STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/2/25 through 2/6/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# AOVZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/2/25 through 2/6/25. Event ID# AOVZ11. The following intakes were investigated NC00216577, NC00215498, NC00211229, NC00224621, NC00226172 and NC00214579. 9 of the 16 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	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	F 550		3/5/25

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

Electronically Signed | 03/02/2025

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, resident family, and staff interviews, the facility failed to provide incontinence care in a manner to maintain the residents' dignity for 3 of 5 residents reviewed for dignity (Residents #1, #206 ,and #9). Findings included: 1. Resident #1 was admitted to the facility on 04/05/24. Resident #1's quarterly Minimum Data Set (MDS) dated 01/20/25 indicated her cognition was moderately impaired. She required moderate assistance with toileting hygiene, shower/bath, and dressing. She was occasionally incontinent	F 550	1. The Director of Nursing immediately provided incontinent care and changed the bed linen for resident #1 on 2/2/25. The CNA for resident #1 provided a shower on 2/3/25 related to strong smell of urine and the mattress appeared wet. The Director of Nursing initiated education to provide rounding every 2 to 3 hours and if call light is on to provide care as needed for resident #206 and resident #9 starting on 2/3/25. 2. The Director of Nursing initiated education to provide rounding every 2 to 3 hours and if call light is on to provide care as needed for all residents starting on	

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F 550	Continued From page 2 with bowel and bladder. An observation was conducted on 02/02/25 at 10:54 AM of Resident #1 sitting on the side of her bed with the bedside table in front of her. The surveyor observed her sheet with a very large wet area with a brown ring around it in the center. Resident #1 stated the staff did not put a pull-up on her or check on her last night and she saturated her clothes and bed. She explained that she wore pull-ups at night time and she needed assistance with incontinence care. The surveyor observed a note taped to the closet door that read, "I am incontinent and need help going to bathroom!!! (Even at night)". She indicated a nurse put the note on the door a while back because the NAs didn't assist her at night. Resident #1 also stated the note on the door did help some but there were still times that night shift didn't come in her room. She further explained that she did use her call bell for assistance, but the night staff would come in and turn it off without assisting her. An interview was conducted on 02/04/25 at 6:10 AM with Nursing Assistant (NA) #1. She verified she did work the night of 02/01/25 and that she was Resident #1's direct care NA. She indicated she checked on Resident #1 at 6:00 AM on the morning of 02/02/25 and she was not soaked. She explained she put a pullup on Resident #1 and checked on her at 3:00 AM and about 6:00 AM. An interview was conducted on 02/02/25 at 11:50 AM with Nursing Assistant (NA) #4. She verified she was the direct care NA for Resident #1. NA #4 stated Resident #1 and her bed were saturated this morning (02/02/25) when she	F 550	2/3/25. The Director of Nursing also educated to ensure appropriate briefs are applied to prevent leakage causing strong smell of urine on 2/3/25. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will complete education for the nursing staff to make sure call lights are answered timely to be complete before 2/27/25. The Director of Nursing will complete education for the nursing staff to make sure rounding is taking place every 2-3 hours to ensure residents are provided incontinent care timely to also be complete by 2/27/25. The Director of Nursing and Unit Managers will conduct a random audit on 5 residents 3 times a week x 12 weeks to ensure sure call lights are being answered timely and staff is making rounds every 2-3 hours to ensure incontinent care is provided timely. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted randomly by the Director of Nursing and Unit Managers on 5 residents 3 times a week x 12 weeks to ensure sure call lights are being answered timely and staff is making rounds every 2-3 hours to ensure incontinent care is provided timely. The	

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F 550	Continued From page 3 entered the room. She explained she did not have a pull-up or brief on, so she provided incontinence care and removed the linens from her bed. An observation was conducted on 02/03/25 at 8:35 AM of Resident #1's room. A strong smell of urine was present, the bed was without sheets, and the mattress appeared wet. Resident #1 was not in her room. An interview was conducted on 02/03/25 at 8:50 AM with Nursing Assistant (NA) #4. She verified she worked full time on day shift and was normally the direct care NA for Resident #1. She stated Resident #1 did have a pullup on this morning (02/03/25) however, she and her bed were saturated with urine. She explained that she gave Resident #1 a shower and removed the linen from the bed. She then explained this was a reoccurring problem. A follow-up interview was conducted on 02/04/25 at 12:35 PM with Resident #1. She stated she was very embarrassed when her room smelled like urine and to have wet clothes on. She explained that it was not right for the staff on night shift not to assist her. She explained she sometimes reminds them, but they don't listen to her. She had not filed a grievance regarding the concern because she forgot to do it. An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing. She stated she was unaware Resident #1 had not received incontinence care consistently on night shift. She also stated she expected all residents to be provided with incontinence care timely.	F 550	Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	

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F 550	Continued From page 4	F 550		

2. Resident #206 was admitted to the facility on 01/30/25.

Baseline care plan, dated 01/30/25, revealed Resident #206 required assistance with activities of daily living.

Resident #206's Minimum Data Set (MDS) assessment was "in progress".

Admission/Readmission Data Collection, dated 01/30/25, revealed Resident #206 was alert and oriented to person, place, and time. She was frequently incontinent with bowel and bladder and wore briefs. She also required assistance from one staff member with activities of daily living.

An interview was conducted on 02/02/25 at 6:21 PM with Resident #206's and her family member. The family member stated on 02/01/25 at 5:10 PM when dinner trays were being served, he told the Nursing Assistant (NA) (did not know the NAs name) that the resident needed incontinence care to be provided because Resident #206 was wet. He also stated the NA told him she would be back, however, no one returned to change her. He indicated he turned the call bell on at 5:20 PM and at 5:40 PM a nurse and an NA (did not know their names) were in the hallway, he stopped them and told them Resident #206 needed incontinence care to be provided but they did not come into the room to assist. The family member stated he then put the call bell on again at 5:45 PM but no one responded. He explained that he walked up the hall, looked at the nurses' station and down all the halls but he did not see anyone at all. He stated by this time his mom and the bed were saturated with urine. At 6:30 PM a different NA came by the room, and he stopped her and

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asked if she could provide incontinent care to Resident #206, which she did. Resident #206 stated that what her son had stated was correct, they didn't come after being asked several times.

