STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted from 06/25/24 through 06/27/24. Event ID# GV5W11. The following intakes were investigated NC00212883, NC00213987, NC00216524, NC00217025, NC00218143, NC00218428, NC00218523, and NC00218541. 11 of the 33 complaint allegations resulted in deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		7/24/24

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

Electronically Signed | 07/18/2024

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F 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to treat residents (Resident #1, and Resident #2) with dignity and respect when staff failed to provide the resident with a bed bath or shower. The residents expressed anger, frustration, and embarrassment. This was for 2 of 8 residents reviewed for dignity. The findings included: 1.Resident #1 was admitted to the facility on 8/30/18 and re-admitted on 7/3/23 with diagnoses which included diabetes, atherosclerotic heart disease, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment dated 4/15/24 indicated that Resident #3 was cognitively intact, dependent on staff for toileting, and required substantial maximum assistance with bathing. Review of Care Plan dated 4/15/24 revealed Resident #1 required assistance with activities of	F 550	Resident #1 was provided a shower on 06/26/2024 by CNA. Resident #2 was provided a shower on 07/02/2024 by CNA. A quality review was completed by the Nursing Manager on current residents to ensure residents are treated with dignity and respect by being offered and receiving care specific to showers or bed baths on 07/16/2024. Identified residents were scheduled and provided showers or bed bath. An ad hoc Quality Assurance Performance Improvement Committee was held on 07/16/2024 to formulate and approve a plan of correction for the deficient practice. The Nursing Manager re-educated nursing staff including all shifts, part-time and prn on Resident Rights related to dignity and respect by ensuring residents receiving care specific to showers or bed baths on 07/22/2024. Staff will not be	

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F 550	Continued From page 2 daily living (ADL) care to include bathing. An interview with Resident #1 on 6/26/24 at 11:48 am revealed that the facility frequently ran out of briefs, wash cloths, and towels. She stated yesterday (6/25/24) that she no washcloth and she had to wash herself off with disposable wipes. She further indicated that she did not get a bath today (6/26/24) because the facility ran out of wash cloths and towels. Resident #1 stated this made her feel angry and frustrated. In an interview with NA #5 on 6/26/24 at 12:15 pm she stated that she had been employed for the facility since December 2023 and that they had been short of towels and wash cloths for the past 2 to 3 months. NA #5 further indicated that Resident #1 did not get a bath today (6/26/24) because she did not have clean washcloths available. NA#5 stated that when washcloths and towels became available that she did go back and bath residents that had not had their bath that morning because many were already up and she would not have time to complete her assignment if she did. She stated she told the Director of Nursing (DON) about a month ago and was told the facility was trying to order more washcloths and towels. 2.Resident #2 was admitted to the facility on 10/28/23 and re-admitted on 11/7/23 with diagnoses which included hemiplegia, hemiparesis, cerebral infarction (stroke), chronic obstructive pulmonary disease, and diabetes. The Quarterly Minimum Data Set (MDS) assessment dated 5/14/24 indicated that Resident #2 was cognitively intact and required substantial maximum assistance with bathing and	F 550	allowed to return to work until education is complete. The Executive Director will meet with the Resident Council on 07/24/2024 to advise of the internal update in quantity of linens and to outline the plans going forward to ensure residents feel respected. The Director of Nursing and/or Nursing Manager will conduct random Quality Reviews of residents to ensure residents are treated with dignity and respect through personal resident interview and by cross-referencing shower documentation and ensuring residents are receiving a bed bath or shower. This will be accomplished by interviewing 5 randomly selected interviewable residents and reviewing the individualized plan of care documentation for 5 randomly selected non-interviewable residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nursing Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 550	Continued From page 3	F 550		

toileting.

Review of Care Plan dated 5/13/24 revealed Resident #2 required extensive assistance with one staff member for activities of daily living (ADL) care to include bathing.

During an interview with Resident #2 on 6/27/24 at 8:10 am she stated that she did not get a shower on her shower day 6/25/24 and did not get a bed bath on 6/26/24 because the facility did not have any towels or wash cloths. She further indicated the facility did not have disposable wipes. She stated this was an ongoing issue and she was not sure how long it had occurred. She stated that it made her feel uncomfortable and dirty when she could not get a bath or shower and that embarrassed her.

In an interview with NA #5 on 6/26/24 at 12:15 pm she stated that she had been employed for the facility since December 2023 and that they had been short of towels and wash cloths for the past 2 to 3 months. NA #5 further indicated that Resident #2 did not get a bath yesterday (6/25/24) or today (6/26/24) because she did not have clean towels or washcloths available. NA#5 stated that when washcloths and towels became available that she did go back and bath residents that had not had their bath that morning because many were already up and she would not have time to complete her assignment if she did. She stated she told the Director of Nursing (DON) about a month ago and was told the facility was trying to order more washcloths and towels.

