STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS HEALTH AND REHABILITATION	430 BROOKWOOD AVENUE NE , CONCORD, North Carolina, 28025

(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
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

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E0039 SS = F	Continued from page 1 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E0039		

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E0039 SS = F	Continued from page 2 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or	E0039		

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E0039 SS = F	Continued from page 3 (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:	E0039		

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E0039 SS = F	Continued from page 4 (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a	E0039		

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E0039 SS = F	Continued from page 5 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102]	E0039		

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E0039 SS = F	Continued from page 6 (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	E0039		

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E0039 SS = F	Continued from page 7 prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide documentation of having conducted training exercises specifically to test the facility's emergency preparedness plan. The deficient practice had the potential to affect all residents and staff. The findings included: The emergency preparedness plan was reviewed with the Administrator on 6/19/25 at 11:45 AM. The emergency preparedness plan did not include any documentation of community-based emergency exercises, a full-scale community or facility-based exercise, or any unannounced staff drills. The Administrator was interviewed on 6/19/25 at 11:45 AM and reported that the previous maintenance director	E0039		

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E0039 SS = F	Continued from page 8 left the facility in December 2024, and the facility had not conducted any community-based emergency exercises, or a full-scale facility-based exercises, or unannounced staff drills. The Administrator reported that they were unable to locate any records of drills conducted prior to December 2024. The Administrator reported the community-based exercises, full-scale community or facility-based exercises should be conducted annually. During an interview on 6/19/25 at 3:00 PM, the Maintenance Director reported he was unable to find any records of community-based emergency exercises, a full-scale community or facility-based exercise, or any unannounced staff drills for the previous year. A follow-up interview was conducted by phone on 6/20/25 at 11:05 AM with the Administrator and she reported she had not been able to locate any documentation of any community-based, facility-based, or unannounced staff emergency drills. The Administrator reported she expected the facility to participate in annual testing of the emergency plan with community-based, facility-based exercises, and staff drills.	E0039		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/16/25 through 06/19/25. Additional complaint intakes were received after the team left the facility on 06/19/25. Additional information was obtained for the investigation of the additional intakes, as well as additional information regarding other survey matters, daily from 06/23/25 through 06/27/25. Therefore, the exit date was changed to 06/27/25. Event ID# KRWY11. The following intakes were investigated NC00231762, NC00231793, NC00231607, NC00231412, NC00231196, NC00229817, NC00228746, NC00228068, NC00227532, NC00227443, NC00227392, NC00227367, NC00227097, NC00226656, NC00226415, NC00225894, NC00225824, NC00225783, NC00225785, NC00225560, NC00225492, NC00224665, NC00224655, NC00224478, NC00224292, NC00224234, NC00223291, and NC00222853. 31 of the 104 complaint allegations resulted in deficiency.	F0000		
F0553 SS = D	Right to Participate in Planning Care	F0553		

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F0553 SS = D	Continued from page 9 CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, responsible party, and staff interviews, the facility failed to afford the resident and/or responsible party the right to participate in the care plan process for 2 of 3 (Resident #28 and Resident #60) reviewed for quarterly care plan reviews. Finding included:	F0553		

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F0553 SS = D	Continued from page 10 a. Resident #28 was admitted to the facility on 7/25/2019 with respiratory disease. During a review of Resident #28's medical record a care plan meeting invitation or documentation of a care plan with the resident and/or Responsible Party was not found. Resident #28's care plan was revised on 4/4/2025. A quarterly Minimum Data Set assessment dated 4/6/2025 indicated Resident #28 was moderately cognitively impaired. On 6/17/2025 at 3:02 pm an interview was conducted with Resident #28 and the Responsible Party and the Responsible Party stated they had not had a care plan meeting for several months. b. Resident #60 was admitted to the facility on 4/15/2022 with diagnoses of dementia and brain injury. A significant change Minimum Data Set assessment date 4/7/2025 indicated Resident #60 was severely cognitively impaired. Resident #60's care plan was revised on 12/5/2024 and 3/7/2025. During a phone interview with the Responsible Party on 6/16/2025 at 12:23 pm she stated she had not been invited to a care plan meeting for several months. Social Worker #1was interviewed on 6/25/2025 at 1:11 pm and she stated she came to the facility in 4/2025, and the care plan meetings had not been completed quarterly when she arrived. Social Worker #1 stated she started the care plan meetings two weeks ago. Social Worker #1 stated the care plan meetings were scheduled according to the Minimum Data Set schedule quarterly and the facility's electronic dashboard lets her know when the assessments are due and she sends out an invitation to the resident and responsible party, and all of the	F0553		

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F0553 SS = D	Continued from page 11 department managers are also notified of the care plan meeting. During an interview with Social Worker #2, who no longer worked at the facility, on 6/25/2025 at 1:21 pm she stated she began working at the facility in 12/2024 and the care plan meetings were already behind when she came to the facility, and she was not able to get them caught up. Social Worker #2 stated she left the facility on 3/2025. The Administrator was interviewed on 6/19/2025 at 3:16 pm and she stated a care plan meeting has not been completed for Resident #28 and Resident #60 since before the facility's last recertification survey on 4/18/2024. The Administrator stated the care plan meetings have not taken place and she was not aware of them not being done until this survey. The Administrator stated the Social Worker should have scheduled the meeting, and the Admissions Coordinator should have notified the family and/or residents of the meetings quarterly.	F0553		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance	F0585		

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F0585 SS = D	Continued from page 12 policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility	F0585		

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F0585 SS = D	Continued from page 13 as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Resident Representative (RR) interviews, the facility failed to implement their grievance policy and procedure by failing to promptly address grievances, notify the resident and/or RR of the action that was taken to resolve their concerns or follow up with the Resident Representatives regarding resolution. This deficient practice occurred for 2 of 3 residents (Resident #220 and Resident #518) reviewed for grievances. The findings included: The facility's concerns/grievances policy and procedure dated 3/01/25 read in part: The management staff is charged with listening and responding to questions, needs, problems or concerns brought to their attention by patients and/or families within the facility. The Administrator serves as the grievance official and is responsible for overseeing the grievance process. 1. Nursing Staff, Social Work, Discharge Planners or any other team members receiving questions or issues of concern regarding care and/or services are to immediately respond at point of service in effort to satisfactorily resolve issues of concern. 2. If an issue of concern cannot be immediately and satisfactorily resolved at point of service, the patient/family member will be notified that the concern is being submitted to the appropriate department manager and that follow-up for resolution will be provided as quickly as possible. The facility grievance form is to be promptly submitted by the staff member. 3. The department manager receiving the concern	F0585		

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F0585 SS = D	Continued from page 14 actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern). The department manager will follow up with the patient/family to determine satisfaction, record and send their actions to the Administrator. a. Resident #220 was admitted to the facility on 10/30/24 and was discharged home on 12/24/24. His admitting diagnoses included intracranial hemorrhage (brain bleed). The admission Minimum Data Set (MDS) assessment dated 11/6/24 revealed Resident #220 was severely cognitively impaired. A review of the facility's grievance log from November 2024 to June 2025 indicated Resident #220's RR had filed a grievance on 12/11/24. A grievance/concern form dated 12/11/24 completed by the Former Social Worker revealed Resident #220's RR reported various items of clothing and personal hygiene products missing, and a detailed list of the items was attached to the form. The grievance was assigned to an individual/department to investigate on 12/16/24 but no name of the individual/department. The documented action taken indicated staff were made aware of the missing items, but no items were found. There was no follow-up or resolution documented on the grievance form. A phone interview was conducted with Resident #220's RR on 6/20/25 at 2:44 PM. The RR revealed she filed a grievance with the Former Social Worker on 12/11/24 because Resident #220 was missing clothing and some other personal items from his room. The RR stated she called several times and left messages for the Former Social Worker to check on the status of the grievance, but the calls were not returned. The RR indicated that Resident #220 was discharged home on 12/24/24, and no one at the facility provided any type of follow up or resolution regarding the items she reported missing. b. Resident #518 was admitted to the facility on 11/22/23 and discharged from the facility on 2/17/25. His admitting diagnoses included anoxic (complete lack of oxygen) brain injury. The annual Minimum Data Set (MDS) assessment indicated Resident #518 was severely cognitively impaired and was dependent on staff for all activities of daily living. A review of the facility's grievance log from November 2024 to June 2025 revealed a grievance was filed by	F0585		

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F0585 SS = D	Continued from page 15 Resident #518's RR on 11/22/24. A grievance/concern form dated 11/22/24 completed by the Former Social Worker indicated Resident #518's RR reported concerns related to nail care, Resident #518 not being dressed daily and staff keeping his room too dark. The grievance was referred to the nursing department. There was no other information documented on the form. A phone interview conducted with Resident #518's RR on 6/20/25 at 11:05 AM revealed she reported to the Former Social Worker she was concerned that Resident #518 was not receiving regular nail care and requested he was seen by the Podiatrist. The RR indicated the Former Social Worker did not provide any follow up regarding the grievance and it was not resolved. During a phone interview with the Former Social Worker on 6/19/25 at 11:08 AM she indicated she was employed at the facility November 2024 through March of 2025 and was responsible for completing grievance forms. She revealed after receiving a grievance and filling out the form she delegated the grievance to the appropriate department manager to investigate and resolve. She stated after the department manager addressed and resolved the grievance, she notified the resident and/or RR and provided verbal follow-up on the action taken to resolve their concern. The Former Social Worker stated she did not recall ever receiving a grievance from Resident #518's RR related to his care, a request to see the Podiatrist, or that she filled out a grievance form that was not addressed or completed. She indicated she did recall a grievance filed on behalf of Resident #220 concerning missing clothing and personal items from his room. She stated all departments were notified of the concern and assisted with searching for the missing items, however none of the items were found. The Former Social Worker revealed she notified the Former Administrator they were unable to locate Resident #220's missing items and left the grievance with her to address further. She indicated she was unsure if the Former Administrator did anything further with the grievance, provided follow-up to Resident #220's RR or if it was resolved. The Former Social Worker stated she did not contact or follow-up with Resident #220's RR regarding the missing items because she had no additional information to share or a resolution to her grievance. A phone interview was conducted with the Former Administrator on 6/19/25 at 1:08 PM. She revealed she was employed at the facility from 10/07/24 through 3/27/25. She stated the Former Social Worker was	F0585		