An interview was conducted on 02/04/25 at 2:20 PM with Resident #206. She stated the Nursing Assistant (NA) was good today and had provided incontinence care like she should. She then stated on 01/31/25 she waited 1 hour and 30 minutes for the NA to come and change her and on 02/01/25 she waited 1 hour and 20 minutes to be changed. She explained that her family member timed the occurrences because no one would answer her call bell or respond to her family member's request for assistance needed. Resident #206 further stated she did not like to be left soaking wet like she was on these two occurrences, even her bed and sheets were wet. She then stated, "it felt yucky, and I stunk". She also explained that she did not know the NAs name that assisted her, only that it was an African American female.

Multiple unsuccessful attempts were made to contact the Nursing Assistant that worked from 4:00 PM until 7:00 PM on 01/31/25 and from 3:00 PM until 7:00 PM on 02/01/25.

3. Resident #9 was admitted to the facility on 2/19/21.

The quarterly Minimum Data Set assessment dated 11/22/24 indicated Resident #9 was cognitively intact and her vision was assessed as adequate.

During an interview and observation with

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Resident #9 in her room on 2/3/25 at 9:07 AM she reported that she was a heavy wetter and had been wearing a wet brief. She stated that she had to wait for an extended period during the night of 2/2/25 before staff would help change her undergarment. She stated she had pressed her call light, but it was turned off and the staff did not assist her for at least an hour afterward. A clock was observed in the resident's room on the wall in front of her bed. She indicated that she felt ignored when she needed help and had to wait. Resident #9 further stated having to wait so long for help to arrive caused her to feel aggravated. She indicated she was uncomfortable having to wear wet briefs.

On 2/3/25 at 6:11 AM Nurse Aide (NA) #1 was interviewed. She stated that she was the only NA who worked 7:00 PM to 7:00 AM on the night shift that day. She stated that it was difficult to get to each resident to provide toileting care throughout the shift. She stated that when she worked alone, she tried to round on everyone at least every 2 hours. She indicated that she had checked on Resident #9 around 5:00 AM, and she didn't need any assistance at that time. NA #1 stated staff calling out was often an issue, leaving the night shift shorthanded. She stated it was difficult to respond to the call lights when multiple residents needed help.

The Director of Nursing (DON) was interviewed on 2/6/25 at 10:01 AM. She stated that NAs were supposed to round on residents every two hours and as needed to provide personal care and that Resident #9 should have received incontinence care. The DON stated that an NA had called out the night of 2/3/25 causing the facility to be short staffed.

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F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to place a resident's call light within reach for 2 of 2 residents reviewed for accommodation of needs (Residents #6 and #14). The findings included: 1. Resident #6 was admitted to the facility on 9/15/17 with diagnoses that included history of stroke, chronic pain, and chronic obstructive pulmonary disease (COPD). Resident #6's active care plan, last reviewed 10/3/24, included the following focus areas: - Activities of Daily Living (ADL) self-care performance deficit related to COPD, chronic pain syndrome and left-sided weakness. One of the interventions was to encourage the resident to use the call light for assistance. - Risk for falls related to history of falls, impaired gait/balance problems related to history of a stroke with weakness, potential side effects related to use of psychoactive drug use, poor safety awareness and impulsive behaviors. One of the interventions included to encourage the resident to use the call light for assistance with transfers.	F 558	1. The call bells for residents #6 and #14 was put into place and attached to the bed by the nursing staff. The Director of Nursing initiated education to make sure all call bells are within place before leaving the residents room to ensure they can call for assistance if needed on 2/5/25. 2. The Director of Nursing and Unit Managers audited all residents to ensure call lights were within reach and clipped to bed on 2/5/25. No other call bells were found out of place, and they all were in reach. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will complete education for the nursing staff to make sure call lights are within reach and attached to bed before leaving the	3/5/25

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F 558	Continued From page 8 A quarterly Minimum Data Set (MDS) assessment dated 12/10/24 indicated Resident #6 was cognitively intact, displayed no behaviors and required maximum assistance from staff to complete ADLs. On 2/2/25 at 11:30 AM, an observation and interview occurred with Resident #6 while he was lying in bed listening to his radio. The call light was lying on the floor to the left side of the bed out of reach. Resident #6 stated he didn't know how long the call light had been on the floor and couldn't recall it sliding off the bed. He went on to say that normally the call light was fastened to his bed covers so that he could use it, but there were times he would have to ask staff who passed by his room to put the call light where he could reach it. He stated he would have to yell out if he needed something as he was unable to get out of bed on his own to reach it. Another observation was made on 2/2/25 at 12:40 PM. Resident #6 was lying in bed listening to his radio. The call light remained on the floor to the left side of the bed out of reach. When asked how he would request assistance, he stated he would use the call light when he could reach it, otherwise he let staff know when they entered the room, were passing by or yelling out for assistance. Resident #6 stated the nurse had been in to give him his medications that morning but left out of his room before making sure his call light was pinned to him. He recalled asking for it and was told they would be right back. On 2/2/25 at 1:15 PM, an interview occurred with Nurse Aide (NA) #3. She was scheduled to care for Resident #6 from 7:00 AM to 7:00 PM on 2/2/25. She explained she was working with one	F 558	residents room before 2/26/25. The Director of Nursing and Unit Managers will conduct a random audit on 5 residents 3 times a week x 12 weeks to ensure sure call lights are within reach for all residents before leaving the residents room. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted randomly by the Director of Nursing and Unit Managers will conduct a random audit on 5 residents 3 times a week x 12 weeks to ensure sure call lights are within reach for all residents before leaving the residents room. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	

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other NA for the entire building (the census on the day of the interview was 54) and had three other hallways to care for. This was the first time she had been over to Resident #6's hall, she was unaware the call light was not within reach and would fix it immediately.

On 2/2/25 at 2:45 PM, an interview was completed with Medication Aide (MA) #1 who was assigned to care for Resident #6 on the 7:00 AM to 7:00 PM shift for the day of the interview. She couldn't recall if his call light was within reach when she provided him with his morning medications.

On 2/5/25 at 9:12 AM, Resident #6 was observed lying in his bed listening to the radio. The head of the bed was elevated, and the call light was noted to be hanging between the headboard and the wall behind Resident #6, out of his reach.