In an interview with Nurse #3 on 6/26/24 at 11:03 am she stated that if her unit ran out of supplies that she had to find someone with a key to central

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F 550	Continued From page 4 supply to access supplies. She stated staff had to wait for towels and wash cloths today (6/26/24) and residents could not get a bath, shower or incontinence care completed until they found wash cloths and that it could take an hour and a half before they found washcloths and towels. In an interview with NA #7 on 6/26/24 at 2:26 pm revealed that she could not give baths to the residents in her assignment in the mornings when she arrived to work because she did not have access to clean wash cloths and towels and this upset the residents and some got angry. An interview with NA #8 on 6/27/24 revealed that she had been employed by the facility for 2 weeks. She stated that she had not had clean wash cloths and towels for morning care for the past 2 weeks so the care did not get done and that the residents would get angry and upset with the NAs. An interview with the Director of Nursing (DON) on 6/27/24 at 10:15 am She stated that residents should be getting their daily bath or shower unless they refused. She stated she was unaware that residents did not get a bath. In an interview with the Administrator on 6/27/24 at 11:45 am it was revealed that he was aware of an issue with a shortage of wash cloths and towels but was not aware residents did not get a bath.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		7/24/24

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F 583	Continued From page 5 confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to safeguard protected health information (PHI) for 1 of 100 residents residing in the facility by leaving confidential PHI unattended and exposed in an area accessible to the public (Resident #11).	F 583	Nurse #4 was educated by Director of Nursing on Residents Rights regarding Resident #11 to provide privacy by ensuring the computer screen is either locked or the laptop is closed and the information will only be visible while	

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F 583	Continued From page 6 The findings included: Resident #11 was admitted to the facility on 6/8/24. An observation was made of an unattended medication cart on the 200 Hall on 06/26/24 11:05 am. Nurse #4 left the medication cart with the Medication Administration Record (MAR) in the computer exposed when he walked away from the medication cart and went down the hall. The computer screen showed the name, picture, and other PHI of Resident #11. Staff and family passed by the exposed computer screen that displayed the PHI of Resident #11. Nurse #3 returned to the medication cart approximately 2 minutes later at 11:07 am. A second observation was made of the medication cart on 200 hall on 6/26/24 at 11:14 am. Nurse #4 left the medication cart with the Medication Administration Record (MAR) in the computer exposed when he walked to the opposite side of the nurse's station to talk to another staff member. The computer screen showed the name, picture, and other PHI of Resident #11. Nurse #3 returned to the medication cart approximately 1 minute later at 11:15 am. During an interview conducted on 06/26/24 at 11:16 am, Nurse #4 stated residents' PHI should not be exposed or left unattended and acknowledged that it was his oversight. He stated had been trained to not leave resident PHI visible to others and that he should have closed his computer before he walked away.	F 583	providing care but shielded from external visibility or other access so personal medical information is not visible to any other staff, resident or visitor on 06/27/2024. A quality review was completed by the Director of Nursing and/or the Nursing Manager by observation of nurses and medication aides administering medications or completing treatments to ensure computer screen is locked or laptop is closed when the nurse is away from the computer on 07/03/2024. No concerns identified during review. An ad hoc Quality Assurance Performance Improvement Committee was held on 07/16/2024 to formulate and approve a plan of correction for the deficient practice. The Nurse Manager educated licensed nurses and medication aides including all shifts, part time and prn to ensure privacy is provided by locking of computer screens or closing the laptop and the information will only be visible while providing care but shielded from external visibility or other access on 07/22/2024. Newly hired nursing staff will be educated upon hire during orientation. Staff will not be allowed to return to work until education complete. The Director of Nursing and or Nurse Manager will conduct random quality reviews by observation of nurses or medication aides administering medications or completing treatments to	

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F 583	Continued From page 7 During an interview with the Administrator on 06/27/24 at 11:45 am he stated all residents' confidential PHI should be protected. He indicated that he would not have expected resident PHI to be accessible in plain view.	F 583	ensure the computer screen is either locked or the laptop is closed when providing care away from the cart. This quality review will include 5 nurse/medication aides 2 times per week for 8 weeks and then weekly for 4 weeks. The Director of Nursing and or Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		

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F 607	Continued From page 8 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to report an allegation of abuse to the Administrator immediately for 1 of 1 resident (Resident #4) reviewed for Abuse. The facility further failed to implement their policy and procedures in the area of resident protection. Findings included: Review of facility policy entitled Abuse, Neglect, Exploitation, & Misappropriation read in part "Protection- any suspect(s), who is an employee or contract service provider, once he/she have been identified, will be suspended pending the investigation" and "Reporting/Response- any employee or contracted service provider who witness or has knowledge of an act of abuse or an allegation of abuse, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse, to the Administrator and to other officials in accordance with State law". Resident #4 was admitted to the facility on 5-8-23. The Annual Minimum Data Set (MDS) dated 6-6-24 revealed Resident #4 was moderately	F 607	Past noncompliance: no plan of correction required.	

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cognitively impaired and was dependent on staff for bathing, and toileting.

In an interview with Resident #4 on 6/25/24 at 12:10 pm she stated that she was touched inappropriately by a male NA when incontinence care was provided a few weeks ago, she could not recall the date or his name. She stated that she reported her concern to two women that worked that day but could not recall their names or what time the event occurred.

