25/24 - medication was given at 10:09 PM (1 hour and 9 minutes late). A review of the Medication Administration Record revealed the following for the administration of Carbidopa-Levodopa Oral Tablet 25-100 MG (9 AM/900, 1 PM/1300, and 5 PM/1700): 09/20/24 - medication was given at 10:49 AM (1 hour and 49 minutes late); 09/20/24 - medication was given at 2:25 PM (1 hour and 25 minutes late); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/21/24 - medication was given at 10:07 AM (1 hour and 7 minutes late); 09/22/24 - medication was given at 10:26 AM (1 hour and 26 minutes late); 09/22/24 - medication was given at 10:09 PM (1 hour and 9 minutes late); 09/24/24 - medication was given at 6:14 PM (1 hour and 14 minutes late); 09/26/24 - medication was given at 11:53 AM (2 hours and 53 minutes late); 09/26/24 - medication was given at 3:19 PM (2 hour and 19 minutes late); 09/27/24 - medication was given at 11:21 AM (2 hours and 21 minutes late); 09/27/24 - medication was given at 3:02 PM (2 hours and 2 minutes late). On 09/27/24 at 4:37 PM, an interview was conducted with the Director of Nursing (DON). She confirmed that medications are to be given within 1 hour prior and 1 after the prescribed time of the medication, per physician order. The DON was provided evidence showing Resident #50's medications have not consistently been provided within the allowed time frames. 2) On 09/23/24 at 11:00 AM, the family member of Resident #29 stated, [Resident #29] only speaks Spanish and there is no staff available that speaks Spanish. I am concerned because there is no way for [Resident #29] to communicate with the staff. The family member also added, There needs to be more supervision. Staff do not come by and check on [Resident #29] very often. The response time to her call light is very long. On 09/23/24 at 11:46 AM, Resident #394, who has a Brief Interview for Mental Status (BIMS) score of 14, complained there is not enough staff. I ring the call light, and it takes about 20 minutes to respond. When I go to the bathroom, it takes 20 minutes or longer to get changed. It is often that this happens. It happens more at night. On 09/25/24 at 11:12 AM, during interview with Resident #394's family member, she stated she does not think there is sufficient staff to meet [Resident #394's] needs. There are no Spanish speaking personnel able to communicate with [Resident 394]. Before admission, they were told that there were Spanish-speaking personnel, and during the care plan meeting, they were told that nurses were trilingual, but they are not. The family member added, I have had to come into the facility to change [Resident #394] since staff were not answering the call light. No one was at the nurse's station to take my calls. I left messages, and no one return the calls. I asked the social worker during the care plan meeting where my voicemails were going, and I was told that she didn't know. No one is at the desk at night. I feel the staff are overwhelmed at night. 3) The following concerns were voiced by residents and family members during the survey process: a) On 09/23/24 at 11:15 AM, Resident #192, whose BIMS is 12, stated, The staff response time to call my light is long. It usually takes an hour for staff to respond. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) On 09/24/24 at 9:50 AM, Resident #194, whose BIMS is 15, stated, I ask staff for a cup of ice and gingerale, but they tell me they don't have soda and never provide it to me. I have also asked staff 2 days ago for some Ben Gay to rub on my shoulder, and still nothing. I asked for some lotion for my back 3 days ago, and I have not received it. The staff keep saying 'OK, OK', but they never do anything. c) On 09/23/24 at 10:50 AM, Resident #193, whose documented BIMS is 15, stated, Usually, there is only 1 nurse on the floor at times. The fastest response time is 25-30 minutes. Usually, it is 2-3 hours before staff answer my call light. 51137 d) On 09/23/24 at 2:35 PM, Resident #63, with a BIMS score of 11, indicating moderate cognitive impairment, stated there is not enough staff; she waits 2 & 1/2 hours to get changed. e) On 09/23/24 at 2:25 PM, Resident #71, who has a BIMS score of 13 said it feels like they are short staffed. There are long wait times to get changed, at least 2-3 times it has been over an hour. f) On 09/23/24 at 10:36 AM, Resident #393, whose BIMS score was 15 and was admitted on [DATE], stated that she had sat in soiled briefs for 5 hours, as she had watched clock. Her family member, who was at bedside, tried to help. The aide, who was unpleasant, told her, 'This is the 2nd time I have to change you'. The family added that [Resident #393] was not provided water and stated that this all occurred during the weekend. It was hard to find any staff to help. It was stated that on Friday night, a random resident walked into Resident #393's room and sat on her floor. The resident was very sweet, but it was a little frightening. g) On 09/23/24 at 12:12 PM, Resident # 66's representative said that this resident did not get changed and dressed until 11:30 AM today. She stated that it does not seem like there is enough staff to take care of the resident's needs. It is worse mostly on weekends. Resident #66 was not interviewable as her BIMS was 04 (severe cognitive impairment). h) On 09/23/24 at 2:47 PM, Resident #33, who has a BIMS score of 15, said the facility is short staffed. It takes at least 45 minutes to answer the call light. i) On 09/24/24 at 10:51 AM, Resident #4, who has a BIMS score of 15, stated, It takes over an hour, or sometimes several hours, to answer the call light. j) On 09/23/24 at 12:54 PM, Resident #395's family member voiced concern with lack of staff. She said, it takes about 45 minutes for [Resident #395] to get changed, and at night she often hears other resident's calling out for help. k. On a follow up interview on 09/27/24 at 9:31 AM, Resident # 395's family member stated she left [Resident 395's] curtain up at a specific height on purpose to see if staff would adjust it, but it was not adjusted at all, and [Resident 395's] TV was left on all night.