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F0585 SS = D	Continued from page 16 responsible for completing the grievance/concern forms, delegating grievances to the appropriate department manager and then providing follow up to the resident and/or RR. The Former Administrator indicated that when a grievance was filed by a resident and/or RR it should have been addressed and resolved within 48 to 72 hours and follow-up should have been provided to the resident and/or RR verbally or in writing. The Former Administrator revealed she reviewed the completed grievance forms to ensure concerns were resolved in a timely manner, and that all information regarding the grievance was documented on the form. She stated she was not aware of any outstanding grievances that were not resolved prior to her leaving the facility nor did she recall observing any incomplete grievance forms. The Former Administrator revealed she was not aware of the grievances filed by Resident #220's RR or by Resident #518's RR.	F0585		
F0640 SS = B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F0640		

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F0640 SS = B	Continued from page 17 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to transmit residents' Minimum Data Set assessments within 14 days of completing assessments for 4 of 5 residents reviewed for transmission of resident assessments (Resident #14, Resident #60, Resident #90, and Resident #61). Findings included: a. Resident #14 was admitted to the facility on 3/10/2025. Review of Resident #14's most recent quarterly Minimum Data Set (MDS) assessment dated 3/16/2025 revealed the assessment was not transmitted until 4/9/2025.	F0640		

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F0640 SS = B	Continued from page 18 The MDS Submission Report indicated Resident #14's quarterly MDS assessment with an assessment reference date (ARD) was not transmitted until 4/9/2025. b. Resident #60 was admitted to the facility on 4/15/2022. A significant change MDS assessment with an Assessment Reference Date (ARD) of 4/7/2025 was transmitted on 4/22/2025. The MDS Submission Report indicated Resident #60's Significant Change MDS assessment was transmitted on 4/22/2025. c. Resident #90 was admitted to the facility on 6/13/2024. A review of her most recent quarterly MDS assessment with an ARD of 3/22/2025 was not transmitted until 4/14/2025. The MDS Submission Report indicated Resident #90's quarterly MDS assessment was transmitted on 4/14/2025. d. Resident #61 was admitted to the facility on 3/28/2024. Resident #61's most recent quarterly MDS assessment with an ARD of 3/10/2025 was transmitted on 3/26/2025. The MDS Submission Report indicated Resident #61's quarterly MDS assessment was transmitted on 3/26/2025. An interview was conducted with the Regional MDS Coordinator on 6/18/2025 at 10:16 am and she stated the MDS assessments were late because the previous MDS Coordinator was not very quick to get assessments transmitted. The Regional MDS Coordinator stated the facility had just hired a new MDS Coordinator. During an interview with the Administrator on 6/19/2025 at 1:59 pm she stated the MDS assessments should have	F0640		

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F0640 SS = B	Continued from page 19 been transmitted within the time required. The Administrator stated at the time of the late transmissions the facility had a turnover of the MDS staff and a new full-time MDS Coordinator had recently been hired. The facility submitted a corrective action plan with a compliance date of 4/26/2025 and it was not validated due to insufficient evidence of compliance.	F0640		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641		

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F0641 SS = D	Continued from page 20 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of dental status for 1 of 34 residents reviewed for accuracy of assessments (Resident #21). Findings included: Resident #21 was admitted on 11/21/18. A review of a dental clinical note dated 4/17/25 indicated Resident #21 had malpositioned, decayed, and missing teeth. A review of the annual Minimum Data Set (MDS) assessment dated 5/10/25 indicated Resident #21 was cognitively intact and had no obvious or likely cavities or broken teeth. During an observation on 06/16/25 at 11:19 AM, Resident #21 was observed with black/brown discolored teeth and missing teeth. On 06/18/25 at 11:37 AM an interview was conducted with MDS Nurse #1. She indicated she completed the dental assessment for Resident #21's Annual MDS assessment and that she was not aware that Resident #21 had any decaying or missing teeth and it should have been coded on the MDS assessment. During an interview on 06/26/25 at 3:02 PM, the Administrator revealed MDS assessments should accurately reflect Resident #21 had decaying and missing teeth and she expected the assessment to be coded correctly for dental status.	F0641		
F0677 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:	F0677		

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F0677 SS = D	Continued from page 21 Based on observations, record review, and resident representative and staff interviews, the facility failed to provide nail care and shave facial hair for 1 of 11 residents reviewed for activities of daily living (ADL) (Resident #56). The findings included: Resident #56 was admitted to the facility 2/24/25 and readmitted 5/2/25. Diagnoses for Resident #56 included stroke and diabetes. A care plan developed on 2/26/25 and revised on 3/21/25 documented Resident # 56 required assistance with all ADL and included the goal that Resident #56 would maintain a clean, neat, odor-free appearance, and be free from discomfort. The significant change Minimum Data Set (MDS) assessment completed 5/7/25 documented Resident #56 as severely cognitively impaired, and he was dependent on others for all ADL care. Resident #56 was observed on 6/16/25 at 12:17 PM. Resident #56 had a full beard that appeared to be approximately ½ inch in length, and the hair was very dense and curly. Resident #56's fingernails extended past his fingertips by more than ¼ inch. An observation of Resident #56 was conducted on 6/17/25 at 11:49 AM. Resident #56 had a full beard that appeared to be approximately ½ inch in length, and the hair was very dense and curly. Resident #56's fingernails extended past his fingertips by more than ¼ inch. Nursing Assistant (NA) #1 was interviewed on 6/17/25 at 11:50 AM. When asked how frequently she provided nail care to residents, she reported she would check their nails every time she bathed them. NA #1 was asked to look at Resident #56's nails and she noted that the nails were long and extended past his fingertips. NA #1 reported she would clip his nails after he was bathed on 6/17/25. NA #1 reported she had been assigned to Resident #56 several times over the past week and had bathed him on 6/16/25 but had not noticed his fingernails. NA #1 was asked about Resident #56's facial hair and she reported that she could shave it. NA #1 reported she had not ever shaved Resident #56's facial hair and she had not asked his family if they wanted him shaved. NA #3 was observed assisting NA #1 with Resident #56's	F0677		

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F0677 SS = D	Continued from page 22 bath on 6/17/25 at 11:50 AM. During the bath, NA #3 was interviewed, and she reported she had provided bathing to Resident #56 "several times" but could not recall the dates. NA #3 reported she had never shaved Resident #56 or clipped his fingernails. NA #3 reported if a resident was unable to communicate their preferences, she asked a family member but had never asked Resident #56's family about shaving Resident #56 was observed again on 6/18/25 at 9:24 AM. His fingernails were trimmed, but he had not had his face shaved and his facial hair remained more than ½ inch in length and remained very dense and curly. Resident #56's Representative was interviewed on 6/18/25 at 1:30 PM. The Representative reported that she offered to bring in a razor to shave Resident #56 but was told by the nursing staff that they had one and would provide that service to him. The Representative did not recall who she had talked to about shaving Resident #56. The Representative explained that she had asked several times for Resident #56 to be shaved and for his nails to be trimmed, but it had not been completed. The Representative explained that Resident #56 had been clean-shaven or had his beard closely clipped prior to his stroke and he would not like to have so much facial hair, and he would not like his nails to be so long. An interview was conducted with Nurse #11 at 6/18/25 at 9:40 AM. Nurse #11 reported that resident nails should be checked by the NA staff during each bath and clipped as needed. Nurse #11 reported she was not aware Resident #56's nails were so long and was not aware Resident #56's representative wanted his face to be shaved. The Director of Nursing (DON) was interviewed on 6/18/25 at 2:25 PM and she reported that she had told the NA staff to provide shaving to Resident #56 prior to the interview. The DON reported NAs should check fingernail length every time the resident received a bath and clip them as needed. The Administrator was interviewed by phone on 6/20/25 at 11:05 AM. The Administrator reported she did not know why Resident #56's nails had not been trimmed, and his beard had not been shaven. The Administrator reported that those should be completed as often as the residents needed. The Administrator reported she expected the staff to complete all ADL care for all residents.	F0677		
F0684	Quality of Care	F0684		

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F0684 SS = G	Continued from page 23 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff, Physician Assistant (PA), and Medical Director interviews, the facility failed to identify a change in medical condition required medical evaluation and treatment. Resident #85 fell and complained of pain to his lower right extremity on 3/17/2025. Resident #85 was assessed by PA #1 on 3/18/25 and an x-ray of the right lower extremity was ordered. The x-ray was completed on 3/19/25 and the results of an intertrochanteric fracture of right femur (type of broken hip that occurs between the bumpy parts at the top of the thigh bone) were reported to the facility on 3/19/25 at 12:13 PM. A medical evaluation and treatment of the fracture was delayed due to the x-ray results not being reviewed by facility staff or communicated to PA #1 until 3/20/25. Resident #85 was sent to the hospital for an evaluation on 3/20/25 and on 3/21/25 Resident #85 received open reduction and internal fixation (a procedure to realign and secure broken bones with metal fasteners) to the right femur. Resident #85 was discharged back to the facility on 3/25/25. The deficient practice occurred for 1of 15 residents reviewed for accidents (Resident #85). The findings included: Resident #85 was admitted to the facility on 3/31/24 with diagnoses which included vascular dementia and hemiplegia (condition of complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following a stroke affecting the left non dominate side. Review of the quarterly Minimum Data Set (MDS) dated 2/9/25 revealed Resident #85 was severely cognitively impaired and was dependent on staff for transfers. Review of Resident #85's care plan created on 7/15/24 with a revision date of 3/17/25 revealed a focus area for at risk for falls and injury related to weakness,	F0684		

