STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 1/27/2025 through 1/31/2025. The survey team returned onsite to validate the credible allegation on 02/06/2025. Therefore, the exit date was changed to 02/06/2025. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness ID #CJM511.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 1/27/2025 through 1/31/2025. The survey team returned onsite to validate the credible allegation on 02/06/2025. Therefore, the exit date was changed to 02/06/2025. Event ID# CJM511. The following intakes were investigated NC00225294, NC00224096, NC00222268, NC00221874, NC00221149, NC00220349, NC00225604, NC00217929, NC00217654, NC00217240, NC00213767, and NC00213460. 12 of the 26 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F551 at a scope and severity (J) Immediate Jeopardy began on 1/24/2025 and was removed on 2/1/2025. Past-noncompliance was identified at: CFR 483.12 at tag F602 at a scope and severity (D)	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		3/3/25

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

Electronically Signed | 02/28/2025

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F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and Resident interviews, the facility failed to treat a dependent resident in a dignified manner when Nurse Aide (NA) #2 failed to change Resident #39's soiled brief upon request of the Resident before she ate her lunch meal for 1 of 1 resident reviewed for dignity and respect (Resident #39). Resident #39 stated she felt belittled and treated like a child. The findings included: Resident #39 was admitted to the facility on 04/13/23. The quarterly Minimum Data Set (MDS) assessment dated 10/28/24 revealed Resident #39's cognition was severely impaired, and the Resident was dependent (helper does all the effort) for toileting. The MDS indicated Resident #39 was always incontinent of bladder and bowel. On 01/27/25 at 2:20 PM during an observation and interview with Resident #39 the Resident was lying in bed on her back. The Resident explained that she could not go to the bathroom by herself and that she wore a brief which had to be changed by the staff. Resident #39 continued to explain that she had a bowel movement before lunch and could smell herself and when the girl brought her lunch meal to her, she told the girl that she had soiled her brief and needed to be changed. The Resident reported that the girl told her that she could not stop and change her at that time because she was passing out lunch trays. During the interview the Resident then lifted her	F 550	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/27/25 resident #39 was provided incontinence care by nursing assistant (NA) #2. Also, NA #2 was educated on 1/27/25 by the Staff Development Coordinator, regarding the residents' right to have incontinent care provided when requested regardless of meal trays being on the floor (awaiting delivery). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/28/25, observation rounds were initiated during mealtimes of incontinent residents to ensure briefs were being changed timely and residents were not being left soiled by the clinical administrative team. No additional concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/26/25, education was initiated by the Staff Development Coordinator (SDC) with all clinical staff (licensed nurses, med aides, and nursing assistants) which included agency clinical personnel on providing incontinent care upon request even during mealtime. Effective March 3, 2025, any facility or agency clinical staff who have not been educated, will not be allowed to work until this education is	

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F 550	Continued From page 3 cover and stated, "see I can still smell myself" and asked if she could get some help. The odor of feces could not be detected at the time of the interview. On 01/27/25 at 2:24 PM the surveyor intervened and notified Nurse #6 Resident #39 had requested for her brief to be changed. During an observation at 2:26 PM on 01/27/25 Nurse #6 and Nurse Aide (NA) #2 went into Resident #39's room to provide incontinence care. Resident #39 stated to NA #2 that she told her before lunch that she had to have her brief changed to which NA #2 replied that she (NA #2) also told the Resident that she could not stop and change her brief when she was in the middle of passing out meal trays because it was cross contamination, and she needed to complete the lunch task first. The NA cleaned a large amount of feces (which permiated through the air when the brief was opened) from Resident #39 and when the NA threw the soiled brief in the trash can, the brief made a loud thud when it was deposited in the trash can. During an interview with NA #2 on 01/27/25 at 2:46 PM the NA stated she was a travel NA and had only been at the facility for about a week. The NA reported that she made her last round on Resident #39 before lunch between 10:00 AM and 11:00 AM and when she went into deliver her lunch tray (close to 1:00 PM) the Resident told her that she needed to be changed because she had messed her brief. NA #2 stated she told Resident #39 that she could not stop and change her then because of the potential of cross contamination. The NA explained that she had been an NA for 30 years and she had always	F 550	received in-person or via telephone by the Staff Development Coordinator or designee. All newly hired nursing staff or clinical agency personnel will receive this education during the orientation process by the Staff Development Coordinator (SDC) or designee on providing residents incontinent care when requested. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or administrative nurse will conduct random observation audits of 10 residents during mealtimes who are incontinent weekly for 4 weeks. every other week x 4 weeks then monthly for 2 months to ensure compliance. The Director of Nursing will complete a summary of the audit results and present them at the Quality Assurance Performance Improvement (QAPI) meeting monthly for 4 months or until compliance is achieved.	

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F 550	Continued From page 4 refrained from providing incontinence care while the meal trays were on the hall because of the potential for cross contamination. NA #2 stated she told the Resident that she would be back after lunch to change her. When NA #2 was asked if she would like to eat while sitting in bowel movement the NA stated, "No." During an interview with the Unit Manager on 01/28 25 at 3:12 PM the Unit Manager explained that how Nurse Aide #2 handled the situation was not acceptable and the facility did not provide care like that. The Unit Manager stated it was a dignity issue as well and NA #2 needed to be educated to the facility's policies. On 01/28/25 at 3:23 PM during an interview with the Administrator and Director of Nursing (DON) the DON explained that Resident #39 should not be expected to eat while soiled and that NA #2 should have provided incontinence care when it was requested.	F 550		
F 551 SS=J	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.	F 551		3/3/25

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F 551	Continued From page 5 (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the	F 551		

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F 551	Continued From page 6 representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, Legal Guardian, and former facility Executive Director interviews, the facility failed to exercise the rights of the Resident's Representative when Resident #115 had unsupervised visits with her son despite restricted visitation instructions from the Legal Guardian. The Legal Guardian stated, on Friday 1/24/2025, she informed the Admission's Director and the Resident Concierge Resident #115 was not to have visits from her son without supervision. Resident #115 was cognitively impaired, was adjudicated incompetent, and had history of sexual interactions with her son that included sexual intercourse, open mouth kissing, and inappropriate touching as witnessed by the previous facility's Executive Director. The Admission's Director left the Social Worker (SW) a note on Friday evening after the SW left for the day telling her to call Resident #115's Legal Guardian regarding visitation and concerns with Resident #115's son. The SW did not learn of the restricted visitation until 1/27/2025 at approximately 5:30 PM when the SW spoke to the Legal Guardian by phone. Resident #115's son had unsupervised and unrestricted visitation from 1/24/2025 through 1/27/2025 until he was asked to leave the room by the SW after the phone call with the Legal Guardian. This deficient practice affected 1 of 1 resident	F 551	Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 01/24/25, the Admissions Director and Resident Concierge were notified by Resident #115's guardian/resident representative that Resident #115 was to have supervised visitation due to a history of a sexual relationship between Resident #115 and Visitor #1. The Admissions Director and Resident Concierge did not report this information to anyone until 01/27/25. The Social Worker was informed via note by the Admissions Director to contact Resident #115's guardian/resident representative regarding visitation on 1/27/25. The Social Worker attempted to reach Resident #115's guardian/resident representative multiple times throughout the day without success. At approximately 2:45pm on 01/27/25 a verbal discussion took place between the Admissions Director and Social Worker regarding the concerns voiced by Resident #115's guardian/resident representative regarding visitation. The Administrator was notified at this time and instructed the	

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F 551	Continued From page 7 (Resident #115) reviewed for guardian directives. Immediate jeopardy began on 1/24/2025 when the Legal Guardian informed the Admission's Director and the Resident Concierge that Resident #115 was to have supervised visitation with Resident #115's son and this was not implemented until 1/27/2025. Immediate jeopardy was removed on 2/1/2025 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: The discharge summary from the hospital dated 1/22/2025 did not include Resident #115's Legal Guardian's wishes. Resident #115 was admitted to the facility on 1/22/2025 with a history of dementia, anxiety, and major depressive disorder. A baseline care plan dated 1/22/2025 did not contain any problems or interventions regarding supervised visitation for Resident #115. An admission minimum data set (MDS) dated 1/27/2025 revealed Resident #115 was moderately cognitively impaired, with no behaviors, wandering, or rejections of care. Resident #115 was coded as dependent on staff for eating, oral hygiene, toileting, bathing, upper body dessing, lower body dressing, and personal hygiene. Resident #115 had clear speech and was understood.	F 551	Social Worker to place Resident #115 on supervised visitation while waiting to obtain further information from Resident #115's guardian/resident representative. The Social Worker immediately went to Resident #115's room and asked Visitor #1 and two additional visitors to leave the room and meet with the Social Worker. During the meeting Visitor #1 was informed that all future visits would need to be scheduled with the Social Worker and supervised. Visitor #1 voiced understanding and exited the facility. Visitor #1 visited Saturday 1/25/2025 and Sunday 1/26/2025 and per the nurse working on the hall for approximately 6 hours each day. The nurse reported she observed Visitor #1 in Resident #115's room while standing out in the hall at the med cart outside of Resident #115's room. The supervised visits will be monitored by the Social Worker, if the Social Worker is not available at the time of the visit, the Administrator will be notified and will ensure that a staff member is assigned to monitor the visit for resident safety. At approximately 5:30pm on 01/27/25 the Social Worker was able to communicate with Resident #115's guardian/resident representative and was able to obtain specifics regarding the circumstances leading up to appointment of a guardian/resident representative with DSS and history with Visitor #1. On 1/30/25, all Residents with guardian/resident representatives were identified by the Social Worker. On	

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F 551	Continued From page 8 Review of a document scanned into the Electronic Medical Record (EMR) on 1/31/2025 contained a "Letters of Appointment Guardian of the Person" State of North Carolina document, dated 5/19/2022. The documentation revealed Resident #115 was adjudicated as incompetent and was appointed a Legal Guardian. Review of a document scanned into the EMR on 1/31/2025 contained a "Guardianship Notification" document from the Department of Social Services (DSS), that was undated. The documentation revealed Resident #115's son was to have restricted visits, 2 days a week, with supervision. A telephone interview was conducted on 1/30/2025 at 3:20 pm with Resident #115's Legal Guardian. The Legal Guardian stated she believes DSS took guardianship over Resident #115 in approximately 2015 due to a sexual relationship with her son. The Legal Guardian stated she had been responsible for Resident #115 since September of 2024. The Legal Guardian stated when Resident #115 was at a previous facility, Resident #115's son had tried to have sex with Resident #115, which led to supervised and limited visitation. The Legal Guardian stated she had spoken to the hospital when Resident #115 was admitted and informed them of the need for supervision and limitation with Resident #115's son. The Legal Guardian stated she had told the Admission's Director and the Resident Concierge on 1/24/2025 when she visited the facility. The Legal Guardian stated she had given the guardianship paperwork to the Admission's Director and the Resident Concierge when she visited in person on 1/24/2025.	F 551	1/30/2025, all residents with visitor restrictions were confirmed. The care plan for resident #115 was updated to reflect the visitation restrictions by the Care Plan Coordinator/Minimum Data Set Nurse on 1/30/2025. The Unit Supervisor completed a head-to-toe assessment on Resident #115 on 01/31/25. No signs of injury or distress were noted. Employees (nursing and housekeeping) that worked on Resident #115's unit from 1/24/25- 1/27/25 were interviewed in person or via phone by the Social Worker and Social Worker Assistant on 1/31/25 to determine if the staff witnessed any inappropriate sexual behaviors with Resident #115. No inappropriate sexual behaviors were identified. On 1/31/25 the resident's roommate was interviewed by the Social Worker to determine if any inappropriate sexual behaviors occurred from 1/24/25-1/27/25 during Visitor #1's unsupervised visits. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Education was performed by the Regional Admissions Director with the Admissions Director and Resident Concierge regarding proper notification to Administrator and/or Director of Nursing when admitting residents and the	

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F 551	Continued From page 9 An interview was conducted on 1/30/2025 at 10:18 am with the Admission's Director. The Admission's Director stated that he had been in contact with the Legal Guardian via email regarding admission paperwork prior to Resident #115 being admitted to the facility. The Admission's Director stated the first time that he had spoken with Resident #115's Legal Guardian in person was on 1/24/2025 at which time the Legal Guardian reported Resident #115 had to have limited and witnessed visitations because of a previous sexual relationship between Resident #115 and Resident #115's son. The Admission's Director stated this sexual relationship had been perceived as okay by Resident #115 and Resident #115's son. The Admission's Director stated that he had let the SW know and stated he had not received any guardianship paperwork as of 1/30/2025. The Admission's Director stated he did not have the guardianship paperwork or paperwork regarding restricted visitation. The Admission's Director stated he had requested the documentation, but it had not been sent. The Admission's Director stated he had sent the admission's paperwork electronically and had not visited with Resident #115's Legal Guardian in person until 1/24/2025. The Admission's Director stated this was the first time he had admitted a resident with a Legal Guardian. A follow-up interview was conducted on 1/30/2025 at 3:51 pm with the Admission's Director. The Admission's Director stated he left a note for the SW to call Resident #115's Legal Guardian on 1/24/2025 and knew that she would not be back at work until 1/27/2025. The Admission's Director stated he had not told the DON, Administrator, or contacted the SW the	F 551	resident's guardian/resident representative made request including restricted/supervised visitation on 1/30/25. Regional Director of Admissions implemented a new form 1/31/2025, "Guardian/resident representative or Power of Attorney Documentation Form", this form is to be completed for all new admissions prior to admission by the Admissions Director. This form will be used to identify if the Resident has a guardian/resident representative appointed or if any restrictions on visitation are in place, or other specific wishes requested by the appointed guardian/resident representative. This form will facilitate communication and ensure the notification of the Administrator and/or Director of Nursing. When a Resident is identified as requiring restricted or supervised visits or other wishes it will be added to the Resident's care plan by the appointed Administrative Nurse. Effective 1/31/25, Guardian/resident representative wishes will be reviewed quarterly or as needed by care plan coordinator and renewed. In addition to the care plan the information will be documented on the Resident's profile under special instructions by administrative nurse. Education was provided to the Care plan Coordinator and social worker on 1/31/2025 by Administrator and Director of Nursing that during baseline care plan and/ or quarterly care plan meetings the guardian/resident representative wishes are reviewed and ensured the wishes are	

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F 551	Continued From page 10	F 551		

evening of 1/24/2025 because he thought the Legal Guardian had just made a request for supervised visitation, not that it was required, based on a history of a sexual relationship between Resident #115 and Resident #115's son.