In an interview with Nurse #2 on 6/25/24 at 4:42 pm he stated that NA #11 reported to him that Resident #4 had made a complaint that she had been inappropriately touched by NA #11 when incontinence care was provided. He stated that this was reported to him soon after he came on duty after 3:00 pm (he did not recall the exact time) on 6/15/24. He stated that he spoke to Resident #4 around 4:00 pm on 6/15/24 during medication pass and she told him that NA # 11 had touched her "private area". Nurse #2 stated that he did not report this to anyone because he did not think it was abuse, because he told Resident #4 that NA #11 had to touch her in her "private area" to provide incontinence care and she had responded "oh, ok". He further stated that at 8:00 pm on 6/15/24 that Resident #4 asked him if she should apologize to NA #11 for accusing him of touching her inappropriately. He indicated that Resident #4 was alert with confusion and often needed to be reoriented (reacquaint someone with a situation or environment). He further stated that he did not feel like this was abuse or that it was reportable so he did not report it. He stated that he did not receive any concerns on shift report from the off-going day shift nurse (Nurse #6).

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Attempts to contact Nurse #6 by phone were unsuccessful during the survey. It was learned from the Administrator that Nurse #6 only worked for the facility on the weekend and worked elsewhere during the weekdays.

In an interview with NA #11 on 6/26/24 at 5:19 pm he stated that on the morning of 6/15/24 (unsure of exact time) when he provided incontinence care to Resident #4 that she accused him of touching her private areas. He further stated that because of the seriousness of the allegation that he immediately reported the concern to Nurse #6, and she did not take it seriously and told him to that she would get another staff member to provide care for Resident #4 for the remainder of the shift. NA #11 stated that he worked a double shift that day and remained concerned about the allegation against him, so he again reported the concern to the evening shift Nurse #2, and he told him that he was the best NA and to just do the best he could. NA#11 stated he did not feel that Nurse #2 took him seriously and that no one cared what he reported to them. He stated he reported the concern to the Central Supply Manager on the morning of 6/17/24 because the Director of Nursing (DON) and the Administrator were not in the facility and that she directed him to report to the Social Worker (SW). The interview further revealed that NA #11 reported the allegation to the SW on the afternoon of 6/17/24 and she told him to not to worry about it because the resident had dementia, and that she would report it to the Administrator. He stated that on 6/18/24 when he arrived at work, he went to the DON office so he could report the concern, but she was not available, so he returned to his hall to begin work. Later that afternoon he stated

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he went to the Administrator's office to report the concern and at that time he was suspended pending an investigation into the concern.
In an interview with the SW on 6/26/24 at 2:56 pm she stated that on 6/17/24 around 3:40 pm NA #11 reported to her that Resident #4 had made an allegation of abuse against him and afterwards she finished her work left the facility for the day without reporting it to the Administrator. She indicated that Adult Protective Services (APS) came into the facility on 6/18/24 and that is when she reported what NA #11 reported to her on 6/17/24.

In review of staffing schedules for 6/15/24 NA #11 was on the schedule assigned to care for Resident #4 for a double shift that included hours from 7:00 am to 11:00 pm.

In review of staffing schedules for 6/16/24 NA #11 was on the schedule assigned to care for Resident #4 for a double shift that included hours from 7:00 am to 11:00 pm.

In review of staff schedules for 6/17/24 3-11 shift NA #11 was assigned to work as medication aide on the 100 hall where Resident #4 resided.

In review of staff schedules for 6/18/24 3-11 shift NA #11 was assigned to work as medication aide on the 100 hall where Resident #4 resided.

In an interview with the Administrator on 6/26/24 at 4:13 pm he stated he had not been made aware of the alleged abuse until 6/18/24 when APS arrived at the facility and informed him, they had received a report of abuse for Resident #4. He stated that on 6/18/24 he learned that the SW had knowledge of the alleged abuse on 6/17/24

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and failed to report the allegation to the Administrator. He indicated that staff who worked on 6/15/24 should have called him at home to report the allegation immediately but did not and stated that staff did not follow the facility's own policy for 2-hour reporting. The interview further revealed that the Administrator was made aware of the alleged abuse on 6/18/24 at 4:15 pm and that he reported it to the local police department on 6/18/24 at 4:30 pm and to the Division of Health Service Regulation (DHSR) on 6/18/24 at 5:10 pm. He further stated that he filed the 5-day report with DHSR on 6/25/24 at 4:15 pm.

The facility provided the following Corrective action plan

Abuse Reporting
Allegation Reported to Facility Administration 06/18/2024
Event occurred on 06/15/2024

On 06/18/2024, at approximately 4:00 pm an Adult Protective Services Supervisor spoke with Facility Administrator regarding an intake they had received on 06/17/2024. The APS worker was escorted to the resident room for interview and upon completion of their discussion, the accused Certified Nursing Assistant was suspended pending investigation following an allegation of inappropriate touching. The initial allegation report was submitted to North Carolina Department of Health and Human Services within an hour of notification to facility administrator. Police were contacted. The physician and resident responsible party were notified. Education of staff started immediately by facility administrator for all on-site staff at that time. Staff scheduler submitted notification to all

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off-shift staff they were not allowed to return to work until education had been completed. Scheduler and Social Worker were suspended for failure to report potential abuse timely.

On 06/19/2024, Resident #4 was interviewed, physician team provided a clinical evaluation and a head-to-toe assessment was completed. Resident #4's roommate was interviewed. An ad hoc Quality Assurance Performance Improvement (QAPI) program was completed and discussed regarding facility plan and monitoring to include education of department heads.