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F0684 SS = G	Continued from page 24 altered mobility status and history of falls. Interventions included providing frequent reminders/cues to request assistance or wait for assistance with ambulation and transfers. A review of nursing progress note dated 3/17/25 at 10:00 PM, written by Nurse #8, revealed Resident #85 was found sitting on the floor with complaints of leg pain and had no new injury. A review of the eCare Triage (process used in healthcare settings to prioritize patients' treatment electronically to help prevent unnecessary emergency department visits) Note dated 3/17/24 at 10:11 PM indicated Nurse #8 contacted the on-call Provider #1 to report Resident #85 had an unwitnessed fall. The note further indicated Resident #85 had no injury and reported leg pain but was able to bear weight. On-call Provider #1 informed Nurse #8 that the pain may be coming from the fall but does not sound like a fracture or a dislocation concern. On-call Provider #1 gave an order for Acetaminophen 325 milligram (mg) 2 tablets by mouth every 8 hours as needed for pain up to 3 days. On-call Provider #1 also instructed Nurse #8 to monitor and report any changes to the provider and to follow up with Resident #85's primary care physician. A review of Resident #85's physician orders revealed an order on 3/17/25 for acetaminophen 325 milligrams (mg) orally two tablets every 8 hours as need for pain management status post fall for 3 days. A review of the initial incident report completed on 3/17/25 , written by Nurse #8, revealed Resident #85 had an unwitnessed fall in his room on 3/17/25 at 10:00 PM. The report indicated Nurse #7 called for Nurse #8 when Resident #85 was found sitting on the floor beside the bed. Nurse #8 completed a head-to-toe assessment with no injury noted. The report further revealed Resident #85 was wearing no skid socks but did not have any footwear in use. Resident #85 was able to move all extremities with right leg pain reported. The incident report did not state how Resident #85 was transferred post fall. Nurse #8 contacted the provider and the Responsible Party. The provider gave Nurse #8 an order for acetaminophen 325 mg 2 tablets every 8 hours as needed for pain which was administered and effective. An interview was conducted with Nurse #8 on 6/18/25 at 5:52 PM. She indicated she was the assigned nurse for Resident #85 on 3/17/25 from 7:00 PM to 7:00 AM and that Nurse #7 called for her when Nurse #7 observed Resident #85 in his room sitting on the floor beside the bed. Nurse #8 indicated she observed Resident #85's	F0684		

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F0684 SS = G	Continued from page 25 bed was in the lowest position, call light was in reach, and he was wearing nonskid socks. Nurse #8 indicated upon interviewing Resident #85 he indicated that he got up unassisted while trying to turn off the room light when he fell. Resident #85 denied hitting his head but reported right leg pain. Nurse #8 indicated there were no visible signs of injury noted at the time. Nurse #8 indicated that she completed a head-to-toe assessment which included moving Resident #85's upper and lower extremities was completed without difficulty. Nurse #8 further revealed that she pressed on the right leg to try and detect any injury, but no injury or source of pain was found. Nurse #8 indicated that although Resident #85 reported right leg pain, upon her assessment she did not discover any signs of injury, so she and Nurse #7 assisted him up to standing position and helped him back to bed. Nurse #8 further revealed that he was bearing weight at the time of the transfer and did not report additional pain or discomfort. Nurse #8 indicated that she notified the responsible party and on-call Provider #1 of the fall. She indicated that she made the on-call Provider #1 aware of the fall, the report of right leg pain and that he was weight bearing at the time of transfer without pain. The on-call Provider #1 ordered acetaminophen 325 mg 2 tablets for pain which she administered to Resident #85 after she received the physician order and put a note in the facility provider's communication book for evaluation. Nurse #8 indicated that at approximately 6:00 AM Resident #85 reported pain in right leg and requested to go to the hospital. Nurse #8 contacted the on-call Provider #2 to make a provider aware of the change, and the provider gave order for ibuprofen but when Nurse #8 returned to Resident #85's room, he had fallen back asleep, so the medication was not administered. Nurse #8 made the on-call Provider #2 aware, and she indicated that because Resident #85 had fallen back asleep and not in significant discomfort the nurse was to allow him to rest and have the facility provider see him in person that morning for further evaluation but to contact the provider again if any changes occurred. A review of eCare Triage Note dated 3/18/25 at 6:19 AM indicated Nurse #8 contacted on-call Provider #2 to report Resident #85 had a fall earlier in the shift , received acetaminophen for pain and requested to be sent to the hospital for pain. The on-call Provider #2 inquired if Resident #85 was willing to try ibuprofen but when Nurse #8 checked on Resident #85 he had fallen asleep. On-call Provider #2 and Nurse #8 agreed that he was no longer in pain as he had fallen asleep. The on-call Provider #2 asked Nurse notify the provider if Resident #85 is in pain and to follow up with primary	F0684		

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F0684 SS = G	Continued from page 26 care physician. Multiple attempts were made to interview Nurse #7 who first observed Resident #85 sitting on floor in his room post fall on 3/17/25, but attempts were not successful. Multiple attempts were made to interview on-call Provider #1 but attempts were not successful. Multiple attempts were made to interview NA #6 who was assigned to Resident #85 on 3/17/25 during the 7:00 PM to 7:00 AM shift but attempts were not successful. An interview was conducted on 6/19/25 at 11:01 AM with Nurse #12 who was assigned to Resident #85 on 3/18/25 during the 7:00 AM to 7:00 PM shift. She indicated that Resident #85 was not in pain and showed no signs of change from his normal behavior during the shift. An interview was conducted on 6/19/25 at 12:17 PM with NA #7 who was assigned to Resident #85 on 3/18/25 from 7:00 AM to 7:00 PM. She indicated Resident #85 showed no changes from normal behavior and did not report pain during this shift. An interview was conducted with on-call Provider #2 on 6/19/25 at 12:52 PM. She indicated that she was contacted by Resident #85's nurse on 3/18/25 at 6:19 AM and was updated on the fall that had occurred earlier in the shift and that Resident #85 had reported pain and requested to go to the hospital. The on-call Provider #2 further revealed that during the consultation with the nurse she discussed adding ibuprofen for pain relief if acetaminophen was not managing the pain. Nurse #8 went back to offer the medication to Resident #85, but he had fallen back to sleep. The on-call Provider #2 indicated that due to Resident #85 falling back asleep and therefore not exhibiting unmanaged pain, she felt it was in the resident's best interest to allow him to sleep and have the nurse contact the facility provider to have Resident #85 evaluated in person. She also indicated that she instructed the nurse to call the on call back if there were any changes in Resident #85 status. A review of physician order dated 3/18/25 at 11:45 am indicated an order for x-ray right lower extremity complaints of pain post fall one time for right lower extremity x-ray. A review of Physician Assistant (PA) #1's note dated 3/18/25 at 4:35 PM indicated PA #1 visited Resident #85	F0684		

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F0684 SS = G	Continued from page 27 for acute visit due to a fall on 3/17/25. PA #1 indicated that Resident #85 reported pain in right hip and right femur during the evaluation and she ordered an x ray. A review of physician order dated 3/18/25 at 6:30 PM indicated an order to x-ray right extremity. Please x-ray tibia-fibula, femur and hip one timely only for right lower extremity x-ray for 1 Day. A review of the administration progress note dated 3/18/25 at 10:05 PM indicated Nurse #8 administered acetaminophen 325 mg 2 tablets for pain. There was no level of pain documented. A review of Resident #85's March 2025 Medication Administration Record (MAR) revealed acetaminophen 325 mg 2 tablets for pain was administered on 3/18/25 at 10:05 PM by Nurse #8. Resident #85 was documented to have pain at level 4 and the medication was effective. The MAR did not indicate if this medication was administered on 3/17/25, 3/19/25, or 3/20/25. A review of the Radiology Report for Resident #85 indicated an examination occurred on 3/19/25 at 10:02 AM and the results were reported on 3/19/25 at 12:13 PM. The finding was an acute transverse non-displaced intertrochanteric fracture and mild osteopenia was noted. The result was reviewed by PA #1 on 3/20/25 at 1:50 PM. A review of progress notes dated 3/19/25 revealed a note authored by Nurse #8 that indicated she administered acetaminophen 325 mg 2 tablets for pain management at 7:27 PM and it was effective. There was no level of pain documented. On 6/19/25 at 9:31 AM a follow up interview was conducted with Nurse #8. She indicated that she did not recall what days she administered the acetaminophen or why the MAR was blank on 3/17/25 and 3/19/25 but if she administered the medication then she should have signed off that it was given. Nurse #8 further revealed that Resident #85's pain was controlled. A review of progress note dated 3/20/25 at 7:13 AM which was authored by Unit Manager #1 indicated Nurse #9 received Resident #85's x-ray results which indicated a right femur fracture. The nurse informed Resident #85 and the Responsible Party and noted PA #1 would assess Resident #85 that morning. A review of progress note dated 3/20/25 at 9:27 AM which was authored by Unit Manager #1 indicated she	F0684		