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation and interview, the facility failed to ensure beverage of choice and timeliness of meals, as per preference for 3 of 4 sampled residents (Residents #18, #31, and #143). The findings included: Review of the Meal Service of Operation schedule revealed breakfast for Wing #3 on the second floor was scheduled for delivery between 8:15 AM and 8:30 AM daily. Residents #18, #31, and #143 resided on this unit. 1) Review of the record revealed Resident #18 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current orders revealed Resident #18 was on a regular textured and thin liquid consistency diet. During an interview on 09/23/24 at 12:49 PM, Resident #18 reported that breakfast was consistently late, being served to her between 9 AM and 10:30 AM, and that she could not get any coffee until the trays arrived to the unit. Resident #18 stated, Yesterday they didn't even have any coffee. They offered me hot chocolate. During an observation and interview on 09/24/24 at 10:25 AM, the resident's finished breakfast tray was still at the bedside. When asked what time she received her breakfast that morning, Resident #18 stated about 9:40 AM. During an interview on 09/25/24 at 12:46 PM, Resident #18 stated she received breakfast about 10:30 AM that morning. When told breakfast was delivered to the first floor about 8:30 AM that same morning, and was she sure her breakfast was that late, Resident #18 stated she was sure, further adding, If I got my breakfast at 8:30 AM I would pass out. 2) Review of the record revealed Resident #31 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 15. During an interview on 09/23/24 at 12:36 PM, Resident #31 stated, They can't get breakfast up here until 9 AM or 10 AM, and didn't get coffee for two days. When asked how he usually got coffee at the facility, the resident stated it usually comes on the tray with his meal. Resident #31 again stated they did not have coffee for two days and when he asked staff for it, they told him they didn't have any coffee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106091	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Wellington Rehabilitation Center The	10330 Nuvista Avenue Wellington, FL 33414

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 - Few	3) Review of the record revealed Resident #143 was admitted to the facility on [DATE]. The record lacked a completed MDS, as the resident had been recently admitted , but the nursing admission assessment documented the resident was alert and oriented. Review of the Food Preferences form dated 09/16/24 documented Resident #143 preferred coffee and milk for all three meals. During an interview on 09/24/24 at 11:10 AM, Resident #143 stated the meals were always late and there was no coffee for two days. The resident stated in frustration, Breakfast at 11:30 AM is ridiculous. Resident #143 further stated, Lunch at 3 PM and dinner at 7:30 PM is crazy. They need more people in the kitchen, or they need to open up earlier. I want meals at a decent time. During an observation and interview on 09/25/24 at 1:01 PM, Resident #143 again stated that food was delivered late every day. The resident further stated, Look! What do I have to do to get whole milk? When asked if she had spoken to anyone about the milk, Resident #143 stated she had and stated it was even documented on her meal ticket. An observation of the resident's meal ticket documented, MILK WHOLE and a pint carton of nonfat milk was observed on the tray. (Photographic Evidence Obtained). During an observation on 09/27/24 at 1:11 PM, lunch had just been served to Resident #143. The meal ticket documented MILK WHOLE. None of the other food preferences were documented in all capital letters. A pint carton of nonfat milk was noted on the meal tray. (Photographic Evidence Obtained). During an interview on 09/27/24 at 1:20 PM, when asked the process for delivery of meals, the second floor Unit Manager (UM) explained the process included checking the meal ticket with the delivered food to ensure the correct meal was provided. When asked if they also check the beverages, the UM confirmed they did. When told about the lack of whole milk for Resident #143 this week, the UM was unsure as to why it happened. When asked if there had been a problem with not having coffee over the weekend or the previous week, the UM stated she was not told of any issues over the weekend, and stated there was not a problem last week. During an interview on 09/27/24 at 1:33 PM, the Regional Food Service Manager stated coffee is always available and was unaware of any recent issues. When told of the lack of whole milk for Resident #143 he again was unsure as to why the resident was not provided her beverage of choice.