Interviews for inter-viewable residents were conducted by Director of Nursing, Regional RN Nurse Consultant, Unit Manager, RN Day Supervisor and RN Evening Supervisor on 06/20/2024 regarding definition of abuse and neglect and if they witnessed it on someone else or personally experienced it. In addition, Unit Manager and RN Evening Supervisor also conducted Skin Integrity tool ("skin sweeps") on 06/20/2024 for non-inter-viewable residents to assess for any signs of abuse. All current staff were interviewed for knowledge of known abuse and neglect, abuse policy and mandatory abuse reporting criteria. Director of Nursing interviewed all staff who worked with the resident on date of allegation and statements were obtained.

The Director of Nursing, Facility Administrator and Unit Manager educated all staff including all shifts, part-time and PRN on the abuse policy which included a test for abuse and abuse questions to validate any known awareness of abuse and validation of who to report abuse to. Education began on 06/18/2024 and staff were

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not allowed to return to work until education, test and abuse question responses were completed. Facility abuse policy and direct test questions included requirements for whom to report to (mandatory reporting immediately to Administrator and/or Director of Nursing). Abuse policy and employee handbook state that the accused employee will be suspended immediately pending investigation and a failure of staff to report immediately, result in disciplinary action including suspension and potential termination of employment.

Facility administration determined on 06/19/2024 to develop a Quality Assurance and Performance Improvement (QAPI) program to ensure resident safety and compliance with our abuse policy including immediate reporting by all staff of any allegations or actual resident abuse. The Director of Nursing and/or Designee will complete quality monitoring of 5 inter-viewable residents using the resident abuse questions and will be completed weekly for 12 weeks and then monthly for 3 months to ensure residents are free from abuse. The DON and/or Designee will complete quality monitoring on 5 non-inter-viewable residents using the facility Weekly Skin Integrity tool on a weekly review for 12 weeks and then monthly for 3 months to ensure residents are free from abuse.

Any abuse allegation cases will be reviewed to ensure the event was reported immediately to the Administrator and/or Director of Nursing and the accused was immediately suspended pending investigation. This will be discussed during QAPI for any incidents where the employee did not immediately report and will include targeted education for all staff. The Director of Nursing

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and/or Designee will conduct random interviews of 5 staff members per week for 12 weeks and then monthly for 3 months to ensure clear understanding of abuse policy and immediate mandatory reporting.

The DON will report on the results of the quality monitoring (audit) and report to the QAPI IDT Committee. Findings will be reviewed by the QAPI Committee monthly and the quality monitoring report (audit) will be updated as indicated.

Date of Compliance = 06/20/2024

The facility's Past Non-Compliance date of 6/20/24 was validated.

The corrective action plan was verified on 6/27/24. Interviews were conducted with a sample of Nursing Assistants, Nurses, and administrative and ancillary staff to verify education was conducted regarding reporting allegations of abuse and reporting timeline requirements. Documentation of in-service records was reviewed.

In an interview with the Director of Nursing on 6/27/24 at 4:05 pm, she stated that all Nurses, Nursing Assistants, therapists, housekeeping, dietary, and administrative personnel had been educated on abuse types, abuse reporting, abuse reporting timelines and that return demonstration of the training was verified through a written test. She stated that PRN (as needed staff), part-time staff and staff that had not reported to work since the onset of the education would be educated prior to being given an assignment. She further stated that the new hire orientation had been

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F 607	Continued From page 16 reviewed and included abuse, what to report, when to report, how to report and who to notify.	F 607		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		7/24/24

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F 655	Continued From page 17 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to create a baseline care plan with the resident or responsible party for one (Resident #7) of three residents reviewed for creation of a baseline care plan upon admission. Findings included: Resident #7 was admitted to the facility on 2/7/2024 and discharged from the facility on 2/11/2024. Resident #7 had multiple diagnoses some of which included acquired absence of right leg below the knee, type 2 diabetes mellitus, peripheral vascular disease, rheumatoid arthritis, and lymphedema. There was no documentation in the electronic medical record of a baseline care plan for Resident #7. Documentation on a paper copy of a Baseline Care Plan and Summary dated 2/7/2024 for Resident #7 revealed the form was filled out with the resident care needs but was unsigned by facility staff, Resident #7, or a resident representative. An interview was conducted with Resident #7 on 6/26/2024 at 12:54 PM. Resident #7 stated he	F 655	Resident #7 no longer resides at the facility. A quality review of residents admitted in the last 30 days was conducted by the Executive Director and the Nursing Manager on 07/17/2024. This quality review was to determine if the baseline care plans for these admitted residents were developed and reviewed with the resident within 48 hours. 20 residents were found to not have a baseline care plan. An ad hoc Quality Assurance Performance Improvement Committee was held on 07/16/2024 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Director of Nursing and Nursing Manager on the expectations of nursing management ensuring that the policy and procedures were adhered to regarding the completion of the baseline care plans on 06/27/2024. The Director of Nursing and or Nursing Manager will conduct quality reviews of 5	