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F0684 SS = G	Continued from page 28 notified PA #1 that the result of the x-ray for Resident#85 was an acute transverse nondisplaced fracture of the femur and that PA #1 referred Resident #85 to orthopedic as soon as possible. A review of the progress note dated 3/20/25 at 11:45 AM authorized by the Assistant Director of Nursing indicated that PA #1 had given an order to send Resident #85 to the hospital and that the Responsible Party was notified by UM #1. Review of hospital progress notes revealed Resident #85 was admitted on 3/20/25 for evaluation of femur fracture. The note further revealed Resident #85 sustained an intertrochanteric fracture of right femur. On 3/21/25 Resident #85 received open reduction and internal fixation (surgical procedure used to treat severe bone fractures) to the right femur. Resident #85 was discharged back to the facility on 3/25/25. Review of orthopedic consult note from the hospital dated 3/21/25 revealed Resident #85 had a Right Intertrochanteric femur fracture. An interview was conducted on 6/18/25 at 3:20 PM with Unit Manager (UM) #1. She indicated that x-ray results were reported to the facility in real time via the Electronic Medical Record (EMR) and that all nurses have access to the report. However, she or a nursing supervisor were normally the nurses that reviewed the results. She also indicated that the mobile x-ray provider may also send a fax and call the facility with any positive reports. UM #1 indicated that Resident #85's x-ray results from his fall on 3/17/25 were uploaded into the EMR on 3/19/25 at 12:14 PM and noted the finding of a right femur fracture. She indicated that she normally leaves her shift around 2:30 PM and that she did not see the x-ray result before she left on 3/19/25. UM #1 further revealed that there was not a nursing supervisor working that evening, so she reviewed the result on 3/20/25 around 7:15 AM. UM#1 indicated that she reported the x-ray results to PA #1 around 9:30 AM on 3/20/25. PA #1 initially ordered an orthopedic referral as soon as possible and was not sure why this was ordered instead of an order for hospitalization. UM #1 indicated that PA #1 later gave a telephone order to the ADON to send Resident #85 to the hospital and Resident #85 was sent out around 10:40 AM. An interview was conducted with Physician Assistant #1 on 6/19/25 at 10:38 AM. PA #1 indicated she became aware of Resident #85's fall when she came into the facility the morning of 3/18/25. PA #1 indicated she	F0684		

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F0684 SS = G	Continued from page 29 reviewed the provider's communication book and saw a note from Nurse #8 related to Resident #85's fall. The note indicated that Resident #85 had an unwitnessed fall, reported pain and requested to go the hospital. She further revealed that she reviewed the triage notes that referenced the on-call provider's interactions with Nurse #8 during the time of the fall. PA #1 indicated that she evaluated Resident #85, and he did not exhibit uncontrolled or high levels of pain but during the range of motion evaluation to the right knee and hip, Resident #85 verbalized pain. PA #1 indicated she did not feel hospitalization was needed at that time due to Resident #85 not having a visible sign of injury, limited pain and a hospitalization would have been very taxing for Resident #85 to endure. She also indicated she ordered an x-ray at that time and expected to receive the result within the next 24 hours. PA #1 indicated she had access to the facility EMR, but she did not receive an alert that the x-ray results showed a positive finding for a right femur fracture. PA #1 further revealed that the notification process was for the Unit Manger to contact her with any positive x-ray results. PA #1 also indicated if she had been made aware of Resident #85's x-ray result on 3/19/25 she would have sent him directly to the hospital that same day. On 6/20/25 at 2:53 PM an interview was conducted with the Medical Director. The Medical Director indicated he did not feel that Resident #85 had experienced any uncontrolled pain or negative outcome after his fall on 3/17/25 due to the delay of hospitalization, however he would have wanted Resident #85 sent to the hospital for evaluation on 3/19/25 once the x-ray results were received. He indicated that he felt the facility nursing staff should have received a phone call from the mobile x-ray provider when they became aware of Resident#85's positive finding for a right femur fracture. On 6/23/25 at 9:10 AM a telephone interview was conducted with the Director of Marketing for Mobile X-Ray provider who completed the X-ray for Resident #85 on 3/19/25. She indicated that the company had a change in systems and was not able to access documentation to determine if the mobile x-ray provider contacted the facility by phone with results of the x-ray. She further revealed that the process was for the results to be automatically uploaded into the Electronic Medical Record (EMR) and the staff have access to this information in real time. She further explained that a fax is also sent and if there was a positive report such as a femur fracture then the provider would contact the facility by phone.	F0684		

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F0684 SS = G	Continued from page 30 Multiple attempts were made to interview the Orthopedic surgeon, but attempts were not successful. An interview was conducted on 6/26/25 03:01 PM with the Administrator. She indicated the process for the mobile x-ray provider to report x-ray results to the facility staff was for the mobile x-ray provider to load the results in the electronic medical record, fax the results and to call if there was a positive result. The Administrator indicated the facility did have access to Resident #85's x-ray results in the electronic medical as of 3/19/25 at 12:13 pm but the facility did not receive a fax or phone call from the mobile x-ray provider to alert the staff of a positive x-ray result. She further revealed she would have expected the nursing staff to have been aware of Residents #85's x-ray result the day the results were uploaded in the electronic medical record and for the nurse to have notified the physician of the results that day.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, and Nurse Practitioner (NP) interviews, the facility failed to provide safe transport for a resident (Resident #421) in a wheelchair when Nurse Aide (NA) #5 transported Resident #421 to the shower room in a wheelchair without footrests. Resident #421's feet got caught underneath the wheelchair and she fell forward out of the wheelchair and onto the floor. Resident #421 sustained an acute comminuted fracture (broken into pieces) of the right distal femur (thigh bone just above the knee) requiring hospitalization and surgery. This deficient practice occurred for 1 of 11 residents reviewed for accidents. The findings included:	F0689		

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F0689 SS = G	Continued from page 31 Resident #421 was admitted to the facility on 9/29/22 and discharged to the hospital on 3/24/25. Her admitting diagnoses included stage 4 chronic kidney disease, type 2 diabetes, diabetic neuropathy (nerve damage due to diabetes causing pain, numbness and/or weakness in the feet and hands), muscle weakness, abnormalities of gait and mobility, repeated falls, chronic pain syndrome, coronary artery disease (narrowing of arteries that supply blood to the heart), cerebrovascular accident (stroke), and epilepsy. The significant change Minimum Data Set (MDS) dated 2/12/25 revealed Resident #421 was cognitively intact, used a manual wheelchair and required supervision/touching assistance with wheeling 50 to 150 feet in the wheelchair. The care plan dated 2/12/25 indicated Resident #421 required assistance with activities of daily living due to chronic health conditions, weakness, poor balance and a history of falls. The interventions included 1-person assistance with transfers and the use of a manual wheelchair for mobility. An incident report dated 3/24/25 at 10:00 AM completed by Nurse #6 revealed NA #5 was transporting Resident #421 to the shower room in a wheelchair when her foot was caught under the wheelchair and she was thrown out of the wheelchair to the floor landing on her right side. Resident #421 was complaining of right leg pain and was assessed by Nurse #6 with no visible signs of injury. The NP was notified of the incident and ordered an x-ray. The report further noted that footrests were not being used when the incident occurred. An interview conducted on 6/17/25 at 1:38 PM with NA #5 revealed NA #9 was assigned to Resident #421 on 3/24/25. NA #5 was helping NA #9 with her assigned residents and transported Resident #421 in a wheelchair from her room to the shower room. NA #5 stated the wheelchair did not have footrests but Resident #421 was able to hold her feet up. She revealed while transporting Resident #421 in the wheelchair down the hall she suddenly dropped her feet to the floor, and they got caught underneath the wheelchair. She indicated Resident #421 fell forward out of the wheelchair to the floor landing on her right side. NA #5 stated several staff were in the hall and responded to help and stayed with Resident #421 while she went to notify Nurse #6. She stated Nurse #6 responded immediately and assessed Resident #421. NA #5 revealed Resident #421 was complaining of right leg pain but had no visible injuries or deformities in the leg. She	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS HEALTH AND REHABILITATION	430 BROOKWOOD AVENUE NE , CONCORD, North Carolina, 28025

(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
F0689 SS = G	Continued from page 32 stated Nurse #6 completed an assessment they used the mechanical lift to transfer Resident #421 into the wheelchair and then back into bed. NA #5 stated she did not see any footrests in Resident #421's room and since she was able to hold her feet up, she went ahead and transported her in the wheelchair without them. NA #5 further stated footrests should be used on a wheelchair when transporting a resident because it was a "standard of safety". A phone interview conducted with Nurse #6 on 6/19/25 at 8:40 AM indicated she was Resident #421's assigned nurse on 3/24/25. Nurse #6 indicated at approximately 10:00 AM she was notified by NA #5 that Resident #421 fell out of her wheelchair in the hallway. She revealed NA #5 reported to her she was pushing Resident #421 to the shower room in a wheelchair without footrests and her feet got caught underneath the wheelchair and she fell forward out of the wheelchair onto the floor. Nurse #6 indicated when she responded Resident #421 was lying on her right side and reported right hip and leg pain. Nurse #6 revealed she assessed Resident #421 and there were no visible signs of injury. She indicated Resident #421 had no visible signs of injury and was transferred with a mechanical lift back into the wheelchair and brought back to her room. She stated Resident #421 was transferred with the lift back into bed and was resting comfortably. Nurse #6 revealed she notified NP #1 of the incident, and she gave an order for an x-ray of Resident #421's right hip and leg. Nurse #6 indicated she administered pain medication to Resident #421 that was ordered as needed and monitored her closely. She stated the x-ray was completed and the results indicated Resident #421 had a right femur fracture. She revealed NP #1 arrived at the facility, assessed Resident #421, reviewed the x-ray results, and gave the order to transfer Resident #421 to the ED for further evaluation. Nurse #6 stated she was unsure why NA #5 did not use footrests on the wheelchair, but they should have been used for safety. The radiology results report dated 3/24/25 at 1:38 PM indicated an x-ray obtained of Resident #421's right leg revealed an acute transverse (straight across) mildly comminuted fracture (broken into pieces) at the distal femur (thigh bone just above the knee). The NP note dated 3/24/25 at 5:00 PM indicated Resident #421 was seen due to a fall from the wheelchair and complaints of right hip and leg pain. Resident #421 was being transported to the shower room in a wheelchair without footrests and her feet got stuck under the wheelchair and she fell forward out of the wheelchair onto the floor. The NP noted the wheelchair footrests	F0689		