NA #6 was interviewed on 2/5/25 at 10:00 AM. She observed Resident #6's call light hanging on the back of headboard out of reach. NA #6 explained she was assigned to care for Resident #6 from 7:00 AM to 3:00 PM and thought she had clipped it to his covers after personal care had been rendered that morning. She retrieved the call light and hooked it to Resident #6's blankets within reach.

The Director of Nursing was interviewed on 2/6/25 at 9:32 AM and stated Resident #6's call light could have fallen off the bed if he reached for a snack, but staff should be ensuring the call lights are clipped within reach, so they don't fall off the bed.

2. Resident #14 was admitted to the facility on

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01/16/25 with diagnoses that included intervertebral disc degeneration and repeated falls.

Resident #14's active care plan, dated 01/16/25, indicated she was at risk for falls related to intervertebral disc degeneration and repeated falls. The interventions included ensuring her call light was within reach and encouraging Resident #14 to use it for assistance as needed.

Resident #14's admission Minimum Data Set (MDS) dated 01/22/25 indicated her cognition was intact. Resident #14 required maximal assistance with toileting hygiene, shower/bathe self, dressing, bed mobility, transfers, and personal hygiene. She was occasionally incontinent with bladder and always incontinent with bowels.

An observation was conducted on 02/02/25 at 11:00 AM of Resident #14. She was observed asleep lying on her bed. Her call light was on the floor under the left side of her bed.

An observation was conducted on 02/02/25 at 12:10 PM of Resident #14. She was sitting in her wheelchair about an arm's length from the left side of the bed. Her call light remained out of reach on the floor under the left side of her bed.

An observation and interview were conducted on 02/02/25 at 1:01 PM with Resident #14. She was sitting in her wheelchair on the left side of the bed. Her call light was on top and in the center of her bed. She indicated that after the Nursing Assistant (NA) got her out of bed she made the bed and put the call bell in the center of it before exiting the room. Resident #14 propelled herself

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F 558	Continued From page 11 to the left side of her bed and stated if she attempted to reach for the call bell, she would fall face first out of her wheelchair. She then stated she would have to yell for assistance if she needed anything and hope that someone would hear her. She explained when the NA was in a hurry, they didn't pay attention to where they put the call bell and whether it was in her reach. She then indicated it was frustrating if she couldn't reach the call bell because she could not get the staff's attention. An observation and interview were conducted with Nursing Assistant (NA) #3 on 02/02/25 at 1:15 PM. She verified she was the direct care NA for Resident #14. She verified she did put Resident #3's call bell in the center of her bed and that Resident #3 could not reach the call bell from where the wheelchair was positioned. She indicated that Resident #3 would propel herself in the wheelchair and she figured if she needed it, she would move over to get it. An interview was conducted on 02/04/23 at 10:00 AM with the Director of Nursing (DON), she stated the call light device should always be in the resident's reach.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		3/5/25

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F 584	Continued From page 12 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to ensure a safe environment as evidenced by exposed wires to the bed control cord (Room #108) and to clean the vents of the Packaged Terminal Air Conditioner (PTAC-Room #108). The facility also	F 584	1. The Maintenance Director replaced the bed controller for room #108 on 2/6/25 to ensure a safe environment. The Housekeeper cleaned rooms #112, #128, #144, #120, #122, #126, and #129 on 2/6/25 to ensure residents□ rooms are	

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F 584	Continued From page 13 failed to ensure resident rooms were clean and in good repair (Rooms #112, 128, 144, 120, 122, 126, and 129). This was for 8 of 18 resident rooms reviewed for comfortable, clean and homelike environment. The findings included: 1a. On 2/3/25 at 11:33 AM, Room 108's bed control was observed lying on the mattress to the right of the resident's pillow. The bed control cord was noted with approximately 1 inch of yellow electrical tape below the control box. Beyond the yellow electrical tape was approximately ¼ inch of exposed wires showing. On 2/5/25 at 9:00 AM, the Maintenance Director observed the bed control unit for Room 108. He explained that the outer casing protecting the wires tore very easily. He acknowledged that he had wrapped the yellow electrical tape to the bed control cord when exposed wires were first seen but was unable to state when that was. He went onto say the bed control "used low voltage so wouldn't hurt a resident" if wires were exposed and he would need to rewrap the bed control cord for the exposed wires. When asked if the bed controls could be replaced, he stated "yes, but I try to tape them first". The Maintenance Director stated he tried to do frequent checks of the controls for any exposed wires on the cords but had lost his assistant in December 2024 and was doing the best he could. The Administrator was interviewed on 2/6/25 at 9:25 AM and stated that she expected bed control units not to have exposed wires. b. On 2/2/25 at 11:10 AM, Room 108's PTAC vent	F 584	clean, comfortable, and homelike environment. 2. The Maintenance Director will audit all bed controllers to ensure they are in a safe working order by 2/26/25. There were no other deficiencies. The Director of Nursing audited all residents□ rooms to ensure they were clean, comfortable, and homelike on 2/6/25. There were no other deficiencies. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. The Housekeeping Supervisor will complete education by 2/26/25 on thoroughly cleaning a resident□s room to ensure clean like environment for all housekeepers. The Maintenance Director was educated to ensure all bed controllers will be in safe working condition on 2/6/25. The Maintenance Director will do random audits on 5 bed controllers a week for 12 weeks to ensure thy are in good, safe, working condition starting 2/25/25. Department heads will also audit bed controllers periodically while completing their daily room rounds. The Executive Director will do random audits on 5 rooms a week for 12 weeks to ensure there are clean and homelike environment provided	