An interview was conducted on 1/30/2025 at 10:38 am with the Resident Concierge (assistant/advocate). The Resident Concierge stated Resident #115's Legal Guardian had stopped by the Admission's Director's office on 1/24/2025 and voiced concerns about family relations and had stated Resident #115's son had sex with Resident #115, which was perceived as being okay by the family. The Resident Concierge explained that he was present in the office at the time of the visit and stated Resident #115's Legal Guardian had requested restricted and supervised visits to ensure that Resident #115 was okay. The Resident Concierge was unable to explain why he didn't tell anyone about the information obtained from the Legal Guardian.

An interview was conducted on 1/30/2025 at 9:59 am with the Social Worker (SW). The SW stated Resident #115 was admitted to the facility last week (1/22/2025) and stated she had a Legal Guardian. The SW stated the Legal Guardian had not contacted the facility prior to Resident #115 being admitted. The SW stated last Friday (1/24/2025) the Legal Guardian had come by the facility after she had left for the day and stopped to talk to the Admission's Director and the Resident Concierge regarding concerns about Resident #115's son visiting and left a message for the SW to call her back. The SW stated she made multiple attempts on 1/27/2025 to contact the Legal Guardian and received a call back at

reflected on the Resident's care plan which will add the information to the KARDEX.
On 1/31/2025 the Social Worker was educated by the Administrator on the process for supervised visits and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. Supervised visits will be conducted as follows: Visitor will call the facility to schedule the visit with the Social Worker. Day of supervised visit visitor will come to the facility and ask for the social worker at the front reception desk. Social Worker will accompany the visitor to the Resident room or room decided on by Resident or visitor. Social Worker will remain present during the visit to monitor for Resident safety. When the visit is completed, the Social Worker will accompany the visitor to the front lobby and the visitor will exit the facility. If the Social Worker is not available, the Administrator will be notified and will ensure that a staff member is assigned to monitor the visit for Resident safety. If a visitor comes to the facility after hours that require supervised visits, the staff will ask the visitor to leave the facility and schedule the visit with the Social Worker. If the visitor refuses to leave, the facility staff will call law enforcement to have the visitor removed from the facility and notify the Administrator and Director of Nursing.
On 1/31/2025 all certified nursing assistants were educated by the Staff development Nurse on supervised visitation process, where to identify on the

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F 551	Continued From page 11 approximately 5:30 pm. The SW stated she was told by the Legal Guardian that Resident #115's son was to have supervised visitation due to Resident #115's son attempting to perform sexual acts with Resident #115. The SW stated she had been told by the Admission's Director that the type of relationship Resident #115 and Resident #115's son had been consensual. The SW stated the Legal Guardian informed her at Resident #115's previous facility, Resident #115's son had to have scheduled supervised visitation due to Resident #115's son attempting to perform sexual acts, which she did specify. The SW stated Resident #115's son had been present at the facility every day from 1/22/2025 until 1/27/2025 and no staff members had observed any inappropriate behavior. The SW acknowledged that Resident #115's son had not had any supervised or restricted visitation since admission to the facility. The SW stated Resident #115's roommate was alert and oriented and had not mentioned any inappropriate behavior to staff. The SW stated after her conversation with the Legal Guardian on 1/27/2025 she went to Resident #115's room, where she observed three other men at the bedside in addition to Resident #115's son. The SW stated she asked the visitors to leave and advised Resident #115's son he would have to contact her to schedule supervised visitation and was not to visit Resident #115 unsupervised. A follow-up interview was conducted on 1/30/2025 at 3:48 pm with the SW. The SW stated she was notified by the Admission's Director on the morning of 1/27/2025 that she needed to contact Resident #115's Legal Guardian regarding scheduled visits with Resident #115's son. The SW stated she did not	F 551	KARDEX visitation restrictions, to notify administrative on call number if restrictions are not followed, and that facility is to adhere to any guardian/resident representative wishes. On 1/31/2025 all Nurses were educated by the Staff development Nurse on supervised visitation process, where to identify on the KARDEX visitation restrictions, where the visitation restriction will be located on the Resident profile chart under special instructions, and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. Nursing staff will understand this is information that is expected to be passed along in the report. On 1/31/2025 All Administrative Nurses were educated by the Director of Nursing on the process for supervised visitation, how to add to the KARDEX on visitation restrictions, where the visitation restriction will be added on the Resident profile chart under special instructions, and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. If a resident was identified as needing new restrictions the appointed administration nurse by the Administrator or Director of Nursing will notify the nurse on the hall and front desk, and will add restriction to Kardex, and resident chart under special instructions. All newly hired nurses, certified nursing assistants, and/or social workers will	

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F 551	Continued From page 12 remember notifying the Director of Nursing (DON) or the Administrator on 1/27/2025 prior to speaking with the Legal Guardian around 5:30 pm. The SW was not sure why she had not alerted administrative staff about the concerns voiced by the Legal Guardian. The SW stated she did not have a copy of the guardianship papers and stated the facility had requested those documents. An interview was conducted on 1/30/2025 at 11:55 am with Nurse Aide (NA) #1. NA #1 stated she frequently cared for Resident #115 since she was admitted to the facility. NA #1 stated she worked day shift (7:00 am to 7:00 pm). NA #1 stated she had seen Resident #115's son arrived at the facility as early as 7:00 am and stated he stayed throughout the day. NA #1 stated Resident #115's son kept the curtain pulled in Resident #115's room. NA #1 stated Resident #115's son acted "odd" but did not specify. NA #1 stated she had not witnessed any inappropriate behavior between Resident #115 and Resident #115's son. Resident #115's son was unavailable for interview. An interview was conducted on 1/30/2025 at 11:25 am with Resident #72. Resident #72 was alert and oriented to person, place, time, and event. Resident # 72 acknowledged that she had been Resident #115's roommate since she was admitted to the facility. Resident #72 stated Resident #115's son visited Resident #115 every day, including the weekend 1/25/2025 and 1/26/2025, since she had been admitted to the facility until Monday (1/27/2025) when the SW came and told him he needed to leave. Resident	F 551	receive this education during the orientation process by the Staff Development Coordinator (SDC) or designee on supervised visitation process, where to identify on the KARDEX visitation restrictions, to notify administrative on call number if restrictions are not followed, and that facility is to adhere to any guardian/resident representative wishes. An audit will be completed weekly for 4 weeks, then monthly for 3 months of all residents with guardian/resident representative to ensure this information is correct in resident chart by admission coordinator. All residents with supervised visits will be audited by social workers 4 weeks, then monthly for 3 months to ensure care plan is correct and listed in special instructions. The findings of the audit will be reported to the QAPI committee monthly for 3 months to determine frequency, identify trends, and/or the need for further education for continued compliance.	

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#72 stated Resident #115's son would arrive around 8:00 am and stay all day until dinner trays were served between 4:00 pm and 5:00 pm. Resident #72 stated staff would bring Resident #115's son a guest tray at lunch. Resident #72 stated when Resident #115's son arrived each day, he would pull the curtain and keep the curtain closed the remainder of the day. Resident #72 stated Resident #115's son made her uncomfortable because he would stand at the door and look at her. Resident #72 stated she left the room on occasion to go to the common area at which time Resident #115 and Resident #115's son were alone in the room.

An observation was conducted on 1/27/2025 at 12:47 pm of Resident #115. Resident #115 was not visible from the door due to the curtain being pulled. After entering the room, Resident #115 was observed lying in bed and Resident #115's son was sitting in a chair by the window next to her bed. Both were fully clothed.

An observation was conducted on 1/30/2025 at 11:24 am of Resident #115. Resident #115 was lying in bed and did not respond when she was asked questions and did not make eye contact.

An interview was conducted on 1/30/2025 at 1:52 pm with the Director of Nursing (DON). The DON stated Resident #115 had recently been admitted to the facility on 1/22/2025 and reported Resident #115 was placed on supervised visitation after DSS notified facility staff of an inappropriate relationship between Resident #115 and Resident #115's son on 1/27/2025. The DON stated she was not made aware that the request for supervised visitation was made on 1/24/2025. The DON stated the Legal Guardian should have

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made the facility aware of the need for supervision prior to admission to the facility and stated that the Admission's Director and/or Resident Concierge should have notified her or the Administrator on 1/24/2025. The DON stated she would have honored the Legal Guardian's request starting 1/24/2025 if she had been made aware.

An interview was conducted on 1/30/2025 at 3:55 pm with the Administrator. The Administrator stated Resident #115 was placed on supervised visitation on 1/27/2025. The Administrator stated she was not made aware the Legal Guardian had requested Resident #115 to have supervised visitation with Resident #115's son on 1/24/2025. The Administrator stated if she would have known on 1/24/2025 she would have implemented the supervised visits immediately. The Administrator was not able to recall what time, or who brought to her attention the concern regarding Resident #115 and her son.

A telephone interview was conducted on 1/30/2025 at 12:07 pm with the Executive Director at Resident #115's former facility. The Executive Director stated he was very familiar with Resident #115 and stated that she resided at his facility from 1/29/2024 through 1/22/2025. The Executive Director stated Resident #115 was discharged from the facility to the hospital on 1/22/2025 due to requiring a higher level of skilled care. The Executive Director stated Resident #115 had a Legal Guardian after she was removed from the care of Resident #115's son. The Executive Director stated Resident #115 required supervised and limited visitation with Resident #115's son while at his facility due to inappropriate sexual behaviors such as open

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mouth kissing and inappropriate touching. The Executive Director stated Resident #115's son had stated Resident #115 "was the only woman he had ever known." The Executive Director stated he had not reported the need for supervised visitation or limited visitation to the hospital when Resident #115 was transferred because he assumed Resident #115's Legal Guardian would be responsible for that.

The Administrator was notified of Immediate Jeopardy on 1/30/2025 at 5:44 pm.

The facility provided the following credible allegation of Immediate Jeopardy Removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 01/24/25, the Admissions Director and Resident Concierge were notified by Resident #115's guardian/resident representative that Resident #115 was to have supervised visitation due to a history of a sexual relationship between Resident #115 and Visitor #1 (Resident #115's son). The Admissions Director and Resident Concierge did not report this information to anyone until 01/27/25. The Social Worker was informed via note by the Admissions Director to contact Resident #115's guardian/resident representative regarding visitation on 1/27/25. The Social Worker attempted to reach Resident #115's guardian/resident representative multiple times throughout the day without success. At approximately 2:45pm on 01/27/25 a verbal discussion took place between the Admissions Director and Social Worker regarding the concerns voiced by Resident #115's

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guardian/resident representative regarding visitation. The Administrator was notified at this time and instructed the Social Worker to place Resident #115 on supervised visitation while waiting to obtain further information from Resident #115's guardian/resident representative. The Social Worker immediately went to Resident #115's room and asked Visitor #1 and two additional visitors to leave the room and meet with the Social Worker. During the meeting Visitor #1 was informed that all future visits would need to be scheduled with the Social Worker and supervised. Visitor #1 voiced understanding and exited the facility. Visitor #1 visited Saturday 1/25/2025 and Sunday 1/26/2025 and per the nurse working on the hall for approximately 6 hours each day. The nurse reported she observed Visitor #1 in Resident #115's room while standing out in the hall at the med cart outside of Resident #115's room.

The supervised visits will be monitored by the Social Worker, if the Social Worker is not available at the time of the visit, the Administrator will be notified and will ensure that a staff member is assigned to monitor the visit for resident safety. At approximately 5:30pm on 01/27/25 the Social Worker was able to communicate with Resident #115's guardian/resident representative and was able to obtain specifics regarding the circumstances leading up to appointment of a guardian/resident representative with DSS and history with Visitor #1.

On 1/30/25, all Residents with guardian/resident representatives were identified by the Social Worker. On 1/30/2025, all residents with visitor restrictions were confirmed. The care plan for

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Resident #115 was updated to reflect the visitation restrictions by the Care Plan Coordinator/Minimum Data Set Nurse on 1/30/2025.
The Unit Supervisor completed a head-to-toe assessment on Resident #115 on 01/31/25. No signs of injury or distress were noted.

Employees (nursing and housekeeping) that worked on Resident #115's unit from 1/24/25-1/27/25 were interviewed in person or via phone by the Social Worker and Social Worker Assistant on 1/31/25 to determine if the staff witnessed any inappropriate sexual behaviors with Resident #115. No inappropriate sexual behaviors were identified. On 1/31/25 the resident's roommate was interviewed by the Social Worker to determine if any inappropriate sexual behaviors occurred from 1/24/25-1/27/25 during Visitor #1's unsupervised visits.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Education was performed by the Regional Admissions Director with the Admissions Director and Resident Concierge regarding proper notification to Administrator and/or Director of Nursing when admitting residents and the resident's guardian/resident representative made request including restricted/supervised visitation on 1/30/25. Regional Director of Admissions implemented a new form 1/31/2025, "Guardian/resident representative or Power of Attorney Documentation Form", this form is to be completed for all new admissions prior to admission by the Admissions Director. This form

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will be used to identify if the Resident has a guardian/resident representative appointed or if any restrictions on visitation are in place, or other specific wishes requested by the appointed guardian/resident representative. This form will facilitate communication and ensure the notification of the Administrator and/or Director of Nursing. When a Resident is identified as requiring restricted or supervised visits or other wishes it will be added to the Resident's care plan by the appointed Administrative Nurse.

Effective 1/31/25, Guardian/resident representative wishes will be reviewed quarterly or as needed by care plan coordinator and renewed. In addition to the care plan the information will be documented on the Resident's profile under special instructions by administrative nurse.

Education was provided to the Care plan Coordinator and social worker on 1/31/2025 by Administrator and Director of Nursing that during baseline care plan and/ or quarterly care plan meetings the guardian/resident representative wishes are reviewed and ensured the wishes are reflected on the Resident's care plan which will add the information to the KARDEX.