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F 655	Continued From page 18 had just had surgery to remove his leg and while he was at the facility nobody went over his plan of care with him or his wife. An interview was conducted with the Director of Nursing (DON) on 6/27/2024 at 9:39 AM. The DON explained that she became the full time DON at the facility in March of 2024 and up until that time the facility did not have a consistent system in place for the preparation of baseline care plans. The DON explained in February, it was "hit or miss" if the baseline care plans were completed and the paper documents were not being uploaded into the electronic record system. The DON stated she currently had a system in place for the completion of baseline care plans, but she did not have a performance improvement plan or monitoring to confirm compliance.	F 655	randomly selected resident charts 3 times per week for 8 weeks and then weekly for 4 weeks to ensure baseline care plans are developed and implemented within 48 hours with summary of care plan to the resident or their representative. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and quality monitoring (audit) will be updated as indicated.	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		7/24/24

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F 657	Continued From page 19 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to update the care plan after the quarterly assessment for 1 of 4 residents reviewed for care plans (Residents #3). Findings included: Resident #3 was admitted to the facility on 10/28/23 with diagnoses which included diabetes, muscle weakness, and right below the knee amputation. The Quarterly Minimum Data Set (MDS) assessment dated 4/28/24 indicated that Resident #3 was cognitively intact. Review of care plan history revealed that the last care plan for Resident #3 was dated 1/25/24. Review of the electronic medical record (EMR) for Resident #3 revealed that there was no documentation of a care plan meeting being held since 1/25/24. An interview with Resident #3 on 6/27/24 at 9:09 am revealed that he did not know if a care plan review meeting had been held since 1/25/24.	F 657	Resident #3 care plan was reviewed and revised by Minimum Data Set (MDS) Coordinator on 07/16/2024. The care plan was updated to accurately reflect the resident plan of care. A quality review was conducted by the MDS Coordinator of current residents to ensure care plans are reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments on 07/16/2024. Seventeen (17) care plans were identified that needed to be reviewed and revised. Identified care plans will be reviewed and revised by 07/19/2024 by the MDS Coordinator. An ad hoc Quality Assurance Performance Improvement Committee was held on 07/16/2024 to formulate and approve a plan of correction for the deficient practice. The Executive Director provided re-education to the MDS Coordinator and Interdisciplinary Team to include the Director of Nursing and Unit Manager on	

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F 657	Continued From page 20 In an interview with MDS Nurse #1 on 6/26/24 at 2:34 pm it was revealed that care plan meetings were triggered after the completion of each MDS assessment update. She stated that Resident #3's MDS assessment was last updated 4/28/24 and a care plan review meeting should have followed. The interview further revealed that the care plan review should have been held quarterly, and the Social Worker (SW) planned the care plan review meetings. In a phone interview with SW on 6/26/24 at 2:56 pm it was revealed that she was aware that Resident #3's care plan had not been reviewed on time. She stated that she had not held care plan review meetings regularly in the past few months because she did not have an assistant and she was behind. She stated that she addressed more urgent matters by prioritization until she could get caught up. The SW added that care plan review meetings should be held on admission, quarterly, annually, and as needed. An interview with the Director of Nursing on 6/26/24 at 3:50 pm revealed that a care plan review meeting should be held regularly to review the resident's plan of care. She stated that Resident #3's care plan review had not been done on time because the SW did not have an assistant. She stated the facility was aware the care plan reviews were behind. In an interview with the Administrator on 6/26/24 at 4:13 pm he stated that he was aware that care plan meetings were not being held on time. He further indicated that care plan meetings were not on time because the SW did not have an assistant and was behind in her work. He stated	F 657	care plan timing and revision to include care plans must be reviewed by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments on 07/16/2024. The MDS Coordinator will conduct randomly selected quality reviews of 5 resident care plans to ensure reviewed and revised by the IDT team after each assessment for 3 times per week for 8 weeks and then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) will be updated as indicated.	

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F 657	Continued From page 21 he felt care plan reviews were behind related to a changeover in the SW position. He stated Resident #3's care plan review should have been up to date.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and resident interviews, the facility failed to provide a bed bath or shower for 3 of 7 dependent residents (Resident #1, Resident #2, and Resident #12) reviewed for activities of daily living (ADL) care. The findings included: 1. Resident #1 was admitted to the facility on 8/30/18 with diagnoses including diabetes, atherosclerotic heart disease, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 4/15/24 indicated that Resident #1 was cognitively intact, dependent on staff for toileting, and required substantial maximum assistance with bathing. Review of Care Plan dated 4/15/24 revealed Resident #1 required assistance with ADL care to include bathing. An interview with Resident #1 on 6/26/24 at 11:48	F 677	An internal review by the Executive Director in connection with the Housekeeping/Laundry Supervisor with HCSG, our contracted Housekeeping/Laundry provider, determined the quantity of wash cloths and towels was not sufficient enough on hand to provide a full rotation of the shower/bath schedule which resulted in some residents receiving a bed bath instead of the preferred shower. The Executive Director re-educated the Housekeeping/Laundry Supervisor on ensuring residents have an adequate supply of towels and wash cloths and available to the staff on 06/27/2024. Resident #1 was provided a shower/bed bath on 06/26/2024. Resident #2 was provided a shower/bed bath on 07/02/2024. Resident #12 was provided a shower/bed bath on 07/05/2024. A quality review was completed by the Nursing Manager on current residents on Activities of Daily Living (ADL) care	7/24/24