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F 584	Continued From page 14 had a large amount of grey dust particles and dried white material throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. The Housekeeping Manager was interviewed on 2/4/25 at 2:53 PM and explained that the housekeepers cleaned the outside of the PTAC units but anything inside the vents would be taken care of by the Maintenance department. On 2/5/25 at 9:00 AM, an observation of room 108 was conducted with the Maintenance Director. He explained that housekeeping cleaned the outside of the PTAC and anything inside the vents would be cleaned by the Maintenance department. The Maintenance Director added that PTAC's were to be cleaned monthly and confirmed the vents to room 108's PTAC was dirty with various particles in it and required cleaning. The Administrator was interviewed on 2/6/25 at 9:25 AM and stated that she would expect the PTAC's to be clean. 2. On 2/2/25 at 12:38 PM, in room 112, there were multiple areas of the wall under both of the overbed lights with exposed dry wall. This room was occupied by a resident. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM and observed the walls of Room 112 with exposed sheetrock under both of the overbed lights. He explained that as a room became unoccupied, he was fixing walls and installing back splashes to these areas. He was unable to state if this room was scheduled to be repaired.	F 584	for residents starting 2/25/25. The Executive Director will review in QAPI monthly for 3 months. 4. The Maintenance Director will do random audits on 5 bed controllers a week for 12 weeks to ensure thy are in good, safe, working condition starting 2/25/25. The Executive Director will do random audits on 5 rooms a week for 12 weeks to ensure there are clean and homelike environment provided for residents starting 2/25/25. Findings will be reviewed by QAPI committee monthly for 3 months until compliance is achieved. 5. 03/05/2025	

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F 584	Continued From page 15 On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike. 3a. On 02/03/25 at 8:35 AM, in room 128, there were multiple areas of the wall on the right side of the headboard and on the wall to the right when entering the room with exposed dry wall. This room was occupied by a resident. An interview was conducted on 02/05/25 at 03:07 PM with the Maintenance Director. He indicated that he observed the walls of Room 128 with exposed dry wall on the right side of the headboard and on the wall to the right when entering the room. He explained that as a room became unoccupied, he would fix the walls and install back splashes into these areas. He then stated this room was not scheduled to be repaired. On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike. b. On 02/03/25 at 8:35 AM, in room 144, there were multiple areas of the wall on the right side of the PTAC with exposed dry wall. This room was occupied by a resident. An interview was conducted on 02/05/25 at 03:07 PM with the Maintenance Director. He indicated that he observed the walls of Room 144 with areas of the wall on the right side of the PTAC with exposed dry wall. He explained that as a room became unoccupied, he would fix the walls and install back splashes into these areas. He then stated this room was not scheduled to be	F 584		

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repaired.

On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike.

4. On 02/03/25 at 8:35 AM, in room 128, the floor under the bed had a brown coffee cup, food crumbs, 3 pencils, and a clear plastic cup on it. The floor beside the bed had a brownish dried liquid (like water was spilled on dirty floor) spot. This room was occupied by a resident.

An observation and interview were conducted on 02/03/25 at 12:15 PM with the Housekeeping Manager in room 128. The floor appeared to have been mopped, the food crumbs, brownish dried liquid (like water was spilled on dirty floor, and water cup were removed from floor. However, the brown coffee cup and pencils were still located on the floor under the bed but were pushed up towards the headboard. The Housekeeping Manager stated that the housekeepers don't touch the residents' personal belongings due to residents accusing them of taking their items, but the coffee cup and other trash should have been removed. She expected the rooms to be neat, clean, and free of debris. She removed the coffee cup and other items from under the bed.

An interview was conducted on 02/03/25 at 3:15 PM with the Housekeeping District Manager. He stated he was not aware the housekeeping staff were not "touching" the residents' belongings when cleaning the rooms. He stated he expected the rooms to be clean, neat, and free of trash and debris. The items should be removed and/or swept up prior to mopping.

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An interview was conducted on 02/05/25 at 11:52 AM Housekeeper #2. She verified she worked 02/03/25 and was assigned room 128. She stated she did clean room 128 and that she thought she got all the "stuff" from under bed A. She explained that she had a bad back and she didn't bend all the way over to see under the beds, she just took the mop and tried to blindly sweep under the bed. She verified there was trash and a brown coffee cup under the bed that she did not get out because she could not reach it.

5. On 2/2/25 at 11:46 AM room #120 was observed to have multiple areas of black scuff marks on the window wall as well as the wall at the head of the bed. This room was occupied by a resident.

The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. He was unable to state if room #120 was scheduled to be repaired.

Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned.

At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping had a list of areas to be cleaned every day. She stated staff was supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls.

The District Manager for housekeeping was

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interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He also indicated that maintenance was responsible for repairing damaged walls.

On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the environment to be well maintained and homelike for the residents.

6. On 02/02/25 at11:53 AM room #122 was noted to have black scuffs and a partially painted wall by the closet where the television was placed. Paint streaks were also noted on the 3 walls that surrounded the bed. Blue paint was streaked on the white wall at the head of the resident's bed, and white paint streaks were noted on the blue wall on the door wall. The white ceiling also had blue paint streaks on it over the blue wall.

The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. The Maintenance Director stated room #128 was due to be painted as the walls were partially painted from a prior repair. He presented a piece of paper with multiple rooms highlighted for repairs, but room #128 was not on the list. He was unable to state if room #128 was scheduled to be repaired.

Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned.

At 9:08 AM on 2/6/25 the Housekeeping Manager

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was interviewed. She stated that housekeeping has a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls.

The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He also indicated that maintenance was responsible for repairing damaged walls as this was beyond the scope of housekeeping.

On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the residents' rooms to be clean, well maintained, and homelike for the residents.

7. On 02/02/25 at 12:11 PM room #126 was noted to have black scuff marks on the walls at the right and head of the resident's bed. This room was occupied by a resident.

The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. Room #126 was not on the highlighted list of rooms to be repaired at the time of the interview. He was unable to state when the room would be scheduled for repair. He stated that he lost his assistant in December 2024 and was doing the best that he could.

Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible

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dirt when the rooms were cleaned, but that housekeeping was not responsible for fixing scuff marks or damaged walls.

At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping had a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls.
The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He stated that housekeeping is responsible for cleaning vertical and horizontal surfaces, removing trash, and dust mopping followed by wet mopping of the residents' rooms. He also indicated that maintenance was responsible for repairing damaged walls since this was beyond the scope of housekeeping.

On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the residents' rooms to be well maintained and homelike for the residents.

8. On 02/03/25 09:07 AM room #129 was observed to have peeling paint on the wall by the window. The wall also had brown marks beside the resident's bed.