On 1/31/2025 the Social Worker was educated by the Administrator on the process for supervised visits and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. Supervised visits will be conducted as follows: Visitor will call the facility to schedule the visit with the Social Worker. Day of supervised visit visitor will come to the facility and ask for the social worker at the front reception

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desk. Social Worker will accompany the visitor to the Resident room or room decided on by Resident or visitor. Social Worker will remain present during the visit to monitor for Resident safety. When the visit is completed, the Social Worker will accompany the visitor to the front lobby and the visitor will exit the facility. If the Social Worker is not available, the Administrator will be notified and will ensure that a staff member is assigned to monitor the visit for Resident safety. If a visitor comes to the facility after hours that require supervised visits, the staff will ask the visitor to leave the facility and schedule the visit with the Social Worker. If the visitor refuses to leave, the facility staff will call law enforcement to have the visitor removed from the facility and notify the Administrator and Director of Nursing.

On 1/31/2025 all certified nursing assistants were educated by the Staff development Nurse on supervised visitation process, where to identify on the KARDEX visitation restrictions, to notify administrative on call number if restrictions are not followed, and that facility is to adhere to any guardian/resident representative wishes. On 1/31/2025 all Nurses were educated by the Staff development Nurse on supervised visitation process, where to identify on the KARDEX visitation restrictions, where the visitation restriction will be located on the Resident profile chat under special instructions, and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. Nursing staff will understand this is information that is expected to be passed along in the report.

On 1/31/2025 All Administrative Nurses were

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educated by the Director of Nursing on the process for supervised visitation, how to add to the KARDEX on visitation restrictions, where the visitation restriction will be added on the Resident profile chart under special instructions, and to ensure to respect and follow the guardian/resident representative wishes as though the resident is making the decision themselves. If a resident was identified as needing new restrictions the appointed administration nurse by the Administrator or Director of Nursing will notify the nurse on the hall and front desk, and will add restriction to Kardex, and resident chart under special instructions.

IJ removal date: 2/1/2025

A validation of immediate jeopardy removal was conducted on 2/6/2025. An audit was conducted on 1/30/2025 to identify which residents had a guardian or representative and to ensure that any visitor restrictions were honored. Interviews with facility staff (housekeeping and nursing) revealed staff knew who required restricted/supervised visitation and what to do if a restricted visitor showed up at the facility unscheduled or refused to leave (which included notifying law enforcement). Interviews with the Admission's Director and Resident Concierge revealed they had received education regarding changes to the admissions process which included gathering guardianship information, restrictions with visitation, and information regarding limited visitation on a new form. The Admission's Director and Resident Concierge also verbalized guardianship papers would be received/reviewed prior to a resident being admitted and the Administrator and Director of Nursing would be notified immediately. Interviews with staff who

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F 551	Continued From page 21 participate in baseline care plan meetings and quarterly meetings revealed staff would review guardian/representative wishes at each meeting and their wishes would be reflected in the care plan. Interviews with the Social Worker and Receptionist revealed restricted/supervised visitors were to call to schedule a supervised visit with the SW, when the visitor arrived at the facility, the Receptionist should notify the SW, the SW should remain with the visitor for the duration of the visit and should walk them out following the visit. The immediate jeopardy date of 2/1/2025 was validated.	F 551		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/3/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 22 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to maintain the bed remote in good repair for 1 of 21 rooms on 200 hall (Room 205-B) reviewed for environment. The findings included: On 01/27/25 at 11:40 AM an observation of room 205 revealed bed B was raised approximately waist high and the bed remote was attached to the right-side rail. The coiled cord to the bed remote was missing approximately 8 inches of the rubbery outside covering exposing the wire inside the cord. The bed was occupied by a resident during the observation. On 01/27/25 at 3:10 PM an observation was made of the bed which was in low position. The Resident was not in the bed and the bed remote was attached to the right-side rail and remained	F 584	Address how corrective action will be accomplished for those residents found to have been affected: On 1/28/2025 resident bed 205 B remote was replaced by the Maintenance Assistant, once it was brought to the facility's attention. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/30/2025 all resident bed remotes were evaluated by the Social Worker for exposed wiring. The bed remotes identified with exposed wires were corrected on 1/30/25 by the Maintenance assistant. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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	345163	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 584	Continued From page 23 unchanged. An observation was made of the bed remote in room 205-B on 01/28/25 at 1:45 PM which remained unchanged. On 01/28/25 at 3:49 PM an interview was conducted with Nurse Aide (NA) #1 who explained the resident in bed 205-B was not able to utilize the bed remote. An interview was conducted with Nurse #2 on 01/30/25 at 10:46 AM. The Nurse explained that she was assigned to room 205. Nurse #2 observed the exposed wire on the bed remote and the Nurse stated everyone who worked with the Resident in bed 205-B should have noticed the exposed wire including herself and notified the Maintenance Supervisor. The Nurse explained that she usually called the Maintenance Supervisor when she needed to report a concern. On 01/30/25 at 10:59 AM an interview and observation were made of Nurse Aide (NA) #3 using the remote to room 205-B. NA #3 was shown the bed remote cord and the NA stated she did not notice it the day before but that it could be a hazard and needed to be reported and changed. During an interview with the Maintenance Supervisor on 01/30/25 at 11:13 AM the Maintenance Supervisor explained that he made routine rounds on the residents' bed rails once a month and tightened them as needed. Accompanied the Maintenance Supervisor to room 205-B to observe the exposed wire in the cord and the Maintenance Supervisor stated that he did not notice the cord in the condition it was in	F 584	All clinical personnel and agency clinical staff were educated by 2/28/25 by the Staff Development nurse on the process of notifications of broken equipment, exposed wires, or other facility needed repairs to the Maintenance department via the TELS work order system. Staff will be educated during the orientation process of notification to the Maintenance department regarding broken equipment, exposed wires, or other facility needed repairs via the TELS work order system by the Staff Development Coordinator or designee. Effective March 3, 2025, any facility or agency clinical staff who have not been educated, will not be allowed to work until this education is received in-person or via telephone by the Staff Development Coordinator or designee Indicate how the facility plans to monitor its performance to make sure that solutions are sustained An audit will be completed weekly for 4 weeks, then monthly for 3 months of all bed remotes for frayed and exposed wires and functionality by the Maintenance team. The findings of the audit will be reported to the QAPI committee monthly for 3 months to determine frequency, identify trends, and/or the need for further education for continued compliance.	

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F 584	Continued From page 24 during his monthly checks and if he had he would have replaced it. The Maintenance Supervisor continued to explain that the exposed wire was a low hazard potential because of the low voltage involved but stated cosmetically it does not look good and needed to be replaced. On 01/31/25 at 12:08 PM an interview was conducted with the Administrator and Director of Nursing. The Administrator indicated the nurse aides should have alerted the maintenance department of the faulty equipment.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Consultant Pharmacist interviews, the facility failed to protect a resident's right to be free of misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation (Resident #28). The findings included: Resident #28 was admitted to the facility on 04/10/24. Review of a quarterly Minimum Data Set (MDS)	F 602	Past noncompliance: no plan of correction required.	

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dated 07/24/24 revealed that Resident #28 was cognitively intact and received as needed pain medication during the assessment reference period.

A physician order dated 08/05/24 read Oxycodone/Acetaminophen (controlled pain medication) 10/325 milligrams (mg) by mouth every 6 hours as needed.

Review of a facility reported incident dated 09/11/24 read in part, it was brought to the attention of the facility that a card of narcotics was unaccounted for. The accused employee was listed as Medication Aide #1. The report was signed by the Assistant Director of Nursing (ADON).

Medication Aide #2 was interviewed on 01/29/25 at 10:06 AM. She stated that she reported to work on 09/11/24 and was responsible for Resident #28. She stated that as she was preparing Resident #28's medications that included Oxycodone/Acetaminophen she noted that he only had one pill left. Medication Aide #2 stated that Resident #28 requested his Oxycodone regularly and if he ran out, he would be very upset, so she asked Unit Manager #1 to call the pharmacy to obtain additional Oxycodone for Resident #28.

A statement dated 09/12/2024 and written by Unit Manager #1 revealed that when Medication Aide #2 notified her that Resident #28 needed more oxycodone, she called the pharmacy who told her that a delivery of oxycodone was signed for by Nurse #7 at the facility on the previous shift. Unit Manager #1 immediately notified the previous ADON about the missing narcotics.

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Unit Manager #1 was unavailable for interview during the investigation.

The previous ADON was unavailable for interview and did not write a statement.

Nurse #7 was interviewed on 01/30/25 at 1:35 PM who stated that he had worked the night shift from 7:00 PM to 7:00 AM on 09/11/24. Nurse #7 stated that the pharmacy delivery usually arrived between 10:00 PM to 2:00 AM. During his shift he received a delivery of medication from the pharmacy. Nurse #7 stated that he signed the pharmacy slip and took the medication and then put the medications that belonged to his medication cart in the cart and delivered the medications that belonged to the other medication cart to Medication Aide #1 who was responsible for the other cart. Those medications included a card of Oxycodone for Resident #28. Nurse #7 again confirmed that he had signed for Resident #28's Oxycodone but had handed them to Medication Aide #1 who was responsible for that medication cart.

A review of the shipping manifest of 60 Oxycodone-Acetaminophen 10-325 mg tablets for Resident #28 was signed for by Nurse #7 and contained his signature with a date of 09/11/2024. No time was documented on the slip.

A review of a computer screenshot from the pharmacy revealed Nurse #7 received medications at 2:04 AM on 09/11/2024 for 400-hall.

Medication Aide #1's statement written on 09/11/2024 revealed that at midnight Nurse #7

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handed her the narcotics that were meant for her medication cart. She took them from his hands and took them to her assigned cart. She reported sitting down in a chair placed in front of her cart in plain sight of the nursing stations and proceeded to add the narcotics into the narcotics book. She stated that while doing that, Nurse #7 approached her with another box filled with regular medications. Medication Aide #1 reported putting the narcotics away and then labeled and put away the regular medications as well. She wrote that she did not double-check what medications should have been there although she would do that next time.

Attempts to interview Medication Aide #1 were unsuccessful.

An interview was conducted with the Director of Nursing (DON) on 01/29/2025 at 9:22 AM and revealed that the missing narcotics were reported on 09/11/2024. The dayshift Medication Aide #2 went to the Unit Manager asking for a refill on Resident #28's oxycodone. When she called the pharmacy, she confirmed delivery of the oxycodone to the facility on 09/11/2024. Nurse #7 had signed the copy for the pharmacy courier. The DON stated she went back and ensured it was not in the facility by searching the cart and the medication room. She reviewed the narcotics sign in sheet, and Resident #28 narcotics were not signed into the medication cart. Medication Aide #1 was assigned to the cart during the time of delivery. This prompted an investigation on 09/11/2024 and an initial 24-hour report to the state survey agency. The DON notified the Medical Director. She reported that Resident #28 was assessed and found to have no adverse reactions, and she requested a refill from the

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pharmacy. Nurse #7 was interviewed and he explained signing in all the medications that he received for 300-hall and 400-hall. He gave the 400-hall medications to Medication Aide #1 whom he had worked with for a long time. When Medication Aide #1 was interviewed, she stated that she did not receive oxycodone for Resident #28. Medication Aide #1, Medication Aide #2, and Nurse #7 were drug tested and suspended pending outcome of investigation. Medication Aide #1's drug test was sent to an outside lab as a neutral party, and it came back positive for oxycodone. Medication Aide #2 and Nurse #7 tested negative. When Medication Aide #1 came in to work, the ADON told her she tested positive for oxycodone. She stated that she had a prescription and would go home to get the prescription. Medication Aide #1 never provided proof of a prescription and was terminated on 09/16/2024.

A telephone interview with the Consultant Pharmacist #1 was conducted at 4:05 PM on 01/30/2025. He explained that he was aware of the missing oxycodone for Resident #28. He stated that he performed monthly medication monitoring and attended Quality Assurance and Performance Improvement (QAPI) meetings. Consultant Pharmacist #1 revealed that he was on site monthly and performed medication cart spot checks on the contents of the medication carts, the narcotic count sheets, and the actual narcotic cards.

On 02/04/2025, the Consultant Pharmacist provided copies of the signed manifest and information that Medicare Part D was billed for the missing oxycodone. The DON was notified that proof of restitution must be made for the

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missing oxycodone at 02/03/2025 at 4:10 PM. On 02/05/2025 at 3:58 PM, the Administrator emailed a copy of the invoice that stated "bill facility only" for the replaced oxycodone.

The Administrator was interviewed on 01/31/2025 at 2:10 PM and stated that at each shift change each Nurse or Medication aide should check in and sign narcotics on the count record using legible signatures. She revealed that narcotics sign in and out audits were reviewed at each Quality Assurance and Performance Improvement (QAPI) meeting.

The facility provided the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Day shift Medication Aide #2 reported to Unit Manager #1 that Resident #28 was out of his Oxycodone 10mg in the morning of 09/11/2024 at approximately 9:00 AM. The Unit Manager #1 reported to the Assistant Director of Nursing (ADON) on 09/11/2024 directly after being notified a narcotics card was missing from the night shift delivery. ADON investigated the delivery of Narcotics and received a signed copy of the missing narcotic manifest that showed the Oxycodone 10mg for resident #28 was signed for by Nurse #7 on 09/10/2024 during the shift of 7:00 PM to 7:00 AM. Manifest was time- stamped when packaged at the pharmacy for delivery at 09/10/24 at 6:05 PM.

Facility met with QA team and determined of past non-compliance on 09/11/2024.

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ADON spoke with Nurse #7 and received a written statement on 09/11/2024 that he handed the questioned narcotics to the 400 hall Medication Aide #1 after signing them in from pharmacy delivery. Medication Aide #1 called by ADON and verbally stated she did receive narcotics from Nurse #7 but did not receive one for Resident #28. The ADON audited Resident #28 medication administration record, and it showed the resident did not miss any doses of his PRN medication and had no negative effects from the narcotics card going missing. The facility replaced the medication 09/12/2024 prior to the resident running out of his current prescription and no other doses were missing from this resident.

The Assistant Director of Nursing suspended Nurse #7, Medication Aide #1, and Medication Aide #2 on 09/11/2024 pending investigation and drug screen. The Assistant Director of Nursing completed the 24-hour report to the Division of Health and Human Services (DHHS) on 09/11/2024. The Assistant Director of Nursing then furthered investigation of the missing narcotic card; and conducted interviews, and drug test with the Nurse #1, Medication Aide #1, and Medication Aide #2 on 09/12/2024. The Director of Nursing submitted the five-day report upon completion of the investigation on 09/16/2024 to DHHS.