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F0689 SS = G	Continued from page 33 were observed in Resident #421's room on the floor behind the bed and education was provided to Resident #421 and nursing staff on the importance of using the footrests for safety. Resident #421 was assessed and noted with bilateral lower extremity edema (swelling), however this was her baseline due to stage 4 chronic kidney disease. Resident #421 was non-compliant with fluid restrictions, refused to proceed with outpatient dialysis treatments and discussion of hospice services were ongoing with the resident and her family. Further examination of Resident #421's right leg revealed no deformities or visible signs of injury however the x-ray results were reviewed and indicated an acute transverse (straight across) mildly comminuted fracture (broken into pieces) at the distal femur (thigh bone just above the knee). The NP ordered Resident #421 to be transported to the Emergency Department (ED) for further evaluation. A nurse's note dated 3/24/25 written by Nurse #6 indicated Resident #421's x-ray results revealed a right femur fracture and order was received from NP #1 to transfer Resident #421 to the ED. Resident #421 left the facility via emergency medical services and transported to the ED for further evaluation. A review of the hospital records dated 3/24/25 revealed Resident #421 was evaluated in the ED due to a fall from a wheelchair and initial x-rays obtained at the facility indicated a right distal femur fracture. An x-ray obtained in the ED confirmed the right distal femur fracture. Resident #421 had surgery to repair the fracture on 3/25/25 and was discharged from the hospital to a skilled nursing facility on 4/17/25. During a phone interview with NP #1 on 6/18/25 at 10:00 AM she revealed she was notified on 3/24/25 that Resident #421 had a fall from her wheelchair and was complaining of right hip and leg pain. She stated she ordered an x-ray of Resident #421's right hip and leg to be obtained at the facility. NP #1 revealed she did not recall the time, but she was notified the x-ray results were received and arrived at the facility to assess Resident #421 and review the x-ray results. NP #1 indicated Resident #421 was lying comfortably in bed and she completed an assessment. She revealed Resident #421 was noted with swelling to both of her legs but that was her baseline due to stage 4 chronic kidney disease, non-compliance with fluid restrictions and refusal to proceed with dialysis treatments. NP #1 stated Resident #421 had no visible deformities or injuries to her right leg however the x-ray results indicated a right femur fracture. NP #1 revealed she gave an order to transport Resident #421 to the ED for	F0689		

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F0689 SS = G	Continued from page 34 further evaluation. NP #1 indicated Resident #421 fell from the wheelchair due to footrests not being used and her feet were caught under the wheelchair. NP #1 indicated staff reported to her they were unable to find the footrests however she observed them on the floor in Resident #421's room behind the bed. NP #1 stated she educated Resident #421 and the nursing staff on the importance of using footrests on the wheelchair for safety. She revealed Resident #421 was transferred to the ED on 3/24/25 but did not return to the facility and she was unsure what treatment she received in the hospital or the outcome of her injury. A phone interview was conducted with Resident #421 on 6/24/25 at 10:58 AM. She stated she did not recall many details of the incident that occurred on 3/24/25 but that a staff member was transporting her in a wheelchair and she fell out of the wheelchair onto the floor. Resident #421 indicated she fractured her right leg and remained in the hospital for a while following surgery. Resident #421 revealed she was currently residing in another nursing facility receiving therapy services and continues to recover from the leg fracture. During a phone interview with the Former Administrator on 6/19/25 at 1:08 PM she stated her employment at the facility ended on 3/27/25 and her last day in building was 3/24/25. She indicated she did not recall the incident that occurred with Resident #421 however staff should have used footrests on the wheelchair for safety.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F0690		

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F0690 SS = D	Continued from page 35 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review, physician, and staff interviews, the facility failed to change a suprapubic catheter per the Urologist's order for 1 of 2 residents reviewed for catheter care (Resident #56). The findings included: Resident #56 was admitted to the facility on 2/24/25 and readmitted 5/2/25. Diagnoses for Resident #56 included stroke and obstructive reflux uropathy (a blockage in the urinary tract that causes urine to flow backwards into the kidneys). A care plan dated 2/28/25 and revised on 3/25/25 addressed Resident #56's suprapubic catheter and indicated that the catheter would be changed according to physician orders. A Urologist note for Resident #56 dated 4/15/25 included an order to "continue suprapubic tube changes at the facility once per month or as needed for clinical indications (blockage, leakage, signs of infection or malfunction). Review of the medical record revealed no record of the Urologists order to continue monthly suprapubic catheter changes. Hospital discharge orders dated 5/2/25 included an order to change the suprapubic catheter every 4 weeks. The discharge orders noted Resident #56's catheter had been changed on 4/23/25 upon admission to the hospital.	F0690		

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F0690 SS = D	Continued from page 36 A physician order for Resident #56 dated 5/7/25 directed for the catheter to be changed as needed (PRN) for clinical indications including signs of infection, obstruction, or when the closed system was compromised. The significant change of condition Minimum Data Set (MDS) assessment dated 5/7/25 assessed Resident #56 to be severely cognitively impaired. The MDS documented Resident #56 had an indwelling urinary catheter for urine elimination. Review of the Medication and Treatment Administration Records for April and May 2025 for Resident #56 revealed he had a catheter change completed on 4//16/25 in the facility. There were no documented suprapubic catheter changes for May 2025. During an interview with Nurse #4 on 6/19/25 at 9:27 AM, she revealed that when a resident has an order to change their catheter, the order showed in the treatment administration record on the due date. Nurse #4 reported she was assigned to Resident #56 this date and was frequently assigned to Resident #56. Nurse #4 reported she did not recall having an order to change Resident #56's catheter. Nurse #4 reported Resident #56 went to the Urologist to have the catheter changed. The Physician was interviewed on 6/19/25 at 8:29 AM. The Physician reviewed the Urologist order to "continue suprapubic tube changes at the facility once per month or as needed for clinical indications (blockage, leakage, signs of infection or malfunction)" and reported the facility should have written the order to continue monthly catheter changes as well as change the catheter as needed. The Physician explained the facility should have called the Urologist to clarify the order. The Physician reported he was not aware Resident #56 did not have a suprapubic catheter change in May 2025. An interview was conducted with Nurse #12 on 6/19/25 at 12:00 PM and she reported that she did not recall seeing an order in the medication or treatment administration record to change Resident #56's catheter every month. Nurse #5 was interviewed on 6/19/25 at 12:33 PM by phone. Nurse #5 reported she frequently provided care to Resident #56 and had not seen an order to change his suprapubic catheter. Nurse #5 reported she thought Resident #56 went to the Urologist to have the catheter changed. The Director of Nursing (DON) was interviewed by phone	F0690		

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F0690 SS = D	Continued from page 37 on 6/20/25 at 11:05 AM. The DON reported a physician order would trigger the monthly catheter change, but the order had been entered as "as needed" catheter change, and staff had not clarified with the Urologist if the catheter was to be changed monthly or as needed. The DON reported staff should clarify any unclear physician orders. The Administrator was interviewed with the DON on 6/20/25 at 11:05 AM. The Administrator added that Resident #56 had an order to change the catheter every 30 days and that order was discontinued when he was hospitalized and readmitted to the facility. The Administrator reported expected unclear physician orders to be clarified by the nursing staff.	F0690		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff and Responsible Party interviews the facility failed to store an enteral feeding syringe with the plunger separated from the syringe for 1 of 4 resident (Resident #60) reviewed for enteral feeding management. This deficient practice has the potential for bacterial growth and contamination.	F0693		

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F0693 SS = D	Continued from page 38 Findings included: A physician's order dated 3/22/2025 indicated Resident #60's enteral feeding (intake of food through the gastrointestinal tract when you can't eat regularly by mouth) tube should be flushed with 30 milliliters of water before and after each medication administration. Resident #60 was admitted to the facility on 4/15/2022 and recently readmitted on 3/27/2025 with diagnoses of dementia and gastrostomy (surgical procedure that involves creating an artificial opening in the abdomen to insert a tube directly into the stomach). A significant change Minimum Data Set (MDS) assessment dated 4/7/2025 indicated Resident #60 was severely cognitively impaired and received 51% or more of his calories from enteral feedings and 501 milliliters or more of his fluid intake from enteral feedings. On 6/16/2025 at 11:32 am Resident #60 was observed in his bed with the head of the bed elevated. Resident #60's enteral feeding was infusing at 60 milliliters an hour and the enteral feeding syringe was laying on the bedside table with the plunger engaged and clear liquid with white sediment in the syringe. Nurse #4, who was standing at the medication cart, was asked on 6/16/2025 at 11:35 am to observe Resident #60's enteral feeding syringe. She stated she had just started on the assignment and would change out the syringe for a new syringe. During an observation of Resident #60 on 6/17/2025 at 3:18 pm he was lying in bed with his head elevated with an enteral feeding syringe laying with the plunger engaged and a clear liquid with sediment noted in the tip of the syringe. Nurse #4 was interviewed on 6/17/2025 at 3:19 pm and she stated she gave Resident #60 his medications with the enteral feeding syringe at 8:30 am and gave him his medications at 12:00 pm. Nurse #4 stated she had not changed the enteral feeding syringe and had used the same syringe for administering Resident #60 medications and flushes. Nurse #4 stated she usually stored the enteral feeding syringe with the plunger engaged and did not know she should leave the plunger out of the syringe until it was dry to prevent bacteria growth. Nurse #4 stated she would place a new syringe for Resident #60's medication administration and flushes. On 6/18/2025 at 8:33 am Resident #60 was observed in bed and an enteral feeding flush syringe was on his	F0693		