The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls, painted walls as needed, and installed backsplashes at the head of the beds to reduce damage from beds and wheelchairs hitting the walls. The

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Maintenance Director stated that he checked the condition of the rooms as he walked the halls and kept a paper of what rooms needed repairing. He was unable to state if room #129 was on the list as scheduled to be repaired.

Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned. She stated that housekeeping could wipe the brown marks off the wall, but the peeling paint was the responsibility of maintenance to repair.

At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping has a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls. She stated that she would have housekeeping staff #1 wash the brown marks off the wall in room #129.
The Housekeeping Manager stated once the staff turned in their completed task sheets for the day that she inspected the rooms for the areas reported to have been cleaned.

The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty such as the brown marks on Resident #129's wall. He stated that housekeeping is responsible for cleaning vertical and horizontal surfaces, removing trash, and dust mopping followed by wet mopping of the residents' rooms. He also indicated that maintenance was responsible for repairing damaged walls since this was beyond the scope

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F 584	Continued From page 22 of housekeeping. On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the environment to be well maintained and homelike for the residents.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		3/5/25

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F 656	Continued From page 23 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized and comprehensive care plan in the areas of pain and opioid medications (Resident #21), and the facility failed to implement a care plan area for safety (Resident #25). This was for 2 of 18 residents whose care plans were reviewed. 1. Resident #21 was admitted to the facility on 1/1/22 with diagnoses that included unspecified abnormalities of gait, osteoarthritis, and chronic pain syndrome. A review of the medication orders for Resident #21 for December 2024 revealed an order for oxycodone 5 milligrams, give 2 capsules by mouth every 4 hours as needed for pain that was active from 11/7/24 until 12/16/24. The order was changed to oxycodone 5 milligrams, give 1 capsule by mouth every 4 hours as needed for pain with a start date of 12/19/24 and end date of 12/31/24. The order was renewed 12/31/24 with a	F 656	1. The MDS Coordinator corrected the care plan in the area of opioid medication for resident #21 on 2/5/25. The Unit Manager placed a fall mat to the left side of the bed for resident # 25 on 2/4/25. 2. The Director of Nursing audited any resident on an Opioid medication to ensure they have a care plan for pain management on 2/26/25. The Director of Nursing audited all fall care plans to ensure they have appropriate interventions in place on 2/27/25. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice.	

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F 656	Continued From page 24 discontinued date of 1/2/25. A review of the December MAR revealed Resident #21 reported pain levels to nursing that ranged from 2 to 6 each day and was administered oxycodone 5 mg every 4 hours as needed for pain. The 5-day Minimum Data Set (MDS) assessment dated 12/24/24 indicated Resident #21 was cognitively intact with a depressed mood without behavioral concerns. She was coded as having pain occasionally and for receiving an opioid. Active orders reviewed for January 2025 revealed Resident #21 had an order for oxycodone 5 milligrams, give 2 tablets by mouth every 6 hours as needed for pain. The order was active from 1/2/25 until 1/28/25. The medication orders for February 2025 revealed Resident #21 had an order for morphine sulfate, give 20 milligrams by mouth every six hours as needed for pain. A review of the MAR for January 2025 revealed the resident reported pain levels to nursing that ranged from 3 to 10 daily and received oxycodone 5 milligrams every 6 hours as needed for pain. The care plan updated 1/9/25 did not have a focus for pain management. A review of the medication administration record (MAR) for February 1-3, 2025, revealed that Resident #21 reported pain levels to nursing that ranged from 4 to 5 each day and was administered morphine sulphate 20 milligrams every 6 hours as needed for pain.	F 656	3. The MDS Coordinator was educated on 2/26/25 to ensure any resident who is taking an Opioid will have a pain care plan and if the residents are a fall risk, then the care plan will be based on the fall interventions by the Director of Nursing. The Director of Nursing will do random audits weekly on 3 residents currently taking Opioids have a pain management care plan in place and accurate for 12 weeks starting 2/26/25. The Director of Nursing will do random audits weekly on 3 residents currently a fall risk to ensure the care plan is in place and reflects the fall interventions for 12 weeks starting 2/26/25. 4. The Director of Nursing will do random audits weekly on 3 residents currently taking Opioids have a pain management care plan in place and accurate for 12 weeks starting 2/26/25. The Director of Nursing will do random audits weekly on 3 residents currently a fall risk to ensure the care plan is in place and reflects the fall interventions for 12 weeks starting 2/26/25. The Facility will bring to QAPI monthly for 3 months. The Facility will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	

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On 2/5/25 at 3:00 PM the MDS nurse was interviewed. She verified the care plan for Resident #21 did not include a focus for pain. She stated that it should have been added at the time the MDS was completed.

The Director of Nursing (DON) was interviewed on 2/6/25 at 10:01 AM. She stated that a focus for pain should have been added to Resident #21's care plan.

2. Resident #25 was admitted to the facility on 4/5/23 with diagnoses that included Parkinson's disease, muscle weakness and Alzheimer's disease.

A review of Resident #25's physician orders included an order dated 8/14/23 for a fall mat to the left side of the bed when in bed.

Resident #25's active care plan, last reviewed 9/26/24, included a focus area for risk for falls related to dementia, muscle weakness, lack of coordination, cognitive impairment, impaired mobility, poor safety awareness , impulsive behaviors and history of falls. One of the interventions was to place a fall mat to the left side of the bed when in bed.

A quarterly Minimum Data Set (MDS) assessment dated 12/10/24 indicated that Resident #25 had moderately impaired cognition and required moderate assistance for bed mobility and transfers. He was not coded with any falls.

On 2/2/25 at 11:00 AM, Resident #25 was observed lying in bed. There was no fall mat to either side of the bed.

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On 2/3/25 at 2:14 PM, Resident #25 was observed lying in bed with his eyes closed. There was no fall mat present to the left side of the bed. There was no fall mats observed in Resident #25's room or bathroom.

On 2/4/25 at 6:11 AM, Resident #25 was observed lying in bed. There was no fall mat to the left side of the bed.

Nurse Aide (NA) #1 was interviewed on 2/4/25 at 6:18 AM and stated she had been assigned to care for Resident #25 during the 7:00 PM to 7:00 AM shift on the day of the interview. She stated she had been employed at the facility for two months, had never seen a fall mat in Resident #25's room nor was she aware he needed to have one at bedside.