The Administrator notified the local Police Department on 09/12/2024, The Board of Nursing and Drug Enforcement Agency (DEA) on 09/13/2024.

Facility notified the Medical Director on

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09/11/2024 of the missing PRN narcotic card and the residents involved. Residents on 400 hall were assessed on 09/11/2024 and 09/12/2024 by interview and pain assessment with no concerns noted.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

A 100% audit was conducted on 09/12/2024 by the Assistant Director of Nursing and Staff Development Coordinator of the control sheets and each medication on all medication carts to verify that all narcotic medication and control sheets were accounted for. It was discovered that 1 medication for a resident of the same hall had a discrepancy on the same night in question with (error and mark through). There was noted from previous months where Nurses and Medication Aides had borrowed a medication for another resident that was out of a prescription. The borrowing of medicine caused no harm to the residents that had borrowed medication. The residents were made aware of the findings of the audit on 09/13/2024. The medical director was made aware of the findings of the audit on 09/13/2024.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Education was initiated with all licensed Nurses and Medication Aides by the Director of Nursing or Staff Development Coordinator on the pharmacy guidelines related to maintaining narcotics on the controlled medication from pharmacy. The nurses will document the number

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of sheets in the narcotic count book for the number of medication packages located in the locked med cart. If a medication is discontinued two nurses will remove the card and the medication record and document the number of cards and the sheets that remain on the cart. The nurse will give the removed sheet to the Director of Nursing and/or Designee to maintain. Two nurses will return the discontinued meds to the pharmacy and two nurses will sign and verify. The medications will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurses will give a copy of the record and a copy of the returned to pharmacy sheet to the Director of Nursing and/or Designee. Two nurses will complete a shift-to-shift count to verify that the number listed on the narcotic record matches the amount of medication in the cart and verify that the numbers of sheets are correct. Nurses and Medication Aides will understand that marking out and placing errors when a mistake pull from a narcotic card was completed. This information must be placed on the designated spot on the narcotic sheet where an explanation and signatures are located.

The Director of Nursing and/or Designee will continue to maintain file folders for narcotics in the facility for receiving and returning meds and verify narcotic medication count of delivery manifest sheets received from pharmacy. The facility will follow the facility's guidelines in maintaining control medications. The nurse will document the number of sheets in the narcotic count book for the number of medication packages located in the locked med cart. If a medication is discontinued two nurses will remove the card and the medication record and document the number of cards and the sheets

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that remain on the cart. The nurse will give the removed sheet to the Director of Nursing and/or Designees to verify. The medication will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurse will give a copy of the record and a copy of the returned to pharmacy sheet to the Director of Nursing and/or Designee. Two nurses will complete a shift-to-shift count to verify that the number listed on the narcotic record matches the amount of medication in the cart and verify that the numbers of sheets are correct. Nurses and medication aides will understand that marking out and placing errors when a mistake pull from a narcotic card was complete. This information must be placed on the designated spot on the narcotic sheet where an explanation and signatures are located.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Nursing and/or Designee will audit medication carts related to narcotic count being correct, the medication cards match the control sheets, the shift-to-shift count sheet are being signed at the start and at the end of the shift and any narcotic that needs to be wasted is being signed appropriately by 2 nurses. Auditing will be completed by DON Weekly times 4 weeks, then twice a week for 3 months, then monthly. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement committee monthly for any needed improvement.

The Administrator was interviewed on 01/31/2025 at 2:10 PM and stated that at each shift change

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each Nurse or Med aide should check in and sign narcotics on the count record using legible signatures. She revealed that narcotics sign in and out audits were reviewed at each Quality Assurance and Performance Improvement (QAPI) meeting.

Compliance Date: 9/17/2024

The corrective action plan was validated on 02/05/2025.

During the onsite validation on 02/05/25, it was observed that staff were entering new narcotic entries correctly and documenting appropriately on the declining count sheet. Upon narcotic book review, it was noted that shift-to-shift counts were performed and documented with 2 signatures. A count of the number of narcotic sheets was documented at each count. A review of the narcotic count sheet audit by the DON was reviewed and found to be performed. An observation of the narcotic count sheets and actual narcotic cards in the cart were found to be matching. Staff interviews revealed that they had received education on the new process of having 2 nurses sign in controlled substances, not scribbling on the count sheet, and using the description box on the back of the narcotic count sheet for any mark throughs for corrections or wastes. Upon observation, the medication room on the 400-hall had a locked tote that was empty and available for wasted narcotics. Upon observation, the DON was maintaining file folders with narcotic tracking information. The Administrator was interviewed and stated that the results of the narcotic count audits were discussed in each QAPI meeting. The corrective action plan's completion date of 09/17/24 was

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F 602	Continued From page 35 validated.	F 602		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Gradual Dose Reduction (Resident #93) and weight loss (Resident #92) for 2 of 30 residents reviewed for MDS assessments. The findings include: 1. Resident #93 was admitted to the facility on 03/29/24 with diagnoses that included schizophrenia. A review of Resident #93's physician orders dated 09/26/24 for risperidone 1 milligram (mg) (an antipsychotic medication used to treat symptoms of psychosis) by mouth twice a day. A review of Resident #93's Medication Administration Record (MAR) for 12/2024 and 01/2025 indicated the Resident received risperidone 1 mg by mouth twice a day. A review of Resident #93's Minimum Data Set (MDS) assessment dated 01/06/25 indicated the Resident received an antipsychotic medication on a routine basis and no Gradual Dose Reduction (GDR) had been attempted and no physician documentation of GDR as clinically	F 641	Address how corrective action will be accomplished for those residents found to have been affected: Resident #93's MDS Assessment with ARD of 01/06/2025 was modified for correction on 2/28/2025 by the Director of Clinical Reimbursement Resident #92's MDS assessment with ARD of 12/21/2024 was modified for correction on 2/28/25 by the Director of Clinical Reimbursement. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current Residents receiving antipsychotic medications on a routine basis were reviewed for accuracy of coding for N0450 within the past 90 days on 2/28/25 by the Director of Clinical Reimbursement. Those MDS identified with inaccurate coding of N0450 were modified by the Director of Clinical Reimbursement on 2/28/25. All current Residents MDS assessments were reviewed for accuracy of coding for K0300 for the past 90 days on 2/28/25 by the Director of Clinical Reimbursement. Those MDS identified with inaccurate coding of K0300 were modified by the	3/3/25

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F 641	Continued From page 36 contraindicated was noted. A review of Resident #93's Psychiatry progress note dated 12/19/24 revealed the use of antipsychotic medication was clinically appropriate at this time. The medication was reviewed for possible GDR and any reduction in regimen was likely to risk decompensation and was not recommended. An interview was conducted with MDS Nurse #1 on 01/30/25 at 9:33 AM who explained that he completed Resident #93's MDS for no physician documentation as clinically contraindicated because he overlooked the Psychiatry progress note dated 12/19/24. During an interview with the Administrator and Director of Nursing on 01/31/25 at 12:08 PM the Administrator stated her expectation was for the MDS to be accurately completed to reflect the residents. 2. Resident #92 was admitted to the facility on 05/23/24 with diagnoses that included alcoholic cirrhosis of liver, chronic kidney disease, heart failure, and protein-calorie malnutrition. A review of Resident #92's weights were as follows: 7/18/2024- 191.6 pounds (lbs.) 8/13/2024- 183.0 lbs. 9/13/2024- 157.6 lbs. Review of Resident #92's most recent nutritional assessment dated 11/08/24 revealed the following statement: "significant weight loss noted at 30 days, at 90 days, and at 180 days with	F 641	Director of Clinical Reimbursement on 2/28/25. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The MDS Coordinator was educated on accurate coding of Gradual Dose Reduction (GDR) status of N0450 on 1/30/2025 by the Director of Clinical Reimbursement. The MDS Coordinator was educated on accurate coding of significant weight loss in K0300 on 1/30/2025 by the Director of Clinical Reimbursement. Effective 3/3/2025, all new MDS Coordinators will be educated during the orientation process regarding proper coding of section N0450 and K0300 of the MDS and will not be allowed to work until this education is completed by the Director of Clinical Reimbursement. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To ensure accurate coding of N0450, GDRs for Residents receiving routine antipsychotics will be reviewed daily in the morning meeting with interdisciplinary team x 4 weeks, then every other week x 2 weeks, then monthly for 2 months with results presented at the monthly QAPI meeting by the MDS Coordinator until the interdisciplinary team concludes the goal has been achieved. To ensure accurate coding of K0300, weights will be reviewed for Residents having scheduled MDS assessments for the calendar week in the morning meeting	

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F 641	Continued From page 37 weight trending down since admission. A review of Resident #92's quarterly Minimum Data Set assessment dated 12/21/24 revealed him to be cognitively impaired. He was coded as not having had any significant weight loss. Review of Resident #92's weights at the time the Minimum Data Set assessment was completed revealed he had a 16.04% weight loss from 7/2024 to 9/2024. During an interview with MDS Nurse on 01/30/25 at 4:02 PM he acknowledged that Resident #92's quarterly Minimum Data Set assessment from 12/21/24 was inaccurate and it should have reflected Resident #92's significant weight loss. He reported he "just missed it" and stated that when looking at his notes, his notes even indicated that Resident #92 had lost a significant amount of weight. During an interview with the Director of Nursing on 01/30/25 at 4:23 PM she reported she was familiar with Resident #92 and stated that he had experienced significant weight loss during his time at the facility. She reported she did not know how that information would have been missed on Resident #92's quarterly Minimum Data Set assessment. She indicated she expected Minimum Data Set assessments to be completed accurately and thoroughly to reflect the individual resident and their care needs. An interview with the Administrator revealed she expected Minimum Data Set assessments to accurately reflect the care needs of residents and stated Resident #92's quarterly Minimum Data Set assessment dated 12/21/24 should have	F 641	with the interdisciplinary team x 4 weeks, then every other week x 4 weeks, then monthly for 2 months with results presented at the monthly QAPI meeting for 4 months by the MDS Coordinator until the interdisciplinary team concludes the goal has been achieved.	

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F 641	Continued From page 38 reflected his significant weight loss.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to request a Preadmission Screening and Resident Review (PASARR) Level II evaluation for a resident with a new mental health diagnosis for 1 of 3 residents reviewed for PASARR (Resident #23). The findings include: A Preadmission Screening and Resident Review (PASARR) Level I evaluation was completed at the time of admission on 08/03/2015 for Resident #23.	F 644	Address how corrective action will be accomplished for those residents found to have been affected: A Preadmission Screening and Resident Review (PASARR) Level II evaluation was completed for Resident #23 on 1/30/2025 by the Administrator Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Clinical Reimbursement completed an audit of all Resident PASARRs in the facility on 1/28/2025.	3/3/25

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F 644	Continued From page 39 Resident #23 was readmitted to the facility on 09/20/2019 with diagnoses, in part, of Type 2 diabetes mellitus, vascular dementia, and cognitive communication disorder. A quarterly Minimum Data Set (MDS) assessment dated 10/26/2024 revealed that Resident #23 was cognitively intact. The Psychiatric Nurse Practitioner (NP) evaluated Resident #23 on 11/25/2024, 12/05/2024 and 12/20/24 and diagnosed her with depression. The NP continued the medication regimen of Doxepin (an antidepressant) and trazodone (an antidepressant), On 01/24/2025 the NP diagnosed Resident #23 with major depressive disorder and psychosis and prescribed Depakote for mood stabilization. An interview with Social Worker (SW) on 01/28/25 at 3:30 PM revealed that she had been in this role at the facility for nine months, however, was not responsible for PASARR. An interview with Social Worker Aide on 01/28/2025 at 3:45 PM revealed that she was responsible for PASARR. She reported that when a resident had a new mental health diagnosis or psychiatric change in condition, she would request a PASARR Level II evaluation. She explained that she was usually notified of mental health diagnosis changes in a meeting or the MDS Coordinator would report to her changes requiring a PASARR Level II evaluation, and the information was obtained from psychiatric or provider notes. On 01/29/2025 at 1:10 PM the Administrator was	F 644	Those residents determined to require PASARR submission were completed on 1/28/25 by the Administrator Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/28/2025, the MDS coordinator was educated on reporting during the morning clinical meeting any new mental health or IDD diagnosis being added to a Resident's diagnosis list from the previous day for the Administrator to submit a Level 2 screen. Effective 3/3/2025, all new MDS Coordinators will be educated during the orientation process regarding new mental health or IDD diagnosis being added to Resident’s diagnosis list and will not be allowed to work until this education is completed by the Director of Clinical Reimbursement. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit verifying that Residents identified as having a new mental health and/or IDD diagnosis with a PASARR Level II screen initiated will be completed weekly x 4 weeks then monthly x 3 months by the Director of Clinical with audit findings reported in the QAPI meeting.	