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F 677	Continued From page 22 am revealed yesterday (6/25/24) she only had one towel, no washcloth and she had to wash herself off with disposable wipes. She further indicated that she did not get a bath today (6/26/24) because the facility ran out of wash cloths and towels. In an interview with Nurse Aide (NA) #5 on 6/26/24 at 12:15 pm she revealed that she could not bathe Resident #1 today (6/26/24) because she did not have clean towels or washcloths. She indicated that she had to work without washcloths or towels every day until around 11:00 am, when they became available from the laundry. She stated that on average Resident #1 did not get a bath 3 to 4 days a week because of no available towels or washcloths. In an interview with Nurse #3 on 6/26/24 at 11:03 am she stated staff had to wait for towels and washcloths today (6/26/24) and residents, such as, Resident #1 and Resident #12 could not get a bath or shower completed until they found washcloths and that it could take an hour and a half before they found washcloths and towels. 2. Resident #2 was admitted to the facility on 10/28/23 and re-admitted on 11/7/23 with diagnoses which included hemiplegia, hemiparesis, cerebral infarction (stroke), chronic obstructive pulmonary disease, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated 5/14/24 indicated that Resident #2 was cognitively intact and required substantial maximum assistance with bathing and toileting. Review of Care Plan dated 5/13/24 revealed	F 677	specific to showers and bed baths on 07/16/2024. No residents were identified as not receiving a scheduled or offered shower or bed bath per review on 07/16/2024.An ad hoc Quality Assurance Performance Improvement Committee was held on 07/16/2024 to formulate and approve a plan of correction for the deficient practice. The Nurse Manager re-educated the nursing staff to include all full-time shifts, part-time and prn on ADL care specific to showers on 07/22/2024. Showers and bed baths will be monitored on the daily shower tracker sheet to ensure showers or bed baths are offered and completed or refusals are documented. Staff will not be allowed to return to work until education is complete. The Executive Director educated the Housekeeping/Laundry Supervisor to maintain a par level of at least 4 times the facility census to be on-hand at all times. Facility and contracted staff were also instructed to advise the Executive Director and/or Director of Nursing or Nurse Manager any time they are told that the facility does not have enough linen. The Director of Nursing and/or Nurse Manager will conduct random quality reviews of residents to ensure residents are provided showers or bed baths with Activities of Daily Living (ADL) care on 5 randomly selected residents 2 times per week for 8 weeks and then weekly for 4 weeks. The Nursing Manager will report	

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F 677	Continued From page 23 Resident #2 required extensive assistance with one staff member for ADL care to include bathing. During an interview with Resident #2 on 6/27/24 at 8:10 am she stated that she did not get a shower on her shower day 6/25/24 and did not get a bed bath on 6/26/24 because the facility did not have any towels or washcloths. She stated this was an ongoing issue and she was not sure how long it had occurred. In an interview with NA #5 on 6/26/24 at 12:15 pm she stated that Resident #2 did not get a shower yesterday (6/25/24) and did not get a bath today (6/26/24) because she did not have clean towels or washcloths available. She indicated that she had to work without washcloths or towels every day until around 11:00 am, when they became available from the laundry. 3. Resident #12 was admitted to the facility on 2/29/24 with diagnoses which included myocardial infarction (heart attack), diabetes, chronic kidney disease, and hypertension (high blood pressure). The annual Minimum Data Set (MDS) assessment dated 5/10/24 indicated that Resident #12 was severely cognitively impaired and required partial to moderate assistance with bathing and supervision for toileting. Review of Care Plan dated 5/8/24 revealed Resident #12 required one person assistance for ADL care to include bathing and toileting. During an interview with Resident #12 on 6/26/24 at 11:50 am Resident #12 stated that she did not get a bath this morning (6/26/24) because they	F 677	the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) will be updated as indicated. The Executive Director will conduct random quality monitoring 2 times weekly for 4 weeks and weekly for 8 weeks for review of the par level of wash cloths and towels to ensure adequate supply available for residents. The Executive Director will report the results of the quality monitoring (audit) to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) will be updated as indicated.	

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	345403	A. BUILDING _____ B. WING _____	C 06/27/2024

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F 677	Continued From page 24 did not have washcloths and towels when she got up. In an interview with NA #5 on 6/26/24 at 12:15 pm she revealed that she could not bathe Resident #12 today because she did not have washcloths or towels, so instead she assisted Resident #12 to wipe off with wipes. She indicated that she had to work without washcloths or towels every day until around 11:00 am, when they became available from the laundry. She stated that on average Resident #12 did not get a bath 3 to 4 days a week because of no available towels or washcloths. In an interview with Nurse #3 on 6/26/24 at 11:03 am she stated staff had to wait for towels and washcloths today (6/26/24) and residents, such as, Resident #1 and Resident #12 could not get a bath or shower completed until they found washcloths and that it could take an hour and a half before they found washcloths and towels. An interview with the Director of Nursing (DON) on 6/27/24 at 10:15 am she was not aware that the facility had been low on towels and washcloths or that residents did not get baths and showers. She stated that residents should be getting their daily bath or shower unless they refuse. In an interview with the Administrator on 6/27/24 at 11:45 am he stated that residents should get a bath or shower each day unless they refuse. He stated that he felt that this concern was related to a shortage of washcloths and towels and that he would address that.	F 677		
F 835 SS=E	Administration	F 835		7/24/24