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F0693 SS = D	Continued from page 39 bedside table in a plastic bag. The tip of the enteral feeding tube was filled with clear liquid and there were ants in the plastic bag on the enteral feeding tube. Nurse #5 was interviewed on 6/18/2025 at 12:58 pm and she stated she had used the syringe once and placed it on the bedside table, but she would discard in a get a clean syringe. Nurse #5 stated she usually washes the enteral feeding syringe after each use and leaves the plunger separate from the syringe to allow it to dry. During an observation on 6/18/2025 at 6:02 pm Resident #60 was observed in bed with his enteral feeding tube syringe lying on a brown paper towel, with the plunger engaged and several ants were crawling around on and in the plunger. Unit Manager #1 was interviewed by phone on 6/19/2025 at 9:10 am and she stated the staff should clean the enteral feeding tubes with soap and waster and place them on a clean towel to dry with the plunger out of syringe to prevent bacteria growth. On 6/19/2025 at 10:20 am the Director of Nursing was interviewed, and she stated the nurses should know the enteral feeding syringe should be washed after each use and allowed to air dry and then placed in the storage bag. The Administrator was interviewed on 6/19/2025 at 1:59 pm and stated Nurse #4 and Nurse #5 should have followed the facility's procedure for cleaning and storing enteral feeding syringes to prevent bacteria growth.	F0693		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident, hospice nurse, physician, physician assistant (PA), and staff interviews, the facility failed to effectively manage a hospice resident's pain and administer an	F0697		

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F0697 SS = D	Continued from page 40 ordered scheduled pain medication for 1 of 2 residents reviewed for pain control (Resident #100). The findings included: Resident #100 was admitted to the facility on 1/15/25 with diagnoses including breast cancer with metastasis, chronic pain syndrome, and neuralgia (nerve pain). A physician order dated 1/15/25 for gabapentin (a medication used to control nerve pain) 100 milligrams (mg) three times per day with administration times of 9:00 AM, 2:00 PM, and 9:00 PM. Review of the medication administration record for June 2025 revealed Resident #100 received gabapentin three times per day as ordered. The significant change Minimum Data Set (MDS) assessment dated 5/26/25 assessed Resident #100 to be cognitively intact. The MDS documented Resident #100 received scheduled and as needed pain medications, she experienced pain almost constantly, and rated her pain "6" (1-10 scale, 10 most intense pain). A care plan dated 1/16/25 with a revision date of 6/12/25 addressed Resident #100's use of opioid pain medications for severe pain, and interventions included to administer the medications as ordered, observe for signs and symptoms of over-medication, and performing pain assessments as needed. Review of the physician orders for Resident #100 revealed an order written 5/19/25 for oxycodone (an opioid pain medication) 10 mg to be administered every 4 hours as needed (PRN) for pain or shortness of breath. A hospice medication order dated 6/13/25 ordered for oxycodone 10 mg to be administered every 8 hours. Review of the physician orders for Resident #100 revealed the hospice order was not entered into the electronic medical record or electronic physician orders. An interview was conducted with UM #1 on 6/18/25 at 12:46 PM. UM #1 explained that Hospice put handwritten physician orders into her inbox to be entered into the electronic system and once the orders were entered, she gave the order to medical records for filing. UM #1 reported that handwritten orders were checked against the electronic medical record during the morning	F0697		

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F0697 SS = D	Continued from page 41 meeting, but no morning meeting was conducted on 6/16/25. During the interview, UM #1 reviewed the physician orders for Resident #100 and discovered that the hospice order written on 6/13/25 had not been entered into the electronic medical record. UM #1 went to medical records and found the order and reported she had missed the order for oxycodone 10 mg every 8 hours and would enter the order. UM #1 explained that the handwritten hospice orders were checked against the electronic physician orders, but the order for Resident #100 was not reviewed. Pain assessment documentation for June 2025 was reviewed and the documented pain level for Resident #100 was "0" for dates 6/1/25 to 6/18/25. Resident #100 was observed on 6/16/25 at 2:02 PM in bed. Resident #100 reported she was experiencing pain "all over" with most intense pain in her feet. Resident #100 reported the pain medications did not control her pain and she had told the hospice nurse. Nurse #13 was interviewed on 6/16/25 at 2:10 PM and she reported she was on her way to medicate Resident #100 for pain. Nurse #13 reported Resident #100 requested pain medication when she needed it and she had an order for PRN oxycodone. The medication administration record was reviewed and Resident #100 received oxycodone 10 mg on 6/16/25 at 2:26 PM and rated her pain "6". Resident #100 was observed in bed on 6/17/25 at 11:37 AM. She reported she was experiencing pain in her legs and feet, and she was very uncomfortable. Review of the medication administration record reviewed that Resident #100 received oxycodone 10 mg at 8:12 PM on 6/17/25 and she rated her pain as "3". An observation of Resident #100 was conducted on 6/18/25 at 9:46 AM and she reported she was having pain in her neck and her legs. Resident #100 reported she had requested pain medication but had not received it yet. The Hospice Nurse was interviewed by phone on 6/18/25 at 10:01 AM. The Hospice Nurse reported she had completed a visit on Resident #100 on 6/13/25 and had written an order to administer her pain medication administration to every 8 hours for better pain control because Resident #100 was not requesting the PRN pain medication and was in continued severe pain. The Hospice Nurse explained the PRN order for oxycodone	F0697		

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F0697 SS = D	Continued from page 42 would continue, but the scheduled medications should help keep her comfortable. The Hospice Nurse revealed when she reviewed the electronic medication orders for the facility on 6/16/25 the orders were not in the system and Resident #100 was not receiving the scheduled pain medication. The Hospice Nurse reported she had talked to the Unit Manager (UM) #1 and UM #1 had told her that the medications had not been delivered by the pharmacy yet. The Hospice Nurse explained that she would handwrite a physician order and give it to the nurse at the facility. The Hospice Nurse explained that the nursing staff entered the orders into their electronic documentation system, and she did not know why the order had not been implemented. The Physician was interviewed on 6/19/25 at 9:31 AM. The Physician reported he was not aware hospice had changed Resident #100's pain medication administration, and he expected any hospice order to be entered into the electronic medical record and followed. An interview was conducted with PA #1 on 6/19/25 at 9:59 AM. PA #1 reported that she had seen Resident #100 on 6/3/25 and had noted she was not having good pain control, so PA #1 had instructed the nursing staff to do regular pain assessments and administer the PRN oxycodone every 4 hours if needed. PA #1 reported she was not aware Resident #100 pain medication had been ordered to be administered every 8 hours for pain control. The Administrator was interviewed by phone on 6/20/25 at 11:05 AM. The Administrator reported the handwritten hospice order should have been entered into the electronic medical record and the morning meeting on 6/16/25 should have reviewed the handwritten orders against the electronic medical record. The Administrator reported the morning meeting on 6/16/25 was not conducted and the process for hospice orders was not followed.	F0697		
F0761 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.	F0761		

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F0761 SS = E	Continued from page 43 §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 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 record review, observations, and staff interviews, the facility failed to date and label insulin (Medication Cart #3 and Medication Cart #5) and failed to discard an opened out of date insulin injection pen (Medication Cart #3). The deficient practice were found in 2 of 3 medications carts reviewed for medication storage (Medication Cart #3 and Medication Cart #5). Findings included: a. An observation of Medication Cart #3 on 6/19/2025 at 4:45 pm revealed one glargine insulin injection pen that was open and dated and had not been labeled with the resident's name. Medication Aide #2 was interviewed during the medication cart observation on 6/19/2025 at 4:45 pm and stated she did not know why the glargine insulin injection pen was not dated and she was not sure how long it had been open in the cart. b. During an observation of Medication Cart #5 on 6/19/2025 at 3:38 pm a degludec insulin pen was not dated when opened. Nurse #2 was interviewed during the observation of	F0761		

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F0761 SS = E	Continued from page 44 Medication Cart #5 on 6/19/2025 at 3:38 pm and she stated she did not know why the degludec insulin pen was not dated. Nurse #2 stated when she opens a new insulin pen, she dated the label but someone else must have opened that insulin pen and she had not noticed it was not dated and had not used that insulin pen on any residents. c. The manufacturer's directions for insulin lispro pen stated it should be discarded 28 days after opening. Medication cart #3 was observed o 6/19/2025 at 4:45 pm and an insulin lispro injection pen was opened and was dated 5/15/2025. Medication Aide #2 was interviewed during the observation of Medication Cart #3 and she stated she did not know how long lispro insulin could be used after it was opened. She stated she thought the insulin lispro should be discarded after 30 days and she did not realize it was dated 5/15/2025. The Director of Nursing (DON) was interviewed by phone on 6/20/2025 at 9:28 am and she stated the insulin injection pens on medication cart #3 and medication cart #5 should have been labeled with the resident's name along with the date it was opened when placed in the medication cart. The DON also stated the lispro insulin injection pen that was opened and dated 5/15/2025 should have been discarded within 30 days of the date it was opened by the manufacturer's instructions. The DON stated the lispro insulin should have been sent back to the pharmacy after 30 days. During an interview by phone with the Administrator on 6/20/2025 at 8:35 am she stated the nurses and medication aides should have properly labeled and dated the medications when they are placed in the medication cart.	F0761		
F0777 SS = G	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse	F0777		