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F 644	Continued From page 40 interviewed and stated that she was responsible for requesting a PASARR level II evaluations. During an additional interview on 1/31/2025 at 2:10 PM, the Administrator acknowledged that the Level II PASARR should have been sent for evaluation when the resident was diagnosed with depression.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		3/3/25

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F 656	Continued From page 41 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop a person-centered comprehensive care plan that reflected the need for supervised visitation for 1 of 22 residents reviewed for care plans (Resident #4). The findings included: Resident #4 was admitted to the facility on 11/1/2024. A quarterly Minimum Data Set (MDS) dated 11/4/2024 revealed Resident #4 was moderately cognitively impaired with no behaviors. Review of Resident #4's care plans revealed none that addressed supervised visits with a family member.	F 656	Address how corrective action will be accomplished for those residents found to have been affected: The care plan for Resident #4 was developed to include a care plan for supervised visitation on 1/30/2025 by the MDS Coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents were reviewed and those identified requiring supervised visitation were care planned for supervised visitation by the MDS Coordinator on 1/30/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to the MDS	

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F 656	Continued From page 42 "Supervised Visits" documentation for Resident #4 revealed the family member had visited on 12/17/2024 at 1:00 pm with supervision for approximately 1 hour. Resident #4 had supervised visits on 1/14/2025 at 12:00 pm, 1/27/2025 at 1:00 pm, and on 2/4/2025 at 12:00 pm with her family member. An interview was conducted on 1/30/2025 at 9:59 am with the Social Worker (SW). The SW stated Resident #4 was placed on supervised visitation after Resident #4's family member was found handing Resident #4 a pill from the family member's prescription bottle on 11/13/2024. The SW stated supervised visitation was initiated on 11/13/2024 after that incident. The SW was unsure if supervised visitation should be care planned. An interview was conducted on 1/30/2025 at 1:52 pm with the Director of Nursing (DON). The DON stated Resident #4 had been placed on supervised visitation after a family member was seen handing a naproxen to Resident #4 on 11/13/2024. The DON stated Resident #4 should have been care planned for supervised visitation after Resident #4's visits with Resident #4's family member had been restricted. The DON stated the Care Plan Coordinator was new to the role and was not in that role at the time that the care plan should have been updated.	F 656	Coordinator and Care Plan Coordinator regarding the care planning process on 1/31/2025 by the Director of Clinical Reimbursement. Effective 3/3/2025, all new MDS Coordinators will be educated during the orientation process regarding the care planning process and will not be allowed to work until this education is completed by the Director of Clinical Reimbursement. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Care plans for Residents requiring supervised visitation will be reviewed daily (Monday through Friday) in morning meeting by the interdisciplinary team. The MDS Coordinator will audit care plans for Residents requiring supervised visits weekly x four weeks, then every other week x four weeks, then monthly for 2 months with results presented at the monthly QAPI meeting for 4 months until the interdisciplinary team concludes the goal has been achieved.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		3/3/25

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F 658	Continued From page 43 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, Resident Representative and Nurse Practitioner interviews, the facility failed to implement a treatment for an area of skin impairment for 1 of 4 residents (Resident #181) reviewed for pressure ulcers. The findings included: Resident #161 was admitted to the facility on 05/16/24 with diagnoses that included end stage renal disease (ESRD) requiring hemodialysis, diabetes mellitus, severe protein calorie malnutrition, dysphagia (difficulty swallowing) and cerebral infarction. Resident #161 discharged to the hospital on 05/27/24. A review of Resident #161's care plan dated 05/16/24 indicated the Resident was at risk of pressure ulcers related to severe malnutrition, hemodialysis, impaired mobility due to cerebral vascular accident and dysphagia. The interventions included: follow the facility's policy regarding preventing/treating skin breakdown, informing caregivers of any new skin breakdown and monitor/document/report any changes in skin status to include appearance, color, would healing, wound size and stage and any signs and symptoms of infection. Review of Resident #161's Skin Admission Observation dated 05/20/24 and completed by the Wound Nurse revealed documentation of a localized area of blanching erythema (redness of skin) noted to the sacrum. Protective foam dressing was applied. Check placement daily and change PRN (as needed).	F 658	Address how corrective action will be accomplished for those residents found to have been affected: Resident #161 was discharged to the hospital on 5/27/2025; therefore, no further action can be take place. The treatment nurse was educated one on one by the Director of Nursing on 1/28/2025 regarding all skin alteration that require a dressing will have a physician order to monitor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Skin checks were completed on all active residents by the nursing supervisors on 2/4/2025 to ensure treatments and/or dressings were not placed without an active order to monitor. No residents were identified with treatments without a physician order. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/28/25, education was initiated by the Staff Development Coordinator (SDC) with all licensed clinical staff including agency licensed clinical personnel on treatments, protective dressings and skin alterations needing an order for monitoring. Effective March 3, 2025, any facility or agency licensed clinical staff who have not been educated will not be allowed to work until this education is received in-person or via telephone by the	

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F 658	Continued From page 44 A review of Resident #161's 05/21/24 shower sheet (a sheet for the nurse aides to document abnormal skin conditions) completed by Nurse Aide #7 revealed there were no skin issues identified. Review of Resident #161's admission Minimum Data Set (MDS) assessment dated 05/23/24 revealed the Resident's cognition was severely impaired and required substantial to maximal assistance from staff for activities of daily living (ADL). The MDS also indicated the Resident was incontinent of bladder and bowel and was at risk of developing pressure ulcers. There were no pressure ulcers identified on the MDS. A review of Resident #161's Skilled Nursing Shift Charting assessments dated 05/21/24, 05/22/24, 05/24/24, 05/25/24, 05/26/24, 05/26/24 and 05/27/24 indicated there were no pressure areas noted to the Resident's buttocks or sacrum. A review of Resident #161's physician orders from 05/20/24 through 05/27/24 revealed there was no treatment order for skin breakdown prevention on the Resident's sacrum. Review of Resident #161's Treatment Administration Record (TAR) for 05/2024 revealed there was no treatment order on the TAR to monitor the sacrum for skin breakdown or apply a foam dressing for protection daily and as needed. A review of Resident #161's progress notes dated 05/26/24 at 11:30 PM, 05/27/24 at 3:02 AM and 05/27/24 at 7:52 AM written by Nurse #4 indicated the Resident had vomited a moderate	F 658	Staff Development Coordinator or designee. All newly hired nursing staff or clinical agency personnel will receive this education during the orientation process by the Staff Development Coordinator (SDC) or designee on providing treatments, protective dressings and skin alterations needing an order for monitoring. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: All new admission's residents will have a skin observation skin assessment will be audited by the Director of Nursing or designee for skin alteration that require a dressing/treatment for monitoring for a treatment ordered by the physician weekly for 4 weeks, then monthly for 3 months. The Director of Nursing will report the results at the monthly QAPI meeting for 4 months until the interdisciplinary team concludes the goal has been achieved.	

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amount of brown colored emesis with food particles. The intravenous fluids (IV) were turned off. Resident's lung sounds were clear, blood pressure 159/80, pulse 113, respirations 18, temp 98.6 and oxygen saturation (SATs) was 80% on room air. Applied 2 liters of oxygen and SATs came up to 92-93%. Nurse #4 called the Nurse Practitioner (NP) #2 and was given orders to discontinue IV fluids and obtain urine for Urinalysis. The urine was unable to be obtained. The notes further indicated Resident #161's family member came in to see the Resident and was updated on the Resident's condition throughout the night and wanted Resident #161 sent to the hospital for evaluation.

A review of Resident #161's Hospital Records from 05/27/24 hospitalization revealed there was no documentation of a pressure ulcer on the Resident's buttocks.

During an interview conducted with Nurse #1 on 01/28/25 at 4:01 PM the Nurse explained that he took care of Resident #161 on the first shift (7:00 AM - 7:00 PM) several days a week and the Resident did not have any skin breakdown on his sacrum that he was aware of. When asked how he would know if Resident #161 had skin breakdown on his sacrum the Nurse indicated the Resident would have a treatment set up on the TAR for the area affected. The Nurse continued to explain that he worked on 05/25/24 and there was no treatment set up to check and change a dressing to Resident #161's sacrum therefore he did not know to check his sacrum.

An interview was conducted with Nurse #4 on 01/28/25 at 7:35 PM who confirmed that she worked with Resident #161 on the evening shift

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(7:00 PM - 7:00 AM) on 05/25/24 and 05/26/24 and the Resident resided on her hall. The Nurse explained that she recalled the Resident having a "place" on his left side or buttock, but she did not remember the Resident having a dressing in place. The Nurse explained it would be on the TAR to be checked and changed as needed if she had to check his sacrum, but she did not remember Resident #161 having a dressing his sacrum.

During an interview with Nurse Aide (NA) #6 at 7:44 PM on 01/28/25 the NA confirmed she worked with Resident #161 on 05/26/24 on the evening shift (7:00 PM - 7:00 AM) and the Resident resided on her hall. NA #6 explained that the Resident had a pressure ulcer on his left buttock, but she did not remember what the treatment was for the pressure ulcer since she was not responsible for providing the treatments. The NA stated she did recall that she had to assist Nurse #4 with Resident #161 when she had to apply a dressing to his buttock, but she could not recall if Resident #161 had a dressing on his buttocks on the night of 05/26/24.

An interview was conducted with Nurse Aide (NA) #7 on 01/28/25 at 8:36 AM. The NA reported she helped NA #6 with Resident #161's care on the night of 05/26/24 and had worked with the Resident a few times before that night. NA #7 explained that prior to the night of 05/26/24 Resident #161 had little tears on his buttock which had a dressing on it. She stated on the night of 05/26/24 the dressing on the Resident's buttock was not soiled or they would have removed it so that Nurse #4 could have changed it.

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An interview was conducted with the Wound Nurse on 01/29/25 at 2:45 PM and 01/31/25 at 9:27 AM. The Wound Nurse explained that she assessed Resident #161's skin on 05/20/24 and noted a blanchable erythema area on his sacrum that was not open but looked as if it had the potential to open so she opted to apply foam dressing that would provide cushion to the area. The Nurse reported that she did not recall Resident #161 ever having actual skin breakdown on his sacrum, but she had changed the foam dressing a couple of times. The Wound Nurse continued to explain that she would have set up a treatment on the TAR to check Resident #161's sacrum daily for the foam dressing, change it weekly and as needed. The Nurse was informed that the Resident did not have a treatment set up on his TAR for a foam dressing on his sacrum and the Nurse was asked how the other nurses would know to check for the foam dressing. The Wound Nurse replied, they would not know to check for the dressing if it was not on the TAR.

On 01/29/25 at 4:14 PM during an interview with Nurse #3, the Nurse explained that she worked on 05/26/24 on the first shift (7:00 AM - 7:00 PM) and she did not look for a foam dressing on Resident #161's sacrum. The Nurse indicated that if the treatment was not set up on the TAR, then she would not have known to look for it.

During an interview with the Nurse Practitioner (NP) on 01/30/25 at 11:32 AM the NP explained that he remembered Resident #161 who had multiple comorbidities of CVA, severe protein malnutrition and end stage renal disease that required hemodialysis three days a week. The NP reported he could not recall any sacral skin breakdown on the Resident but that if the

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F 658	Continued From page 48 Resident had skin breakdown the NP felt it was unavoidable due to Resident #161's underlying conditions. An interview was conducted with the Administrator and Director of Nursing (DON) simultaneously on 01/31/25 at 12:08 PM. The DON explained that a treatment should have been set up to monitor and replace the foam dressing weekly and as needed in the event a pressure ulcer did develop. The DON stated the Wound Nurse did not work every day of the week so a treatment order would have ensured the Resident's sacrum was being monitored when the Wound Nurse was not on duty.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide incontinence care to a resident upon request (Resident #39) and failed to shave a dependent resident (Resident #27) for 2 of 5 dependent residents reviewed for activities of daily living (ADL). The findings included: 1. Resident #39 was admitted to the facility on 04/13/23 with diagnoses that included cerebral vascular accident (CVA) and atrial fibrillation.	F 677	Address how corrective action will be accomplished for those residents found to have been affected: On 1/27/25 resident #39 was provided incontinence care by nursing assistant (NA) #2. Also, NA #2 was educated on 1/27/25 by the Staff Development Coordinator, regarding the residents' right to have incontinent care provided when requested. On 1/31/25 Resident #27 was shaved by his assigned Certified Nursing Assistant (CNA). Also, NA #9 was educated on 1/31/25 by the Staff Development	3/3/25

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F 677	Continued From page 49 The quarterly Minimum Data Set (MDS) assessment dated 10/28/24 revealed Resident #39's cognition was severely impaired, and the Resident was dependent (helper does all the effort) for toileting. The MDS indicated Resident #39 was always incontinent of bladder and bowel. A review of Resident #39's care plan dated 10/29/24 revealed the Resident had bladder and bowel incontinence related to CVAs, history of urinary tract infections and impaired mobility. The goal was that the risk for urinary tract infections will be minimized/prevented through utilizing interventions such as checking during rounds every couple of hours and as needed for incontinence and cleansing peri area after each incontinent episode. On 01/27/25 at 2:20 PM during an observation and interview with Resident #39 the Resident was lying in bed on her back. The Resident explained that she could not go to the bathroom by herself and that she wore a brief which had to be changed by the staff. Resident #39 continued to explain that she had a bowel movement before lunch and could smell herself and when the girl brought her lunch meal to her, she told the girl that she had soiled her brief and needed to be changed. The Resident reported that the girl told her that she could not stop and change her at that time because she was passing out lunch trays. During the interview the Resident then lifted her cover and stated, "see I can still smell myself" and asked if she could get some help. The odor of feces could not be detected at the time of the interview. On 01/27/25 at 2:24 PM the surveyor intervened and notified Nurse #6 Resident #39 had	F 677	Coordinator, regarding shaving males while being showered or asking for assistance. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility conducted interviews for all alert and oriented Residents with a BIMS of 13 and above. Interviews were conducted by the facility concierge asking Residents if they are satisfied with all daily living tasks provided by staff including bathing, hygiene care, and incontinence care. Those residents with concerns were addressed by the Director of Nursing and Administrator. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Development Nurse provided education to all facility CNAs and agency clinical nursing assistance on the following: Resident Rights/Choice, shaving facial hair, providing ADL care as needed and requested, rounding, and the facility guidelines for providing incontinence care during mealtimes was completed on 2/28/2025. As of 3/3/25 no facility or agency CNA's will be allowed to work until they are educated by the Staff Development Coordinator or designee on Resident Rights/Choice, shaving facial hair, providing ADL care as needed and requested, rounding, and the facility guidelines for providing incontinence care during mealtimes. This education will be provided to all newly hired CNAs as part of the orientation process.	