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F 835	Continued From page 25 CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide effective leadership and implement effective systems to ensure there was an adequate number of washcloths and towels for the provision of resident care. This failure had the potential to affect all the residents in the facility. The findings included: 1a. Resident #1 was admitted to the facility on 8/30/18. The quarterly Minimum Data Set (MDS) assessment dated 4/15/24 indicated that Resident #1 was cognitively intact. An interview with Resident #1 on 6/26/24 at 11:48 am revealed that the facility frequently would run out of washcloths and towels. She stated yesterday (6/25/24) that she only had one towel, no washcloth and she had to wash herself off with disposable wipes. She further indicated that she did not get a bath today (6/26/24) because the facility ran out of washcloths and towels 1b. Resident #2 was admitted to the facility on 10/28/23 and re-admitted on 11/7/23. The quarterly Minimum Data Set (MDS)	F 835	An internal review by the Executive Director in connection with the Housekeeping/Laundry Supervisor with HCSG, our contracted Housekeeping/Laundry provider, determined the quantity of wash cloths and towels was not sufficient enough on hand to provide a full rotation of the shower/bath schedule which resulted in some residents receiving a bed bath instead of the preferred shower. The Executive Director re-educated the Housekeeping Supervisor on ensuring residents have adequate supply of towels and wash cloths and available to the staff on 06/27/2024. The Executive Director and Housekeeping Supervisor completed a quality review of towels and wash cloths to ensure residents currently have adequate supply of towels and wash cloths. The Executive Director and Housekeeping/Laundry Supervisor established a par level of a minimum of 4 times the facility census for towels and wash cloths to be maintained at all times. The Executive Director educated the	

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F 835	Continued From page 26 assessment dated 5/14/24 indicated that Resident #2 was cognitively intact. During an interview with Resident #2 on 6/27/24 at 8:10 am she stated that she did not get a shower on her shower day 6/25/24 and did not get a bed bath on 6/26/24 because the facility did not have any towels or washcloths. She stated not having washcloths and towels was an ongoing issue and she was not sure how long it had occurred. 1c. Resident #12 was admitted to the facility on 2/29/24. The annual Minimum Data Set (MDS) assessment dated 5/10/24 indicated that Resident #12 was severely cognitively impaired. During an interview with Resident #12 on 6/26/24 at 11:50 am she stated that she did not get a bath this morning (6/26/24) because they did not have wash cloths and towels when she got up. In an interview with Nurse Aide (NA) #5 on 6/26/24 at 12:15 pm she indicated that Resident #1 did not get a bath today (6/26/24) because she did not have clean towels or washcloths. She stated that on average Resident #1 did not get a bath 3 to 4 days a week because of no available towels or washcloths. She stated that Resident #2 did not get a bath yesterday (6/25/24) or today (6/26/24) because she did not have clean towels or washcloths available. She further indicated that she could not bathe Resident #12 today because she did not have washcloths or towels, so instead she assisted Resident #12 to wipe off with wipes. She stated that on average Resident #12 did not get a bath 3 to 4 days a week because of no available towels or washcloths. She indicated that	F 835	Housekeeping Supervisor to immediately notify the Executive Director if towels or wash cloths drop below the identified par level on 06/27/2024. The Director of Nursing and or Nursing Manager educated nursing staff to notify the Executive Director at any time wash cloths or towels are unavailable on 07/03/2024. The Executive Director will conduct random quality monitoring 2 times weekly for 4 weeks and weekly for 8 weeks of the par level of wash cloths and towels to ensure adequate supply available for residents. The Executive Director will report the results of the quality monitoring (audit) to the QAPI committee. Findings will be reviewed by QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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she had to work without washcloths or towels every day until around 11:00 am, when they became available from the laundry. She stated that she had made her own wipes/cloths by wetting paper towels and that she had bought her own wipes to use for resident care. She stated that she did what she had to do to ensure the resident was cared for. She stated that she reported this concern through the chain of command and reported it to the unit manager who told her she had to wait for the washcloths and towels to be washed. She stated she told the Director of Nursing (DON) about the lack of washcloths and towels a month ago and was told the facility was trying to order more washcloths and towels. NA #5 stated that she had been employed by the facility since December 2023 and that they had been short of towels and washcloths for the past 2 to 3 months.

In an interview with NA #2 on 6/25/24 at 1:36 pm she stated that she worked short of clean towels and washcloths every day. She stated that she told the nurses, but they often could not find clean towels or wash cloths. She stated the facility had some washcloths but not enough to provide care to all residents. She stated that it was after lunch some days before clean towels and washcloths were received on the hall.

In an interview with NA #6 on 6/26/24 at 12:30 pm she indicated she had worked for the facility since March 2024 and that she had worked short of towels and washcloths on most days. She stated she felt she could not provide proper care to the residents without clean towels and washcloths. She stated the facility stopped providing wipes so she bought her own so she could, at minimum, wipe the residents arm pits and private areas

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when the facility did not have wash cloths and towels available. She stated this occurred mostly on weekdays and was not an issue on the weekend.

In an interview with NA #7 on 6/26/24 at 2:26 pm revealed that she could not give baths in the mornings when she arrived to work because she did not have access to clean washcloths and towels. She indicated that residents did not get a bath or showers when they did not have available washcloths and towels because some residents were already up for the day, and she would not have time to complete her assignments. She stated this happened about 3 to 4 times a week.