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F0777 SS = G	Continued from page 45 specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Medical Director, Physician Assistant (PA), and mobile x-ray provider interviews, the facility failed to notify a medical provider when the results of an x-ray revealing an intertrochanteric fracture of the right femur (type of broken hip that occurs between the bumpy parts at the top of the thigh bone) were reported to the facility on 3/19/25. This resulted in the fracture not being reported to PA #1 until 3/20/25 which delayed Resident #85's transfer to the hospital for evaluation and treatment. Resident #85 was sent to the hospital for an evaluation on 3/20/25 and on 3/21/25 Resident #85 received open reduction and internal fixation (a procedure to realign and secure broken bones with metal fasteners) to the right femur. This occurred for 1 of 15 residents (Resident #85) reviewed for accidents. The findings included: Resident #85 was admitted to the facility on 3/31/24 with diagnoses which included vascular dementia and hemiplegia (condition of complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following a stroke affecting the left non dominate side. Review of the quarterly Minimum Data Set (MDS) dated 2/9/25 revealed Resident #85 was severely cognitively impaired and was dependent on staff for transfers. A review of the nursing progress note dated 3/17/25 at 10:00 PM, written by Nurse #8, revealed Resident #85 was found sitting on the floor with complaints of leg pain and had no new injury. A review of Physician Assistant (PA) #1's note dated 3/18/25 at 4:35 PM indicated PA #1 visited Resident #85 for acute visit due to a fall on 3/17/25. PA #1 indicated that Resident #85 reported pain in right hip and right femur during the evaluation and she ordered an x ray.	F0777		

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F0777 SS = G	Continued from page 46 On 3/18/25, the facility's Physician Assistant (PA #1) ordered x-ray of Resident #85's right lower extremity due to complaints of pain post fall . A review of the Radiology Report for Resident #85 indicated an examination occurred on 3/19/25 at 10:02 AM and the results were reported to the facility via the electronic medical record on 3/19/25 at 12:13 PM. The finding was an acute transverse non-displaced intertrochanteric fracture and mild osteopenia was noted. A review of progress note dated 3/20/25 at 7:13 AM which was authored by Unit Manager #1 indicated Nurse #9 received Resident #85's x-ray results and which indicated a right femur fracture. The nurse informed Resident #85 and the Responsible Party and noted PA #1 would assess Resident #85 that morning. A review of progress note dated 3/20/25 at 9:27 AM which was authored by Unit Manager #1 indicated she notified PA #1 that the result of the x-ray for Resident #85 was an acute transverse nondisplaced fracture of the femur and that PA #1 referred Resident #85 to orthopedic as soon as possible. A review of the progress note dated 3/20/25 at 11:45 AM authorized by the Assistant Director of Nursing indicated that PA #1 had given an order to send Resident #85 to the hospital and that the Responsible Party was notified by UM #1. Review of hospital progress notes revealed Resident #85 was admitted on 3/20/25 for evaluation of femur fracture. The note further revealed resident #85 sustained an intertrochanteric fracture of right femur. On 3/21/25 Resident #85 received open reduction and internal fixation (surgical procedure used to treat severe bone fractures) to the right femur. Resident #85 was discharged back to the facility on 3/25/25. An interview was conducted with Resident #85's Responsible Party on 6/17/25 at 1:58 PM. He indicated that he would have wanted Resident #85 to have been sent to the hospital on 3/19/25 when the positive X-ray results were sent to the facility. An interview was conducted on 6/18/25 at 3:20 PM with Unit Manager (UM) #1. She indicated that x-ray results were reported to the facility in real time via the Electronic Medical Record (EMR) and that all nurses have access to the report. However, she or a nursing supervisor are normally the nurses that review the results. She also indicated that the mobile x-ray	F0777		

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F0777 SS = G	Continued from page 47 provider may also send a fax and call the facility with any positive reports. UM #1 indicated that Resident #85's x-ray results from his fall on 3/17/25 were uploaded into the EMR on 3/19/25 at 12:14 PM and noted the finding of a right femur fracture. She indicated that she normally leaves her shift around 2:30 PM and that she did not see the x-ray result before she left on 3/19/25. UM #1 further revealed that there was not a nursing supervisor working that evening, so she reviewed the result on 3/20/25 around 7:15 AM. UM#1 indicated that she reported the x-ray results to PA #1 around 9:30 AM on 3/20/25. PA #1 initially ordered an orthopedic referral as soon as possible and was not sure why this was ordered instead of an order for hospitalization. UM#1 indicated that PA #1 later gave a telephone order to the ADON to send Resident #85 to the hospital and Resident #85 was sent out around 10:40 AM. An interview was conducted with Physician Assistant #1 on 6/19/25 at 10:38 AM. PA #1 indicated she became aware of Resident #85's fall when she came into the facility the morning of 3/18/25. PA #1 indicated she reviewed the provider's communication book and saw a note from Nurse #8 related to Resident #85's fall. The note indicated that Resident #85 had an unwitnessed fall, reported pain and requested to go the hospital. She further revealed that she reviewed the triage notes that referenced the on-call provider's interactions with Nurse #8 during the time of the fall. PA #1 indicated that she evaluated Resident #85, and he did not exhibit uncontrolled or high levels of pain but during the range of motion evaluation to the right knee and hip, Resident #85 verbalized pain. PA #1 indicated she did not feel hospitalization was needed at that time due to Resident#85 not having a visible sign of injury, limited pain and a hospitalization would have been very taxing for Resident #85 to endure. She also indicated she ordered an x-ray at that time and expected to receive the result within the next 24 hours. PA #1 indicated she had access to the facility EMR, but she did not receive an alert that the x-ray result showed a positive finding for a right femur fracture. PA #1 further revealed that the notification process was for the Unit Manger to contact her with any positive x-ray results. PA #1 also indicated if she had been made aware of Resident #85's x-ray result on 3/19/25 she would have sent him directly to the hospital that same day. On 6/20/25 at 2:53 PM an interview was conducted with the Medical Director. The Medical Director indicated he did not feel that Resident #85 had experienced any uncontrolled pain or negative outcome after his fall on 3/17/25 due to the delay of hospitalization, however he	F0777		

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F0777 SS = G	Continued from page 48 would have wanted Resident #85 sent to the hospital for evaluation on 3/19/25 once the results were received. He indicated that he felt the facility nursing staff should have received a phone call from the mobile x-ray provider when they became aware of Resident #85's positive finding for a right femur fracture. On 6/23/25 at 9:10 AM a telephone interview was conducted with the Director of Marketing for Mobile X-Ray provider who completed the x-ray for Resident #85 on 3/19/25. She indicated that the company had a change in systems and was not able to access documentation to determine if the mobile x-ray provider contacted the facility by phone with results of the x-ray. She further revealed that the process was for the results to be automatically uploaded into the Electronic Medical Record (EMR) and the staff have access to this information in real time. She further explained that a fax was also sent and if there was a positive report such as a femur fracture then the provider would contact the facility by phone. An interview was conducted on 6/26/25 03:01 PM with the Administrator. She indicated the process for the mobile x-ray provider to report x-ray results to the facility staff was for the mobile X-ray provider to load the results in the electronic medical record, fax the results and to call if there was a positive result. The Administrator indicated the facility did have access to Resident #85's x-ray results in the electronic medical as of 3/19/25 at 12:13 pm but the facility did not receive a fax or phone call from the mobile x-ray provider to alert the staff of a positive x-ray result. She further revealed she would have expected the nursing staff to have been aware of Residents #85's x-ray result the day the results were uploaded in the electronic medical record and for the nurse to have notified the physician of the results that day.	F0777		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is	F0806		

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F0806 SS = D	Continued from page 49 initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident, Responsible Party, and staff interviews the facility failed to honor a resident's preference for sandwiches for 1 of 9 residents reviewed for nutritional status (Resident #26). Findings included: Resident #28 was admitted to the facility on 7/25/2019 with heart disease and anemia. A "Food Preference List" dated 3/12/2025 indicated Resident #28 requested peanut butter and mayonnaise sandwiches at lunch. The Food Preference List also had a note that stated "add peanut butter and mayonnaise sandwiches to lunch and dinner tray, and the resident stated she has not been getting the sandwich as requested". On 6/17/2025 at 3:02 pm an interview with Resident #28 was conducted with her Responsible Party was present. Resident #28 was sitting on the side of the bed eating food the Responsible Party brought from home. Resident #28 stated she cannot eat the food from the facility because it was too spicy, and the meat was too hard to chew. Resident #28 stated she had asked for a peanut butter and mayonnaise sandwich several times, but it was not brought to her. The Responsible Party stated she had also told the facility Resident #28 could not tolerate the food or chew the meat and had asked that a peanut butter and mayonnaise sandwich be put on her tray. An observation of Resident #28 during the lunch meal on 6/18/2024 at 12:43 pm revealed there was not a peanut butter and mayonnaise sandwich on her meal tray Resident #28's meal ticket did not include whether she should receive a peanut butter and mayonnaise sandwich. On 6/18/2024 at 1:08 pm Nurse Aide #4 was interviewed and stated Resident #28 liked peanut butter and mayonnaise sandwiches, and she had asked the kitchen to make them for her before, but they would not send the	F0806		

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F0806 SS = D	Continued from page 50 sandwiches to her. During an interview with Nurse #2 on 6/18/2025 at 1:01 pm Nurse #2 stated she was not aware that Resident #28 was not receiving peanut butter and mayonnaise sandwiches as she requested. The Dietary Manager was interviewed on 6/19/2024 at 1:46 pm and he stated he obtained residents' food preferences on admission and updated them quarterly. The Dietary Manager stated he does not remember what Resident #28 stated she likes or disliked but he would have updated the preference sheet. During a follow up phone interview with the Dietary Manager on 6/24/2025 at 4:25 pm he stated Resident #28's meal preferences were updated on 3/12/2025 and he placed a laminated sign on the refrigerator in the kitchen for staff that she should receive a peanut butter and mayonnaise sandwich at lunch every day. He stated the dietary staff should have sent the sandwich at lunch and dinner per Resident #28's request. A quarterly Minimum Data Set assessment dated 4/6/2025 indicated resident #28 was moderately cognitively impaired, required set up assistance for meals, and did not have any significant weight loss or gain. On 6/19/2025 at 12:22 pm Registered Dietitian #2 was interviewed and stated she was not made aware that Resident #2 could not eat the food because it was too spicy; she could not chew the meat because it was too tough; and she would eat peanut butter and mayonnaise sandwiches if they were brought to her. The RD stated the Dietary Manager should have updated Resident #28's likes and dislikes every three months and document her requests. During an interview by phone with the Director of Nursing on 06/20/25 at 09:28 am she stated Nurse Aide #4 should have reported to the nurse she was not able to get what Resident #28 requested when she could not obtain the peanut butter and mayonnaise sandwich from dietary. The Administrator was interviewed on 6/19/2025 at 3:15 pm and stated the kitchen should have sent Resident #28	F0806		