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F 677	Continued From page 50 requested for her brief to be changed. During an observation at 2:26 PM on 01/27/25 Nurse #6 and Nurse Aide (NA) #2 went into Resident #39's room to provide incontinence care. Resident #39 stated to NA #2 that she told her before lunch that she had to have her brief changed to which NA #2 replied that she (NA #2) also told the Resident that she could not stop and change her brief when she was in the middle of passing out meal trays because it was cross contamination, and she needed to complete the lunch task first. The NA cleaned a large amount of feces (which permiated through the air when the brief was opened) from Resident #39 and when the NA threw the soiled brief in the trash can, the brief made a loud thud when it was deposited in the trash can. The NA continued to change Resident #39's bed including the incontinent pad (a thick pad made to protect the bottom sheet from incontinence) and bottom sheet because of Resident #39's soiled brief. There was no redness or skin irritation on the Resident's buttocks. During an interview with NA #2 on 01/27/25 at 2:46 PM the NA stated she was a travel NA and had only been at the facility for about a week. The NA reported that she made her last round on Resident #39 before lunch between 10:00 AM and 11:00 AM and when she went into deliver her lunch tray (close to 1:00 PM) the Resident told her that she needed to be changed because she had messed her brief. NA #2 stated she told Resident #39 that she could not stop and change her then because of the potential of cross contamination. The NA explained that she had been an NA for 30 years and she had always refrained from providing incontinence care while	F 677	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing and/or administrative nurse will conduct random observation audits of 10 residents during mealtimes who are incontinent weekly for 4 weeks. every other week x 4 weeks then monthly for 2 months to ensure compliance. An interview with 10 alert and oriented residents will be completed weekly for 4 weeks, then monthly for 3 months of resident satisfaction of resident choices and ADL care will be completed by the facility Concierge. The results of these audits will be presented by the facility Conciege during the monthly QAPI meeting monthly for 4 months to determine frequency, identify trends, and need the for further education for continued compliance.	

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the meal trays were on the hall because of the potential for cross contamination. NA #2 stated she told the Resident that she would be back after lunch to change her.

On 01/27/25 at 3:08 PM during an interview with Nurse #6 the Nurse explained that incontinence care was to be provided when needed. The Nurse stated she had never heard of not providing incontinence care during meal times.

During an interview with Unit Manager #1 on 01/28/25 at 3:12 PM the Unit Manager explained that NA #2 should have provided incontinence care when it was requested by Resident #39. The Unit Manager stated that incontinence care was to be provided when it was needed, and that NA #2 needed education on incontinence care.

On 01/28/25 at 3:23 PM an interview was conducted with the Director of Nursing (DON) and the Administrator simultaneously. The DON explained that the facility's practice was to provide incontinence care when it was needed. The Administrator indicated that NA #2 should have stopped passing out meal trays and provided incontinence care to Resident #39 then wash her hands afterwards to prevent cross contamination and resume passing meal trays.

2. Resident #27 was admitted to the facility on 03/07/15 with diagnoses that included arthritis, cataracts and chronic obstructive pulmonary disease.

Review of Resident #27's care plan revised 09/24/24 revealed the Resident had a self-care deficit related to impaired mobility, impaired vision and chronic obstructive

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pulmonary disease. The goal that Resident #27 would receive services and assistance to maintain the current level of functioning would be attained by utilizing interventions such as encouraging the Resident to participate with ADL and to provide assistance for the Resident's ADL.

The quarterly Minimum Data Set (MDS) assessment dated 11/26/24 revealed that Resident #27's cognition was intact and required partial/moderate assistance with shaving.

A review of the Shower Schedule indicated Resident #27 was scheduled for showers on Tuesday and Friday first shift (7:00 - 7:00 PM).

On 01/27/25 at 12:18 PM during an interview and observation with Resident #27, the Resident was lying in bed with facial hair that appeared to be a few days growth. The Resident was asked if he normally wore a beard and the Resident stated no, and it would be good to get someone to shave him because he could not shave himself. The Resident stated he needed help from the staff to shave.

An observation was made of Resident #27 on 01/28/25 at 2:45 PM. The Resident was in bed with facial hair from the day before. Resident #27 motion to his face and stated, "I still have it."

On 01/28/25 at 5:10 PM an interview was conducted with Nurse Aide (NA) #1 who reported he was not responsible for Resident #27's care that day but he often worked with the Resident. The NA explained that Resident #27 was alert and oriented and could voice his needs. The NA stated the Resident could assist with some of his ADL, but he could not shave himself. NA stated

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the shaves and nail care were given on shower days and as needed.

On 01/29/25 at 1:02 PM an observation was made of Resident #27 in bed and did not appear to be shaved.

An interview was conducted with Nurse Aide (NA) #8 on 01/29/25 at 5:08 PM. The NA confirmed that she was scheduled to work the hall where Resident #27 resided on 01/28/25 first shift. NA explained that Nurse #2 gave her a list of resident names to provide showers for and Resident #27 was not on the list, but she did give Resident #27 a bed bath and offered to shave him, but he declined.

During an interview with NA #9 on 01/31/25 at 11:30 AM. The NA confirmed she gave Resident #27 a shower on 01/29/25 and did not shave him or offer to shave him. The NA explained that shaves were usually given during showers, but she was not comfortable shaving men because she was scared, she might cut them. NA continued to explain that she usually asked someone to shave the residents for her, but she forgot to ask someone to shave Resident #27 for her. The NA added that Resident #27 did not refuse his showers.

An observation and interview were made with Resident #27 on 01/30/25 12:45 PM. The Resident was in bed eating lunch and explained that he received a shower yesterday evening (01/29/25) but he did not get a shave. He stated he looked like he had a beard, and he needed his shave. Resident #27 stated he did not refuse his shave.

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F 677	Continued From page 54 During an interview on 01/30/25 at 12:55 PM with Nurse #2 the Nurse stated that she was Resident #27's full time Nurse on first shift. The Nurse explained that the Resident was not one to refuse showers and she did not know why Resident #27 did not receive a shave during his shower because he loves the attention from females. On 01/31/25 at 10:15 AM an observation and interview were made of Resident #27 in bed. The Resident touched his face and stated they shaved me yesterday evening (01/30/25) and "no beard today." An interview was conducted simultaneously on 01/31/25 at 12:08 PM with the Administrator and Director of Nursing (DON). The DON explained shaves were given during showers and when requested and that Resident #27 should have been given a shave during his shower on 01/29/25. The Administrator stated NA #9 needed additional training on shaves.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		3/3/25

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F 686	Continued From page 55 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a physician ordered treatment for a resident (Resident #36) with a stage 2 (open sore or ruptured blister) pressure ulcer. The deficit practice was identified for 1 of 5 residents (Resident #36) reviewed for pressure ulcers. The findings included: Resident #36 was admitted to the facility on 1/3/2025. An annual minimum data set (MDS) dated 1/6/2025 revealed Resident #36 was severely cognitively impaired with no behaviors or rejections of care. There was no pressure ulcers coded for Resident #36. A wound care note dated 1/24/2025, authored by the Wound Care Nurse, revealed Resident #36's high risk area to sacrum (area near the lower back/pelvis) was now a stage 2 (open sore or ruptured blister) pressure injury. There was not a cushion noted in Resident #36's wheelchair on 1/23/2025 when wound care was provided. Therapy provided a high-density foam cushion, and an air mattress overlay was placed on Resident #36's bed for pressure reduction. A care plan dated 1/28/2025 revealed Resident #36 was at elevated risk for development of pressure ulcers related to the presence of an actual pressure ulcer with interventions which included having staff report any reddened areas or skin breakdown to the nurse and to provide	F 686	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The wound treatment for resident #36 was completed on 1/29/25 by the wound care nurse. There were no signs the wound had worsened due to not having the treatment completed as ordered. On 2/25/2025, resident #36 pressure injury of concern has resolved and was documented as healed by the wound care nurse. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 2/12/25, the wound care provider and the wound care nurse evaluated all current residents with pressure ulcers to ensure their treatment orders had been completed per the physician order. No concerns were observed. What measures will be put in place of systemic changes made to ensure that the deficient practice will not recur: On 1/29/25, the wound care nurse was educated by the Staff Develop Coordinator on completing wound care treatments per the physician order. Effective 3/3/25 any new wound care nurses will be educated on completing wound care treatments per the physician order. On 2/26/25, all licensed nurses including agency personnel were educated by the Staff Development Coordinator on	

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F 686	Continued From page 56 therapy, evaluation, and treatment as indicated. An observation was conducted on 1/29/2025 at 5:32 pm of Nurse #3 and Nurse Aide (NA) # 4. Nurse #3 and NA #4 performed incontinence care for Resident #36. NA #4 removed Resident #36's brief, Resident #36 was observed to have a nickel size, stage 2 pressure ulcer, that was bleeding, to her sacral area. The stage 2 pressure ulcer was not covered with a dressing. Resident #36 stated her sacral area hurt and asked if staff could put a dressing on her sacral area. An interview was conducted on 1/29/2025 at 5:44 pm with Nurse #3. Nurse #3 stated there was not a dressing on Resident #36's sacral area and verbalized there should have been. Nurse #3 stated the Wound Care Nurse was responsible for placing a dressing on Resident #36's sacral area. Nurse #3 acknowledged there was an active order for a foam dressing to be applied to Resident #36's sacrum. Nurse #3 stated NA #5 (who cared for Resident #36 from 7:00 am to 3:00 pm) had not mentioned that a dressing was not present and stated she should have reported if Resident #36 did not have a dressing or if the dressing had fallen off. An interview was conducted on 1/29/2025 at 6:04 pm with NA #4. NA #4 stated she had not changed Resident #36 until the observation at 5:32 pm. NA #4 stated she had only cared for Resident #36 since 3:00 pm after she received report from NA#5. An interview was conducted on 1/30/2025 at 8:51 am with NA #5. NA #5 stated she worked dayshift (7:00 am to 7:00 pm) and was assigned Resident	F 686	ensuring residents' treatments are present on the resident and if the treatment comes off or becomes soiled after the wound nurse has completed the treatment, the charge nurse is responsible for providing wound care per the physician order. On 2/26/25, the Staff Development Coordinator educated the certified nursing assistants and medication aides on reporting to the charge nurse when a residents' wound treatment comes off or becomes soiled so it can be replaced. Effective 3/3/2025, any facility or agency clinical staff who have not been educated will not be allowed to work until this education is received in-person or via telephone by the Staff Development Coordinator or designee. All newly hired clinical employees or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) or designee on providing wound care treatment per the physician order and notification to the charge nurse of missing or soiled treatments on residents. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of Nursing (DON) or designee will conduct random audits of 5 residents who have been identified as having pressure ulcers to ensure the treatment has been completed, weekly for 4 weeks then monthly for 3 months to ensure adequate compliance. The Director of Nursing or Designee will complete a summary of the audit results and present them at the facility monthly	

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F 686	Continued From page 57 #36 from 7:00 am to 3:00 pm on 1/29/2025. NA #5 stated Resident #36 was frequently incontinent of urine and had to be changed often. NA #5 stated she had checked Resident #36 before breakfast at which time there was not a foam dressing on Resident #36's sacrum. NA #5 stated she changed Resident #36 every 2 hours throughout her shift, and stated at no time did Resident #36 have a dressing to her sacral area. NA #5 stated she witnessed the Wound Care Nurse go into Resident #36's room around lunch and assumed she would have put a dressing on Resident #36 if she needed one. An interview was conducted on 1/31/2025 at 9:26 am with the Wound Care Nurse. The Wound Care Nurse stated Resident #36 was admitted to the facility with wounds to her bilateral lower extremities and a blood-filled blister to her right heel. The Wound Care Nurse stated since admission, those heels have improved, however, Resident #36 developed a stage 2 pressure ulcer to her sacral area. The Wound Care Nurse stated she was responsible for wound care treatments Monday through Friday. The Wound Care Nurse stated she did not change Resident #36's dressing until around 6:00 pm after she was contacted by Nurse #3. The Wound Care Nurse stated she had gone to provide wound care earlier in the shift, before lunch, and stated Resident #36 was frantic and she intended to go back and put the dressing on later. The Wound Care Nurse verbalized there was no foam dressing to Resident #36's sacrum when she provided wound care on 1/29/2025 around 6:00 pm and stated there should have been. The Wound Care Nurse stated if NA #5 had noticed there was not a dressing to Resident #36's sacral area she should have notified Nurse #3. The	F 686	Quality Assurance and Performance Improvement (QAPI) meeting monthly for 4 months or until compliance is achieved.	

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F 686	Continued From page 58 Wound Care Nurse stated Resident #36 had not seen the Wound Care Provider yet and verbalized she planned on having Resident #36 seen by the Wound Care Provider next week. An interview was conducted on 1/31/2025 at 9:41 am with the Staff Development Coordinator (SDC). The SDC stated the Wound Care Nurse was responsible for wound care Monday through Friday and the hall nurse was responsible for wound care on the weekends. The SDC stated Resident #36 should have had a dressing to her sacral area if it was ordered. An interview was conducted on 1/31/2025 at 11:21 am with the Director of Nursing (DON). The DON stated the Wound Care Nurse was responsible for providing wound care Monday through Friday. The DON also stated the hall nurse was responsible for providing wound care on the weekends. The DON stated the Wound Care Provider saw all residents with wounds unless they went to the Wound Care Center or did not consent. The DON stated Resident #36 should have had a foam dressing to her sacral area, and stated if the NA had removed it or noticed it had fallen off, they should have notified the nurse.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		3/3/25

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F 695	Continued From page 59 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to secure an oxygen cylinder stored in a resident's bathroom and failed to ensure an oxygen vent was free from dust and debris for 2 of 2 residents reviewed for respiratory care (Resident #19 and #1). The findings included: 1. Resident #19 was admitted to the facility on 04/29/24 with diagnoses that included hypoxia (low oxygen saturation). A review of Resident #19's physician orders revealed an order dated 04/29/24 for supplemental oxygen at 2 liters per minute continuous for hypoxia. A review of Resident #19's care plan revised 09/18/24 revealed the need for oxygen related to hypoxia with the goal of having no signs or symptoms of poor oxygenation. The interventions included monitoring for signs and symptoms of respiratory distress and providing supplemental oxygen at the prescribed rate. Resident #19's quarterly Minimum Data Set (MDS) assessment dated 12/09/24 revealed her cognition was severely impaired and she had supplemental oxygen. On 01/28/25 at 8:34 AM an observation was made of Resident #19 sitting on her recliner wearing continuous oxygen via cannula delivered at 2 liters per minute. Also observed was a	F 695	Address how corrective action will be accomplished for those residents found to have been affected: The unsecured oxygen cylinder identified in resident #19's bathroom was immediately removed, by the resident's' assigned CNA on 1/28/2025. Resident #1's oxygen concentrator filter was cleaned by the Unit Manager to ensure the oxygen vent was free from dust and debris on 1/31/2025 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing completed an audit of all resident rooms and bathrooms after being notified of the unsecured oxygen cylinder on 1/28/2025 to ensure safety of Resident in all rooms. Additionally, the Director of Nursing audited the oxygen room where all tanks and concentrators are stored to ensure all tanks were being stored properly. The Social Worker completed an audit of all resident rooms to ensure oxygen concentrator vents were free from dust and debris on 1/31/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to the environmental service team on 2/28/2025 by the Administrator that the	