NA #6 was interviewed on 2/5/25 at 10:00 AM. She was assigned to care for Resident #25 from the 7:00 AM to 3:00 PM on 2/5/25. She explained that she hadn't seen Resident #25 with a fall mat next to his bed until it was in his room on 2/4/25. She added that items such as fall mats needed would be on Resident #25's Kardex, but because they worked with a limited number of staff it was hard to review the Kardex each day. She stated she relied on report from the off going shift.

The Unit Manager was interviewed on 2/5/25 at 11:33 AM and stated that she couldn't explain why there was no fall mat next to Resident #25's bed or located in his room until 2/4/25. She felt like he still needed the fall mat for safety as he did attempt to get himself up unassisted at times.

The Director of Nursing (DON) was interviewed

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F 656	Continued From page 27 on 2/6/25 at 9:32 AM and stated she was unsure why Resident #25 did not have a fall mat next to his bed or located in his room or bathroom on 2/2/25, 2/3/25 or 2/4/25. She stated that the NAs should be reviewing resident care guides daily to ensure items such as fall mats were in place as ordered.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		3/5/25

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F 657	Continued From page 28 by: Based on record reviews, observations, and staff interviews, the facility failed to review and revise a care plan following the most recent Minimum Data Set (MDS) assessment in the area of falls (Resident #6) and failed to revise the care plan in the area of side rails (Resident #31). In addition, the facility failed to develop an individualized and comprehensive care plan in the area of Activities of Daily Living (Residents #51 and #205) This was for 4 of 18 resident records reviewed. The findings included: 1. Resident #6 was admitted to the facility on 9/15/17 with diagnoses that included history of a stroke and chronic obstructive pulmonary disease (COPD). The active care plan was last reviewed and revised on 10/3/24. There was a focus area for risk for falls related to history of falls, impaired gait/balance problems related to stroke with weakness, potential side effects related to use of psychoactive medications, poor safety awareness and impulsive behaviors. One of the interventions included a fall mat to the right side of the bed. A review of the physician orders included an order for a fall mat to the right side of the bed that was discontinued on 11/13/24. A quarterly MDS assessment was completed on 12/10/24 and indicated that Resident #6 was cognitively intact, displayed no behaviors and required maximum assistance from staff for activities of daily living (ADL). The active care plan did not indicate it had been	F 657	1. Resident #51 care plan was corrected to reflect the residents ADL□s on 2/5/25. Resident #205 care plan was corrected on 2/5/25 to reflect the residents ADL□s. MDS assessment was corrected for resident #6 related to no fall mat bedside on 2/5/25. Resident #31 care plan stated to use quarter side rails however the order was discontinued the care plan was corrected to reflect no side rails on 2/27/25. 2. To identify other residents that have the potential to be affected, a 30 day look back of residents identified who are at risk for falls to ensure interventions are accurate was conducted by the Regional MDS Coordinator on 2/27/25. A 30 day look back of resident□s care plan to ensure care plans reflects the residents ADLs by the Regional MDS Coordinator on 2/27/25. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. To prevent this from recurring, MDS Coordinator was educated on 2/26/25 ensuring residents who no longer had side rails, or a fall mat is to be removed off the care plan timely and ensure accuracy of ADL□s. To monitor and maintain ongoing	

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F 657	Continued From page 29 reviewed or revised after the 12/10/24 MDS assessment. On 2/4/25 at 6:14 AM, Resident #6 was observed lying in bed with the bed covers over his head. There was no fall mat to the right side of the bed. The MDS Nurse was interviewed on 2/5/25 at 3:17 PM and stated she had been employed by the facility for four weeks. She reviewed Resident #6's care plan and confirmed it had been reviewed and revised on 10/3/24. The MDS Nurse explained that the care plan should have been reviewed and revised following the MDS assessment that was completed on 12/10/24, in which the fall mat to the right side of the bed would have been removed. She was unable to state why the prior MDS Nurse did complete this task. The Director of Nursing (DON) was interviewed on 2/6/25 at 9:32 AM and stated she would expect the care plan to be reviewed and revised as needed following the most recent MDS assessment. 2. Resident #31 was admitted to the facility on 2/17/23 with diagnoses that included dementia, muscle weakness and osteoarthritis. A review of Resident #31's physician orders included an order 8/20/23 for the use of quarter side rails. This order was noted to be discontinued on 2/26/24 by the Unit Manager. A quarterly Minimum Data Set (MDS) assessment dated 11/14/24 indicated that Resident #31 had severe cognitive impairment and required maximum assistance from staff for	F 657	compliance the Director of Nursing will review, and update care plans for 3 residents as indicated as it relates to side rails, fall mats, and ADLs timely weekly for 12 weeks. The Executive Director will review in QAPI monthly for 3 months. 4. To monitor and maintain ongoing compliance the Director of Nursing will review, and update care plans for 3 residents as indicated as it relates to side rails, fall mats, and ADLs timely weekly for 12 weeks. The Facility will bring to QAPI monthly for 3 months. The Facility will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated 5. 03/05/2025	

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bed mobility. She was not coded for any restraint usage.

Resident #31's active care plan, last reviewed 11/25/24, included a focus area for potential limited physical mobility and required use of quarter side rails.

On 2/2/25 at 12:38 PM, an observation occurred of Resident #31 who was lying in bed. There were no quarter inch side rails present to the bed.

The Unit Manager was interviewed on 2/5/25 at 11:49 AM and stated that the quarter inch side rails were discontinued to Resident #31's bed on 2/26/24 as she no longer used them to aide in bed mobility. She felt it was an oversight not to have discontinued the care plan for the side rail use.

On 2/5/25 at 3:17 PM, the MDS Nurse was interviewed and explained that she had been employed at the facility for four weeks. She reviewed Resident #31's care plan and verified that a focus area was present for the use of quarter inch side rails. She also reviewed the discontinued physician order for quarter inch side rails on 2/26/24 and stated the focus area should have been resolved from the care plan. She was unable to state why this had not been done by the prior MDS Nurse.

The Director of Nursing was interviewed on 2/6/25 at 9:32 AM and stated she would expect the care plan to be accurate reflection of Resident #31.