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F0806 SS = D	Continued from page 51 peanut butter and mayonnaise sandwiches as she requested.	F0806		
F0812 SS = F	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. §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, record reviews and staff interview the facility failed to maintain frozen foods at or below 0 degrees Fahrenheit and failed to sanitize a thermometer probe used to test internal temperatures of food. These practices had the potential to affect food served to residents. The findings included: 1. On 6/16/25 at 10:35 a.m., the walk-in freezer was observed with the Dietary Manager (DM). The observation of the walk-in freezer revealed the internal thermostat read 32 degrees Fahrenheit (F). The frozen food items stored in the walk-in freezer were soft to touch. Internal temperatures taken by the Dietary Manager revealed:	F0812		

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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
F0812 SS = F	Continued from page 52 - one sleeve of raw ground beef was 46 degrees F - one case of raw chicken thighs was 28 degrees F - one case of raw sausage patties was 31degrees F - one case of precooked diced turkey was 27degrees F - one case of meatballs was 29 degrees F - one case of fish squares was 27 degrees F - one case of hotdog franks was 37 degrees F The DM was interviewed and stated he first noticed the walk-in freezer was not working properly when he arrived at work this morning (6/16/25) and reported the problem to the facility's Maintenance Assistant at 7:15 a.m. The DM reported he would have to throw out all the food items. During an interview on 6/16/25 at 11:15 a.m., the Administrator revealed the DM made her aware of the walk-in freezer not functioning that morning (6/16/25) at approximately 10:45 a.m. During an interview on 6/16/25 at 11:30 a.m., the facility Maintenance Assistant revealed the DM first made him aware the walk-in freezer was not maintaining proper temperatures on the morning of 6/16/25 at 10:58 a.m. 2. On 6/18/25 at 12:25 p.m. an observation of the lunch meal tray line was made. During the tray line observation, Cook #1 used a soiled hand towel from a food preparation table to wipe the thermometer's probe and proceeded to insert the probe into food items to check the internal temperatures. Cook #1 was interviewed and stated he had not worked at the facility long and indicated he did not receive any training by the Dietary Manager.	F0812		

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F0812 SS = F	Continued from page 53 The Dietary Manager revealed Dietary Cook #1 was rehired and began working at the facility on 6/9/25 and he (the DM) had provided orientation training but did not document it.	F0812		
F0842 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 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,	F0842		

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F0842 SS = D	Continued from page 54 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- (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 record review and staff interviews, the facility failed to maintain accurate records related to documentation of medication administration for 2 of 2 residents reviewed for accurate medical records (Resident #421 and Resident #85). The findings included:	F0842		

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F0842 SS = D	Continued from page 55 1. A review of Resident #421's physician orders revealed an order dated 2/05/25 for tramadol 50 milligrams (mg) to be administered every 12 hours as needed for pain. A nurse's note dated 3/24/25 completed by Nurse #6 indicated Resident #421 was being pushed in a wheelchair to the shower room and her foot was caught under the wheelchair and she was thrown out of wheelchair to the floor. Resident #421 was complaining of right leg and hip pain. A review of the controlled substance count sheet for tramadol revealed a pill was administered to Resident #421 on 3/24/25 at 11:00 AM. A review of Resident #421's March 2024 medication administration record (MAR) indicated tramadol was not documented as administered on 3/24/25. A phone interview with Nurse #6 on 6/19/25 at 8:40 AM revealed she was Resident #421's assigned nurse on 3/24/25. Nurse #6 indicated Resident #421 had a fall from her wheelchair and was complaining of right leg and hip pain. Nurse #6 stated she administered tramadol to Resident #421 due to her complaints of pain, but she did not recall the time. She revealed when a control substance was administered, she documented it was given on the MAR and the controlled substance count sheet. Nurse #6 indicated she was unsure why Resident #421's tramadol was not documented on the MAR as given on 3/24/25 and that she must have just forgotten. During an interview with the Administrator on 6/19/25 at 11:00 AM she stated medication administration should be accurately documented on the MAR. 2. A review of Resident #85's physician orders revealed an order on 3/17/25 for acetaminophen 325 milligrams (mg) orally two tablets every 8 hours as need for pain management status post fall for 3 days. A review of the nursing progress note dated 3/18/25 at 6:19 AM and authored by Nurse #8, indicated Resident #85 fell on 3/17/25 at 10:00 PM. The note further indicated Resident #85 had pain in his right leg and received an order for acetaminophen which "was already	F0842		

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F0842 SS = D	Continued from page 56 given," (meaning the medication had been administered). A review of the administration progress note dated 3/18/25 at 10:05 PM indicated Nurse #8 administered acetaminophen 325 mg 2 tablets for pain. A review of progress notes dated 3/19/25 revealed a note authored by Nurse #8 that indicated she administered acetaminophen 325 mg 2 tablets for pain management at 7:27 PM and it was effective. A review of Resident #85's March 2025 Medication Administration Record (MAR) revealed acetaminophen 325 mg 2 tablets for pain was administered on 3/18/25 at 10:05 PM by Nurse #8. Resident #85 was documented to have pain at level 4 and the medication was effective. The MAR did not indicate if this medication was administered on 3/17/25 or 3/19/25. On 6/19/25 at 9:31 AM an interview was conducted with Nurse #8. She indicated that she did not recall what days she administered the acetaminophen or why the MAR was blank on 3/17/25 and 3/19/25 but if she administered the medication then she should have signed off that it was given.	F0842		
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain effective pest control in 2 of 13 rooms (room #203 and room 216) reviewed for environmental concerns. Ants were observed in room #203 and room #216. Findings included: The facility's extermination invoices were reviewed for the previous 6 months: On 12/11/2024 the facility received an extermination treatment for cockroaches and rodents.	F0925		

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F0925 SS = E	Continued from page 57 On 1/28/2025 the facility received extermination treatment for cockroaches and rodents and no pest were found in the facility during the visit. a. Room #203 was observed on 6/17/2025 at 3:02 pm and ants were on the resident's bedside table and on the floor around her bedside table and bed. There were 5 ants on the floor and 3 ants on the top of the resident's bedside table that were reddish, brown in color. There was no open food or debris on the bedside table or the floor. During the observations the Responsible Party was present and stated they had killed several ants in the resident's room in the past few months and notified staff of the ants, but did not know what staff they told about the ants. On 6/18/2025 at 1:01 pm Nurse #2 stated she had not seen ants in room #203 until 6/17/2025 when the observation was made of room #203 and she was asked to observe the ants. Nurse #2 stated she made the Maintenance Director aware of the ants on 6/17/2025. Nurse Aide #4 was interviewed on 6/18/2025 at 1:08 pm and she stated she had seen several small, brown ants in room #203 several times, but she does not remember who she told. b. On 6/18/2025 at 8:33 am 3 ants were observed in Room #216 crawling on the enteral feeding syringe that was in an open plastic bag which was on top of the bedside table and 2 ants on the towel that was on top of the bedside table. The tip of the enteral feeding tube was filled with clear liquid. Nurse #5, who was present in the room, stated they had been having problems with ants in the resident's rooms, and she had let the Maintenance Director know about the ants before today. During an interview with Nurse #5 on 6/18/20254 at 12:58 pm she stated she had seen ants in room #216 before today and they were on the beside table and the enteral feeding syringe that was in a plastic bag located on the top of the beside table. Nurse #5 stated she notified maintenance of the ants, disposed of the ants on the feeding syringe and the bedside table, and replaced the enteral feeding tube on the bedside table. An observation of Room #216 was conducted 6/18/2025 at 6:02 pm and ants were observed crawling on the bedside table and on an enteral feeding syringe on the bedside table which was inside a plastic bag. During an interview with Nurse #5 on 6/18/2025 at 6:09 pm she stated she did not know what to do about the ants, but she would replace the enteral feeding syringe	F0925		

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F0925 SS = E	Continued from page 58 with a new syringe. Nurse #5 stated she had already notified the Maintenance Director about the ants before today and this morning when the observation was made of the ants on the bedside table and on the enteral feeding syringe that was in a plastic bag on top of the bedside table. During an interview with the Housekeeping Director on 6/19/2025 at 9:20 am she stated she had seen ants in the residents' rooms and the Maintenance Director was made aware and they had an exterminator treat the facility a week ago. The Maintenance Director was interviewed on 6/19/2025 at 9:23 am and he stated the facility was exterminated a week ago for pests and he does rounds to check for pests. An interview was conducted with the Director of Nursing on 6/19/2024 at 10:20 am and she stated she was not aware of ants being in Room #203 or Room #216 but the nursing staff should report any pests to the Nurse or Unit Manager so a work order can be sent to the Maintenance Director. During an interview with the Administrator on 6/19/2024 at 1:59 pm she stated the facility had been exterminated for other pests besides ants in the past two weeks but had not been exterminated for ants because no one had reported the ants to her. The Administrator stated the nursing, housekeeping, and maintenance staff should have notified her about the ants in Room #203 and Room #216 so that the extermination would remove the ants.	F0925		