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F 695	Continued From page 60 free-standing unsecured oxygen cylinder stored upright in the bathroom between two cabinets. According to the gauge the oxygen cylinder was half full of oxygen. At 12:46 PM and 2:53 PM on 01/28/25 the oxygen cylinder remained in Resident #19's bathroom free standing against the wall between the two cabinets. During an interview with Nurse Aide (NA) #1 on 01/28/25 at 2:53 PM the NA explained that staff were educated about oxygen care procedures on hire and as needed which included the oxygen cylinder should be attached to the back of the residents' wheelchairs or stored in the oxygen storage room in holders. NA observed the oxygen cylinder stored up against the bathroom wall and explained that he did not see the cylinder when he was in the bathroom earlier. NA #1 observed the amount of oxygen left in the cylinder and stated it was an accident hazard because it was half full of oxygen and removed the portable oxygen cylinder from the bathroom and returned it to the oxygen storage room. On 01/28/25 at 3:01 PM an interview was conducted with Nurse #1 who explained that the oxygen cylinder tanks should be stored in the oxygen storage room in holders. The Nurse stated he did not notice the oxygen cylinder stored in Resident #19's bathroom earlier that day when he was in the bathroom. An interview was conducted with Unit Manager (UM) #1 on 01/28/25 at 3:08 PM. The UM explained the oxygen cylinders should be attached to the back of the residents' wheelchairs or stored in the oxygen storage room in the	F 695	environmental service team will be responsible for cleaning resident oxygen concentrators during daily room cleaning. On 1/28/2025 education was initiated with all clinical staff including agency personnel on safe storage and securement options for oxygen cylinders by the Staff Development nurse. Education will continue during orientation for all new clinical staff or agency clinical staff regarding safe storage of oxygen cylinders and oxygen concentrators being cleaned properly. Effective 3/3/2025, any facility or agency clinical staff who have not been educated will not be allowed to work until this education is received in-person or via telephone by the Staff Development Coordinator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit to ensure oxygen concentrators are free from dust and debris will be completed by the Environmental Services Manager or designee weekly for 4 weeks, then monthly for 3 months. A rounding observation audit will be conducted to ensure there are no unsecured oxygen cylinders present in Resident rooms or bathrooms by the Assistant Director of Nursing (ADON) weekly for 4 weeks, then monthly for 3 months. The ADON will also monitor the oxygen storage room to ensure all tanks are properly stored. This audit will be completed weekly for 4 weeks, then monthly for 3 months. Audits will be turned in to the Administrator and results will be reported	

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F 695	Continued From page 61 appropriate holders. She stated they had the potential to explode if they had oxygen in them. During an interview with the Administrator and Director of Nursing (DON) simultaneously on 01/28/25 at 3:32 PM. The DON explained that the oxygen cylinders should be stored in the transport caddy or in the oxygen storage room and should not be left in the residents' rooms unsecured. 2. Resident #1 was admitted to the facility on 9/25/2001 with a diagnosis of chronic obstructive pulmonary disease (COPD, a lung disease that causes inflammation and narrowing of the airway which can lead to shortness of breath and difficulty breathing). A physician's order dated 5/14/2024 revealed Resident #1 was ordered to receive oxygen at 2 liters per minute via nasal cannula to maintain oxygen saturation levels greater than 90% as needed for hypoxia (low oxygen levels) and shortness of breath. A quarterly minimum data set (MDS) dated 1/13/2025 revealed Resident #1 was severely cognitively impaired and required the use of oxygen. An observation was conducted on 1/27/2025 at 12:02 pm. Resident #1 was observed lying in bed with oxygen being administered at 2 liters per minute via nasal cannula. The external vent on Resident #1's oxygen concentrator was white with dust. An observation was conducted on 1/28/2025 at 11:19 am. Resident #1 was observed lying in bed with oxygen being administered at 2 liters per	F 695	during QA meetings. The QI committee will review the results of this audit tool monthly to determine frequency, identify trends, and need for further education or disciplinary action for continued compliance.	

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F 695	Continued From page 62	F 695		

minute via nasal cannula. The external vent of Resident #1's oxygen concentrator was white with dust.

An observation was conducted on 1/29/2025 at 8:24 am. Resident #1 was observed lying in bed with oxygen being administered at 2 liters per minute via nasal cannula. The external vent of Resident #1's oxygen concentrator was white with dust.

An interview was conducted on 1/29/2025 at 2:26 pm with the Staff Development Coordinator (SDC). The SDC stated if a resident was ordered to wear oxygen that there would be an order, it would be listed on the Medication Administration Record (MAR), and oxygen use would be care planned. The SDC stated oxygen tubing was changed weekly by Nurse Aides (NAs). The SDC stated she thought the NAs and Nurses were both responsible for cleaning external vents on the oxygen concentrators.

An interview was conducted on 1/29/2025 at 2:30 pm with Nurse #2. Nurse #2 stated she was unsure of how often the external vents on the oxygen concentrators were cleaned or who was responsible for cleaning those.

An observation was conducted on 1/29/2025 at 2:33 pm with the SDC. The SDC confirmed Resident #1's oxygen concentrator was white with dust and stated that it needed to be cleaned.

An interview was conducted on 1/29/2025 at 4:48 pm with the Unit Manager. The Unit Manager stated if a resident required oxygen there would be an order in the resident's chart and the order would show up on the MAR. The Unit Manager

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F 695	Continued From page 63 stated oxygen tubing was changed by night shift staff. The Unit Manager stated she was unsure who was responsible for cleaning the external vents on the oxygen concentrators. An interview was conducted on 1/31/2025 at 11:39 am with the Director of Nursing (DON). The DON stated if a resident required the use of oxygen there would be an order in the resident's chart and the order would show up on the MAR. The DON stated oxygen tubing was changed by night shift nursing staff on Sundays. The DON stated oxygen concentrator vents should be wiped down by nursing staff when the tubing was changed or by housekeeping staff. The DON was not aware that Resident #1 had a dusty filter and stated it should have been cleaned.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		3/3/25

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F 761	Continued From page 64 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove loose and unsecure pills of various shapes, sizes and colors and failed to ensure a medication cart was clean and free of debris for 2 of 3 medication carts reviewed for medication storage (100/200 split hall and 300 hall medication carts). The findings include: a. On 01/29/25 at 1:31 PM an observation was made of medication cart 100/200 hall split along with Nurse #2 which revealed 41 loose and unsecure pills of various shapes, sizes and colors and debris of paper shavings and rubber bands in the bottom of the cart drawers. An interview was conducted with Nurse #2 on 01/29/25 at 1:31 PM who explained that everyone was responsible for keeping the medication carts clean and orderly. The Nurse stated she should have vacuumed the medication cart out prior to the observation. During an interview with Unit Manager (UM) #1 on 01/29/25 at 1:42 PM she explained that the condition of the medication cart was unacceptable and that it was the nurses' responsibility to vacuum the medication carts out once a week.	F 761	Address how corrective action will be accomplished for those residents found to have been affected: All loose medications were immediately removed from the medication carts (100/200 split hall and 300 hall) on 1/29/2025 by the Unit Managers. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Unit Supervisors completed an audit on 1/30/2025 ensuring all medication carts were free from loose medication and debris. Any pills and debris identified were disposed of immediately by the Unit Supervisors. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff development nurses educated all nurses and medication aids on facility standard for medication storage, and labeling. In-service to be completed by 1/30/2025. Staff Development Nurse is responsible for completing the weekly audit of all medication carts to ensure labeling, proper storage, and free from loose pills and debris. This audit will be completed weekly for 4 weeks, then	

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F 761	Continued From page 65 b. An observation was made of medication cart 300 hall along with Nurse #3 at 1:57 PM on 01/29/25. The observation yielded 12 loose and unsecure pills of various shapes, sizes and colors. During the interview with Nurse #3 on 01/29/25 at 1:57 PM the Nurse explained that it was the nurses' responsibility who was on the medication cart to keep it clean and orderly, but she did not have a chance to clean it today (01/29/25) or yesterday (01/28/25). A combined interview was conducted with the Administrator and Director of Nursing (DON) on 01/31/25 at 12:07 PM. The DON explained that it was nursing's responsibility to clean the medication carts weekly and she had recently assigned specific nurses to clean and organize all the medication carts. The DON indicated the nurse on the cart should remove loose pills from the cart on a daily basis.	F 761	monthly for 3 months. Education will be continued during orientation for all new staff or agency nurses on safety of medication storage and the facility guidelines and system of ensuing compliance. Nurses will be responsible for monitoring their assigned cart for expired medications, and discarding medication that is unlabeled, or expired. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The QI committee will review the results of this audit tool monthly to determine frequency, identify trends, and need for further education or disciplinary action for continued compliance.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other	F 801		3/3/25

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F 801	Continued From page 66	F 801		

clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-

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F 801	Continued From page 67 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to employ a director of food and nutrition services that met the minimum qualifications, and it affected 106 of 109 residents. Findings included: On 01/27/2025 at 10:10 AM, the Dietary Manager was interviewed and revealed that he did not have any of the following: certification as a dietary	F 801	Address how corrective action will be accomplished for those residents found to have been affected: All facility residents were identified as being affected. For the affected residents, the facility posted a Certified Dietary Manager position on indeed. Until this position is filled the facility will rely on guidance and support from sister facility CDM and registered dietitian. Address how the facility will identify other	

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F 801	Continued From page 68 manager or food manager, national certification for food service management and safety, an associate's or higher degree in food service management or in hospitality, 2 or more years of experience in the position of Director of Food and Nutrition Services in a nursing facility setting. The Dietary Manager stated that he does have a dietician that he can consult, but he did not know her name. He stated that he could call her if needed. He revealed that he had been at this facility in this kitchen for a total of six months and that he left for a while and then came back. On 01/28/2025 at 10:50 AM, a Dietary Manager at a sister facility was interviewed and stated that she was a Certified Dietary Manager and a Certified Food Protection Professional. She stated that she was there to help the Dietary Manager. She denied having any regular scheduled meeting with the facility Dietary Manager, but he could call her if needed. An Administrator interview on 01/31/2025 at 2:25 PM revealed that she was aware of the facility's need to have Dietary Manager certifications and thought her personal food safety certification would count.	F 801	residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Facility posted a Certified Dietary Manager position on indeed. Until this position is filled the facility will rely on guidance and support from sister facilities CDM and registered dietitian. The sister Facility CDM will be visiting the facility kitchen once a week to monitor operations, food storage, and sanitary standards. Sister facility CDM will be responsible for overseeing the facility's current kitchen manager and will be available by phone for any questions that may arise. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will require Sister facility CDM to turn in rounding sheet weekly x 3 months. The Administrator or designee will present to QI committee will review the results of reports during monthly QA Meeting to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for 3 months or until compliance is achieved.	

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F 804	Continued From page 69	F 804		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident, visitor and staff interviews and test tray, the facility failed to provide food that was appetizing in temperature, texture and palatability for 3 of 3 residents sampled for food palatability (Resident #59, Resident # 15, and Resident # 57). The findings included: a. Resident #59 was admitted on 05/01/2024. The quarterly Minimum Data Set (MDS) dated 01/04/2025 revealed that Resident #59 was cognitively intact. An interview with Resident #59 occurred on 01/27/2025 at 1:05 PM he stated the food was "terrible. They don't give us much breakfast. This morning the eggs were runny and cold. There was no meat. The bread was hard." He said he knew that he could have asked for something different, but he knew it would take a long time and wouldn't be much good either. He stated that he tries to keep a few snacks in his drawer, and	F 804	Address how corrective action will be accomplished for those residents found to have been affected: It was found that Residents #59, #15 #57 were affected by the deficient practice. Facility staff immediately reheated resident food when notified of cool temperatures. Facility conducted in-service with 100% of all cooks on proper food temperatures and the process for documenting temperatures prior to serving each meal on 1/31/25 by CDM and Kitchen manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility conducted in-service with 100% of all cooks on proper food temperatures and the process for documenting temperatures prior to serving each meal. Staff are also educated on proper quality and appearance/ presentation on the plate. Education was provided on 2/24/2025 by the administrator and kitchen manager. Effective 3/3/2025, all	3/3/25

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F 804	Continued From page 70 the nutrition room never had anything. During an interview with Resident #59 on 01/29/2025 at 5:28 PM, he stated regarding lunch "hate them chicken patties. Nobody can eat as much chicken as we have had. The patties were horrible. The cake was not much. It was dry. The slaw had too much mayo. You could squeeze it out." b. Resident # 15 was admitted on 12/30/2021. A review of a grievance/concern form dated 01/22/2024 stated that meal tickets were not followed, the wrong food was coming out on her tray, and the food was cold. The resolution was signed by both Resident #15 and the Administrator on 01/23/2024 that the Administrator would contact contracted vendor to talk to employees about following meal tickets and the importance of timelines. The quarterly Minimum Data Set (MDS) dated 12/28/2024 reviewed that she was cognitively intact. An interview with Resident #15 on 01/27/2025 at 3:45 PM revealed that sometimes she could not eat the food as it was tasteless, cold or didn't look right. An interview was conducted with Resident #15 on 01/28/2025 at 12:38 PM and revealed that the lunch "just wasn't much at all." She stated that it was pasta with little bits of meat and hardly no sauce. It was dry", she explained and that she only had one bite of bread as it was "too hard and just didn't taste like nothing." She revealed that she didn't eat a bite of salad, because it looked	F 804	new dietary staff will be educated during the orientation process regarding proper food temperatures and the process for documenting temperatures prior to serving each meal as well as proper quality and appearance/presentation on the plate. Certified Nursing staff were educated on the importance of passing out the trays timely, and keeping the tray cart door closed when not in use to promote proper food temperatures. This education was completed by a staff development nurse on 2/24/2025. Effective 3/3/2025, all new Certified Nursing staff will be educated during the orientation process on the importance of passing out the meal trays timely, and keeping the tray cart door closed when not in use to promote proper food temperatures. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Food temperature logs will be audited by the Dietary Manager or designee weekly x 4 weeks and monthly x 3 months. The Administrator or designee will conduct a test tray weekly for 4 weeks, then monthly for 3 months to ensure proper temperature, quality and palatability. Administrator or designee will monitor that food stays at the proper temperature as it reaches the Residents. These test trays will be asked for at random to ensure accuracy of this audit. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 804	Continued From page 71 like it hadn't been washed. "It was brown, she stated." Resident #15 was interviewed on 01/29/2025 at 5:12 PM and revealed that lunch wasn't "much" and not good. At 11:10 AM on 01/30/2025 an interview was conducted with Resident #15's visitor who reported that during her visits over the last six months, she observed thin meat that was unidentifiable and a piece of fish that was as hard as cardboard. She stated that on one visit every food item in the dining room was steamed, and that the stewed tomatoes were runny, and the macaroni and cheese looked tasteless. c. Resident #57 was admitted on 07/06/2023. A review of the 11/15/2024 grievance/concern form revealed that Resident #57 voiced complaint about the quality of the facility's food. The resolution signed by the Administrator was that the facility would incorporate resident's likes and dislikes on his tray. A quarterly Minimum Data Set (MDS) assessment dated 12/15/2024 revealed that Resident # 57 was cognitively intact The grievance/concern form dated 01/24/2025 was reviewed and revealed that his food was not good and served cold, so he had to buy his own food. The Dietary Manager signed a resolution that the menus would be changed to be a better fit for the facility. The Dietary Manager wrote that test trays and in-services would be held to make food at a good temperature and quality before trays were sent out.	F 804	The Dietary Manager or designee will present to QI committee the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the QA meeting.	