3. Resident #51 was admitted to the facility on 01/13/25 with diagnoses that included cerebral

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infarction (stroke), hemiplegia and hemiparesis (weakness or paralysis on one side of the body), and aphasia (loss of ability to understand or speak).

Resident #51 ' s active care plan, initiated on 01/13/25, did not include a focus area for activities of daily living.

Baseline care plan, dated 01/13/25, revealed Resident #51 required assistance with activities of daily living. He was dependent on staff for incontinence care, toileting hygiene, personal hygiene, shower/bath, and transfers.

The admission Minimum Data Set (MDS) assessment dated 01/20/25 indicated Resident #51's cognition was severely impaired. He had no behavior and no rejection of care. He was dependent on staff for personal hygiene, toileting hygiene, transfers, and shower/baths.

An interview was conducted on 02/05/25 at 3:16 PM with Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #51 ' s care plan for ADL care and there should have been a focus added. She explained that by the time the MDS assessment was completed the care plan should also be completed. She stated it was an oversight that this intervention was not added on Resident #51 ' s care plan.

An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing (DON). She stated a focus or intervention area for ADL care should have been part of Resident #51 ' s care plan.

4. Resident #205 was admitted to the facility on

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01/20/25 with diagnoses that included osteomyelitis of vertebra, stage 4 pressure ulcer to the sacrum, unstageable pressure ulcer to the left heel and type 2 diabetes mellitus.

Resident #205's active care plan, initiated on 01/20/25, did not include a focus area for activities of daily living.

Baseline care plan, dated 01/20/25, revealed Resident #205 required assistance with activities of daily living. He was dependent on staff for toileting hygiene, shower/bath, and transfers and required moderate assistance with personal hygiene.

The admission Minimum Data Set (MDS) assessment dated 01/27/25 indicated Resident #205's cognition was intact. He had no behavior and no rejection of care. He was dependent on staff for shower/baths, toilet hygiene, dressing, transfers, and bed mobility. He also required moderate assistance with personal hygiene. Resident #205 was always incontinent with bowel and bladder and had range of motion limitations to both sides of his upper extremities. Resident 205's care area triggered for ADL care.

An interview was conducted on 02/05/25 at 3:16 PM with Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #205's care plan for ADL care and there should have been a focus added. She explained that by the time the MDS assessment was completed the care plan should also be completed. She stated it was an oversight that this intervention was not added on Resident #205's care plan.

An interview was conducted on 02/06/25 at 9:33

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F 657	Continued From page 33 AM with the Director of Nursing (DON). She stated a focus or intervention area for ADL care should have been part of Resident #205 ' s care plan.	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 reviews, observations, and family, resident, and staff interviews, the facility failed to provide nail care and/or incontinence care for 8 of 13 residents dependent on staff for activities of daily living (ADL) (Residents #9, #32, #35, #51, #205, #1, #206, and #33). The findings included: 1a. Resident #9 was admitted to the facility on 2/19/21 with diagnoses that included a history of a fractured right femur, history of a stroke, Alzheimer's disease, and diabetes. The care plan updated 7/18/24 indicated Resident #9 required one person staff assist for bathing and personal hygiene. The quarterly Minimum Data Set assessment dated 11/22/24 indicated Resident #9 was cognitively intact. There were no mood concerns, but it was noted that the resident was coded for rejection of care. Resident #9 was dependent on staff for toileting, bathing, and personal care and was incontinent of bowel and bladder.	F 677	1. Resident #9, #32, #33, #35, #51, and #205, was provided nail care to include fingernails trimmed and cleaned on 2/3/25. Resident #1 was provided a shower with bed linen changed on 2/3/25. Resident #206 was provided incontinent care on 2/3/25. 2. The Director of Nursing completed a quality review on all residents on ADL care specific to nail care 2/3/25. Identified residents were provided nail care to include cleaning and trimming. The Director of Nursing completed a quality review on all residents to ensure they were clean and dry on 2/3/25. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice.	3/5/25

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F 677	Continued From page 34 A review of the shower sheets for Resident #9 indicated that on 2/3/25 the resident was given a shower, but nail care was marked as not done. An observation on 2/3/25 at 9:07 AM revealed that Resident #9 had jagged fingernails on both hands that extended beyond the fingertips. The fingernails had a yellow-brown substance underneath all of them. Resident #9 stated at the time of the observation she was not offered nail cleaning during her shower that day. Subsequent observations on 2/4/25 at 11:40 AM and on 2/5/25 at 9:30 AM revealed the resident had jagged fingernails with a yellow-brown substance underneath. On 2/6/25 at 8:50 AM NA #4 was interviewed and confirmed she was the NA assigned to Resident #9 that day. NA #4 stated she was regularly assigned to the E hall where Resident #9 lived. She stated that nail care was completed during showers unless the resident refused. She indicated that Resident #9 had a nail care pouch that sat on her table, and she would try to do her own nail care. She stated Resident #9 refused nail care on her shower day on 2/3/25. She further stated that Resident #9 refused showers and nail care a lot. On 2/3/25 at 12:59 PM the Treatment Nurse was interviewed. She stated at the end of the day she brought the Nurse's Aides (NA) to her office to review if the residents received their shower and if nail care was completed at that time. She stated that she knew the residents were getting their showers because she saw the NAs taking the residents to the shower room.	F 677	3. The Director of Nursing, Nurse Manager or Director of Staff Development nurse re-educate nursing staff on all shifts by 2/26/25 on ADL care specific to trim nails on shower days, when observed to be long, keeping clean and dry specific to rounding every 2 to 3 hours, and as indicated for all residents. Education will be completed by 2/26/25. The Executive Director will review in QAPI monthly for 3 months. 4. The Director of Nursing will conduct a random audit on 5 dependent residents, 3 times a week for 4 weeks, then weekly for 2 months, to ensure all nail care is being completed by keeping nails cleaned & trimmed as indicated and the resident is clean and dry. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	

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The Infection Control (IC) nurse was interviewed on 2/4/25 at 10:33 AM. She stated that she randomly went through the facility checking the residents' fingernails. She stated that the NAs were ultimately responsible for nail care, but that it was lacking lately.

The Director of Nursing (DON) was interviewed on 2/6/25 at 10:01 and stated the Nurse Aides normally do nail care during showers and morning care. She indicated that the Infection Control nurse would assist with nail care sometimes as well. She stated that nail care should be done on shower days and residents should be checked daily for as needed care.