In an interview with NA #1 on 6/27/24 at 8:15 am she indicated that she could not clean resident's hands prior to meals or provide morning care because she did not have access to clean towels and washcloths and she had to wait for clean towels and wash cloths to become available. By the time they arrived from the laundry many of the residents had gotten up for the day.

An interview with NA #8 on 6/27/24 revealed that she had been employed by the facility for 2 weeks. She stated that she had not had clean washcloths and towels for the past 2 weeks so the residents on her assignment did not get a bath and that the residents would get angry with the NAs.

An interview with Nurse #1 on 6/25/24 at 4:21 pm revealed that NAs complained to her that they did not have clean washcloths and that laundry had ordered more washcloths, but they had not arrived.

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In an interview with Nurse #2 on 6/25/24 at 4:53 pm he stated that he worked 3:00 PM to 11:00 PM shift on a regular basis, and the NAs often ran out of washcloths, so they tore up clean briefs and used them as wipes for incontinence care. He further indicated that they were out of washcloths last night. He stated that on days that the facility was short on washcloths that he had passed the concern on in shift report and that administration had been aware of the problem.

In an interview with Nurse #3 on 6/26/24 at 11:03 am she stated staff had to wait for towels and washcloths today (6/26/24) and residents could not get a bath, shower or incontinence care completed until they found washcloths and that it could take an hour and a half before they found washcloths and towels. She further indicated that towels and washcloths were not washed during the night, so they had to wait for linen to be washed in the mornings before they had clean washcloths and towels.

In an interview with Nurse #5 on 6/26/24 at 2:11 pm she stated that she worked part time for the facility as needed and did not work every day. She stated when staff told her they were short on towels and washcloths she checked with laundry and was told towels and washcloths would be available after they had been washed and dried. She stated that it would take until 10:00 am or 11:00 am before clean towels and wash cloths were available.

During an interview with the Housekeeping Director on 6/27/24 at 9:15 am it was revealed that he was an outside contractor, and he oversaw the laundry department as well as other housekeeping duties. He stated that when he

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arrived at the job just over a month ago (exact date unknown) that the facility "hardly had any washcloths" (he had not done a count) so he borrowed washcloths from another facility that also contracted with his company. He stated a week and a half after he borrowed washcloths there was still a shortage. He stated that staff told him they were not permitted to use disposable wipes and threw away washcloths that were soiled with bowel movement. He further indicated that housekeeping staff had reported to him that they saw soiled washcloths in the trash when they disposed of trash in the dumpster. The Housekeeping Director stated that a Periodic Automatic Replacement (PAR) level (an inventory control system that tells you what levels of inventory you should have in stock to fulfil a demand) for washcloths should be eight washcloths' times the number of residents on the census. He stated that with a census of one hundred residents that the facility should have 800 washcloths in stock and that the facility only had approximately 100 washcloths available. He stated the facility did not have any washcloths in storage. He stated the facility was low on towels, but not as low as washcloths, and he did not know how many towels were on hand, because he had not counted. He stated he ordered a large order of towels and washcloths yesterday that should arrive Monday, 7/1/24. He indicated the process to prep soiled linens, towels, and washcloths for the next morning was laundry staff picked up by the soiled linens each evening, washed and dried, and prepped the clean linen cart for the next day before their shift ended at 10:00 pm so clean linen was ready to be rolled out to the units first thing the next morning, but that system did not work at the facility because they did not have enough towels and washcloths.

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He further stated that laundry staff picked up the soiled laundry from the units when they arrived to work at 7:00 am each morning and washed, dried, and folded the laundry and that it took them from 7 am to about 9:30 to get the some linen ready to deliver to the units each day. He stated that he had noticed that staff used pillowcases for incontinence care because they did not have washcloths. The Housekeeping Director explained that since he had been in the position he had been working with the Administrator to resolve the issue of the shortage of washcloths and towels and they were working on establishing a PAR level.

An interview with the Director of Nursing (DON) on 6/27/24 at 10:15 am she was not aware that the facility had been low on towels and wash cloths. She stated the facility was currently in the process of establishing a PAR level with the new Housekeeping Director for towels and washcloths. She stated that when she was hired as the DON on 3/13/24 that staff used disposable wipes for all resident care and did not use washcloths. She stated that the wipes clogged toilets because staff flushed them, so wipes were no longer used. She stated that she educated staff to use washcloths for resident care, and to use the soiled diaper and toilet paper to wipe bowel movement from resident's during incontinence care, but they used the washcloths instead and threw them away. She stated that the facility had an emergency supply of washcloths and staff could ask for them and they would be provided to staff for use for resident care, but they had not asked. The interview further revealed that staff were hoarding and hiding washcloths and that decreased the number of washcloths available for use by all staff.

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F 835	Continued From page 32 In an interview with the Administrator on 6/27/24 at 11:45 am it was revealed that he was aware of an issue with a shortage of washcloths and towels, and he had been working with the Housekeeping Director to establish a PAR level. He further indicated that the facility had used wipes in the past but had stopped because staff and residents had flushed them, and it clogged the toilets. Staff then used washcloths and towels for incontinence care and threw away washcloths soiled with bowel movement and that caused a shortage of washcloths and reduced the number of washcloths and towels available for morning care. The Administrator stated that he would transition back to providing wipes today(6/27/24) for incontinence care.	F 835		