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F 804	Continued From page 72	F 804		

An interview on 01/27/2025 at 9:28 AM with Resident #57 revealed that he didn't like the food at all. He had a well-stocked mini refrigerator in his room with food that family members purchased for him. He stated that he can only eat some of the breakfast but not every day and can't eat lunches or suppers. He stated that today the breakfast didn't have any meat, and it was cold and late.

Resident # 57 was out of the facility for the lunch meal on 01/28/2025.

On 01/29/2025 at 2:40 PM, Resident #57 was interviewed and stated that the lunch was chicken again, and he just could not eat the dry, cold food. He stated that the slaw looked runny, and that he just covered it up and sent it back and ate something from his refrigerator.

On 01/30/2025 at 1:30 PM, Resident #57 stated that he could eat his breakfast this morning, but it was a little cold. He revealed that he tried to eat his lunch, but he did not want it.

On 01/28/2025 beginning at 11:10 AM, all foods on the steam table were checked for proper temperatures with the Dietary Manager, and a test tray was followed from the serving line with the Dietary Manager to the serving cart on the 300- hall. At 12:20 PM on 01/28/2025 after the other resident trays were delivered, the test tray revealed mushy and bland ziti noodles. The breadstick was flavorful, but it wasn't very warm. The salad was not wilted, but it was iceberg lettuce with sparse shredded carrots. When the Dietary Manager tasted the tray, he agreed that the breadstick could be warmer, and he stated

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F 804	Continued From page 73 that the ziti was a little mushy. He stated that most of the time he added tomato and cucumbers to the salad "to spice things up" when he has them in stock. Upon touching the milk carton, it was not very cold; and the Dietary Manager said it was okay. The Dietary Manager stated that it could be better quality for sure, and the food could benefit from being hotter. The Dietary Manager was interviewed on 01/28/2025 at 12:35 PM. He stated that he had a few complaints about the food being bland and cold and said that he would work on it. The Administrator was interviewed on 01/30/2025 at 12:20 PM and revealed that the kitchen had some recent staff turnover, and she was aware of some resident complaints about the food. She stated that a new food vendor was contracted.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/3/25

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F 812	Continued From page 74 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store food items off the floor in the dry goods storage area, remove food items with signs of spoilage stored for use in 1 of 2 walk-in freezers and failed to ensure ice cream stored for use in an upright freezer did not have signs of freezer burn in 1 of 3 nourishment rooms (100 Hall nourishment room). The practices had the potential to affect food served to residents. The findings included: a. An observation on 01/27/2025 at 10:02 AM of the dry goods storage room revealed a mesh bag of onions and a wrapped package of water bottles sitting on the storeroom floor. They were pointed out to the Dietary Manager who stated that they should not be on the floor. An item with a split plastic bag on it on the storeroom floor was pointed out, and the Dietary Manager said that it was an old mixer and didn't need to be on the floor. b. Observations of the freezer shelves on 01/27/2025 at 10:07 AM revealed an expired bag of iceberg lettuce dated 01/21, a container of lettuce covered in plastic wrap with a date of 1/23 that looked wilted and almost soupy. A bin covered in plastic wrap marked pureed beef and a date of 1/23 without a year was on the shelf in the freezer. When asked what would keep his staff from serving it, the Dietary Manager stated that they all know the 72-hour rule, but it needs to be thrown out. He stated the pureed beef should	F 812	Address how corrective action will be accomplished for those residents found to have been affected: The facility kitchen manager corrected each finding directly after being brought to his attention. The kitchen manager utilized a cleaning checklist and completed all tasks. All food storage areas and food prep areas were cleaned to facility standard. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1.Administrator educated all dietary staff regarding cleaning checklist, proper food storage in dry good storage room, walk-in refrigerator, and walk-in freezer, and proper guidelines to ensure all food items are free from any spoilage. 2.Dietary Manager or designee will assign daily cleaning tasks to employees via “Cleaning Assignments” form. 3.Administrator or designee will audit that all tasks on the daily “Cleaning Assignments” are signed and each task was completed weekly x 4 weeks then	

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F 812	Continued From page 75 not be in the freezer. c. An observation of the 100-hall nourishment room was conducted on 01/29/2025 at 1:43 PM and revealed 5 vanilla ice cream packages that looked melted and refrozen due to darker yellow color on the tops inside each container. The Dietary Manager was notified and stated that he would remove them as they should not be there. An interview conducted with the Administrator on 01/31/2025 at 2:25 PM revealed that these examples of food storage with beef, lettuce, onions and ice cream were incorrect and should not have been stored this way.	F 812	monthly x 3 months. 4.Audit will be performed by the Dietary Manager or designee to ensure that the dry good storage room is free from food being stored on the floor weekly x 4 weeks then monthly x 3 months. 5.Audit will be performed by Dietary Manager or designee to ensure that walk-in refrigerator and walk-in freezer are free from any spoiled food items weekly x 4 weeks then monthly x 3 months. 6.Audit will be performed by Dietary Manager or designee to ensure that nourishment rooms in the facility are free from any spoiled food items weekly x 4 weeks then monthly x 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator or designee will present to QI committee will review the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the quarterly QA meeting.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		3/3/25

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F 842	Continued From page 76	F 842		

except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-

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F 842	Continued From page 77 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure accurate medical records when a resident's sacral dressing was incorrectly documented as applied for 1 of 1 resident (Resident #36) reviewed for medical record accuracy. The findings included: Resident #36 was admitted to the facility on 1/3/2025. A wound care note dated 1/24/2025, authored by the Wound Care Nurse, revealed Resident #36's high risk area to sacrum (area near the lower back/pelvis) was now a stage 2 (open sore or ruptured blister) pressure injury. A physician's order dated 1/24/2025 revealed	F 842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/29/25, the wound care nurse was educated by the Staff Development Coordinator regarding documentation on the TAR (Treatment Administration Record) being done once the treatment has been completed. The wound treatment for resident #36 was completed on 1/29/25 by the wound care nurse. There were no signs the wound had worsened due to the treatment being completed after the treatment administration record was signed by the wound care nurse. Effective 3/3/2025, all new wound care nurses will be educated during the orientation process regarding	

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F 842	Continued From page 78 Resident #36 was ordered to have a foam dressing applied to her sacrum, placement checked daily, and dressing to be changed every 3 days or as needed. Review of the January 2025 Treatment Administration Record (TAR) revealed the Wound Care Nurse had documented Resident #36's foam dressing to sacrum as completed for dayshift on 1/29/2025. An observation was conducted on 1/29/2025 at 5:32 pm of Nurse #3 and Nurse Aide (NA) #4. Nurse #3 and NA #4 performed incontinence care for Resident #36. After NA #4 removed Resident #36's brief. Resident #36 had a nickel size stage 2 pressure ulcer to her sacral area that was not covered with a dressing and was bleeding. Resident #36 stated her sacral area hurt and asked if staff could put a dressing on her sacral area. An interview was conducted on 1/29/2025 at 5:44 pm with Nurse #3. Nurse #3 stated there was not a dressing on Resident #36's sacral area and verbalized there should have been. Nurse #3 stated the Wound Care Nurse was responsible for placing a dressing on Resident #36's sacral area. Nurse #3 acknowledged there was an active order for a foam dressing to be applied to Resident #36's sacrum. An interview was conducted on 1/30/2025 at 8:51 am with NA #5. NA #5 stated she worked dayshift (7:00 am to 7:00 pm) and was assigned Resident #36 from 7:00 am to 3:00 pm on 1/29/2025. NA #5 stated Resident #36 was frequently incontinent of urine and had to be changed often. NA #5 stated she had checked	F 842	documentation on the TAR (Treatment Administration Record) being done once the treatment has been completed. 2/25/2025 resident #36 pressure injury of concerned was resolved and documented healed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of current residents with pressure ulcers, TARs and treatment was conducted by the Director of Nursing to ensure the treatment orders that had been signed by the wound care nurse were completed. No discrepancies were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/24/25, education was initiated to current licensed nursing staff including agency clinical licensed personnel regarding completion and signing of treatment orders and following the physician treatment orders by the SDC or designee. Effective 3/3/2025, any facility or agency licensed nurse who has not been educated will not be allowed to work until this education is received in-person or via telephone by the Staff Development Coordinator or designee. All newly hired licensed nursing staff or clinical agency personnel will receive this education during the orientation process by the Staff Development Coordinator (SDC)or designee on providing wound treatment per the physician order and signing the TAR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 79 Resident #36 before breakfast at which time there was not a foam dressing on Resident #36's sacrum. NA #5 stated she changed Resident #36 every 2 hours throughout her shift, and stated at no time did Resident #36 have a dressing to her sacral area. An interview was conducted on 1/31/2025 at 9:26 am with the Wound Care Nurse. The Wound Care Nurse stated Resident #36 developed a stage 2 pressure ulcer to her sacral area. The Wound Care Nurse stated she was responsible for wound care treatments Monday through Friday. The Wound Care Nurse stated she did not change Resident #36's dressing until around 6:00 pm after she was contacted by Nurse #3. The Wound Care Nurse stated she had gone to provide wound care around lunch and charted the dressing change as completed and stated Resident #36 was frantic, so she did not. The Wound Care Nurse stated she intended to go back and put the dressing on later. The Wound Care Nurse stated she forgot to go back and change her documentation or enter a progress note. An interview was conducted on 1/31/2025 at 11:21 am with the Director of Nursing (DON). The DON stated the Wound Care Nurse was responsible for providing wound care Monday through Friday and the hall nurse on the weekends. The DON stated the Wound Care Nurse should not have charted Resident #36's wound care as completed if it had not been done.	F 842	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) or designee will conduct random audits of 5 residents who have been identified as having pressure ulcers to ensure the treatment has been completed and signed for on the Treatment Administration Record, weekly for 4 weeks then monthly for 3 months to ensure adequate compliance. The Director of Nursing will present the findings at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for 3 months or until compliance is achieved.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345163	A. BUILDING: _____ B. WING _____	2/6/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION	**211 MILTON BROWN HEIRS ROAD BOONE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to update a resident's care plan to reflect the removal of a feeding tube for 1 of 1 resident reviewed for feeding tubes (Resident #8). The findings included: Resident #8 was admitted to the facility on 09/24/24 with diagnoses that included partial intestinal obstruction, and gastric ulcer. A review of Resident #8's quarterly Minimum Data Set assessment dated 01/06/25 revealed her to be cognitively intact. She was coded as independent with eating and had no indicated swallowing or nutritional disorders. Review of Resident #8's physician orders revealed the following orders: - Regular diet, regular texture with regular/thin liquids, dated 10/29/24 - Per [physician] discontinue feeding tube - every day, every shift effective 11/20/24 Review of Resident #8's care plan last reviewed on 01/07/25 revealed the following care plan: - [Resident #8] requires tube feeding related to partial gastric obstruction requiring revision of gastric bypass secondary to weight loss and severe protein-calorie malnutrition. Interventions included Resident #8 would remain free from side effects or complications related to the

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 657	Continued From Page 1

feeding tube, her insertion site would remain free from infection, Resident #8 would maintain adequate nutrition and hydration, and she would remain free from aspiration.

During an interview with Resident #8 on 01/28/25 at 12:21 PM, she reported she had not had a feeding tube in some time. She verified she only received nutrition via eating her meals and not from an artificial route.

During an interview with MDS Nurse on 01/30/25 at 4:06 PM, he reported the facility had a designated Care Plan Coordinator who was responsible for updating care plans as resident care needs changed. He reported, however, that the current Care Plan Coordinator was new to the position, and he had been helping the MDS Nurse with care plan revisions and updates. The MDS Nurse stated he should have removed or discontinued Resident #8's care plan for the use of a feeding tube. He also indicated that care plans should be updated at least quarterly and since Resident #8's care plan was reviewed on 01/07/25 and her feeding tube was discontinued on 11/20/24, the feeding tube care plan should have been discontinued or resolved.

During an interview with the Care Plan Coordinator on 01/30/25 at 4:12 PM, he reported he was new to the position and started on 01/01/25. He reported that he was not aware that Resident #8's feeding tube had been discontinued. He reported if he had known that it was discontinued, he would have put a note in Resident #8's chart and either discontinued or resolved the care plan for the tube feeding.

An interview with the Director of Nursing on 01/30/25 at 4:19 PM revealed she expected Resident #8's tube feeding care plan to have been updated to reflect its discontinuation when the care plan was reviewed on 01/07/25.

An interview with the Administrator on 01/30/25 at 4:31 PM revealed she expected care plans to be updated to accurately reflect the care needs of residents.