1b. An observation and interview with Resident #9 occurred on 2/3/25 at 9:07 AM. The room had a strong odor of urine. Resident #9 reported that she was a heavy wetter and had been wearing a wet brief for a long time last night. She stated that she had pushed her call light, but it was turned off. Resident #9 stated she had to wait an extended period before staff helped change her undergarment after the light was turned off. She stated it was about 5:00 AM when the NA helped her. There was a clock noted on the wall located at the end of the resident's bed within her line of vision.

On 2/3/25 at 6:11 AM NA #1 was interviewed. She stated that she was the only NA who worked 7:00 PM to 7:00 AM on the night shift that day and that she was assigned all the halls in the facility. She stated that it was difficult to get to each resident to check on them throughout the shift. She stated the last time she changed Resident #9 was around 5:00 AM when she did

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rounds on the E hall.

The Director of Nursing was interviewed on 2/6/25 at 10:01 AM and stated that NAs were supposed to round on residents every two hours to assist with toileting and as needed to provide personal care.

2. Resident #32 was admitted to the facility on 7/22/21 with diagnoses that included unspecified dementia without behavioral disturbances, diabetes type II, and major depressive disorder.

A review of the care plan revised on 9/13/24 revealed Resident #32 required two person staff assistance with bathing/showering. Staff were to check nail length and trim and clean on bath day and as necessary. The care plan also indicated the resident had a history of refusing showers and should be offered a sponge bath if she refused.

The quarterly Minimum Data Set dated 12/24/24 indicated Resident #32 was cognitively intact without mood or behavioral concerns. She was coded as requiring substantial/maximal assistance with bathing/showering and setup assistance for personal hygiene.

An observation and interview was conducted with Resident #32 on 2/2/25 at 12:54 PM. The resident was noted to have long jagged fingernails that extended beyond the fingertips on both hands. She had chipped nail polish on the nails and there was a black substance noted underneath. Resident #32 stated that she liked having her nails long and pretty. She stated that the Activities Director would paint her nails for her sometimes as part of activities. Resident #32

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stated she had never refused to have her fingernails cleaned when she was given a shower because the NA never asked her if she wanted to have the care done.

Subsequent observations were completed on 2/3/25 at 3:10 PM and 2/4/25 at 10:18 and continued to reveal the fingernails were long and jagged with a black substance underneath the nails.

The shower sheets were reviewed and indicated on 2/3/25 Resident #32 refused a shower but received a bed bath. The shower sheet also indicated she refused nail care.

On 2/5/25 at 9:49 AM NA #2 was interviewed. She stated she gave Resident #32 a shower on 2/3/25. She stated that she usually took a washcloth underneath the resident's nails to clean them, but she missed doing that for Resident #32 on her shower day due to "so much going on" and being pulled to do different things for other residents. NA #2 stated she could only clean Resident #32's nails since she had diabetes, and the nurses had to cut her fingernails. She further stated that Resident #32 liked having long fingernails and would refuse nail care at times.

The Infection Control (IC) nurse was interviewed on 2/4/25 at 10:33 AM. She stated that she randomly went through the facility checking the residents' fingernails. She stated that she would cut the nails of the residents who had diabetes if the NAs informed her it needed to be done. She stated that the NAs were ultimately responsible for nail care, but that it was lacking lately.

On 2/4/25 at 2:34 PM the Activities Director was

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interviewed. She stated pretty nails were offered to residents weekly. The activity included painting nails and occasionally filing them. She stated she did not clip fingernails, and she would let the nurse know if any resident needed their fingernails clipped. She could not recall the last time Resident #32 was at the pretty nails activity.

The Director of Nursing was interviewed on 2/6/25 at 10:01 AM stated the Nurse Aides normally do nail care during showers and morning care. She indicated that the IC nurse would assist with nail care sometimes as well for those residents diagnosed with diabetes. She stated that nail care should be done on shower days, and the residents should be checked daily for as needed care. The DON stated that Resident #32 did receive care and seemed happy to her.

3. Resident #35 was admitted to the facility on 1/25/24 with diagnoses including a displaced fracture of the left femur and acute weakness.

A review of the care plan updated 11/4/24 revealed Resident #35 needed assistance of 1 staff person for bathing and personal hygiene. The care plan also indicated Resident #35 had a history of refusing her showers and bed baths.

The quarterly Minimum Data Set assessment dated 12/26/24 indicated Resident #35 was severely cognitively impaired without mood or behavioral concerns. The resident was coded as dependent on staff for bathing/showering and personal hygiene care.

On 2/2/25 at 6:09 PM Family Member #1 was interviewed. She stated the family visited

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Resident #35 daily and they had noted the NAs rarely cleaned or cut the resident's nails. Family member #1 stated that she had to cut the resident's fingernails herself in the past and needed to cut them again that week. She stated that the facility was often short staffed, and if the NAs saw her with the resident, they would often skip her care.

On 2/2/25 at 11:37 AM Resident #35 was observed with long fingernails that extended beyond the tips of her fingers. There was a black substance underneath the nails. Subsequent observations conducted on 2/3/25 at 12:38 PM and 2/4/25 at 10:18 AM revealed the resident had long fingernails with a black substance underneath them.

The shower sheets were reviewed for Resident #35 on 2/3/25. She was scheduled for a shower every Monday and Thursday. The shower sheets were signed for 1/27/25, 1/30/25, and 2/3/25, but the contents indicating what type of care was provided was incomplete.

On 2/6/25 at 8:50 AM, NA #4 was interviewed. She stated that nail care was completed during showers unless the resident refused. She indicated that Resident #35 refused her shower on 2/3/25 and said she did not want to be touched. NA #4 stated Resident #35 would often refuse showers and request not to be touched. She stated the family would assist her at times when they visited.

On 2/3/25 at 12:59 PM the Treatment Nurse was interviewed. She stated that at the end of the day she brought the NAs to her office to review the care provided to the residents during showers.

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She stated that she was unsure why the shower sheets for Resident #35 were left blank, but she stated that she knew the residents were getting their showers because she saw the NAs taking the residents to the shower room.

The Infection Control nurse was interviewed on 2/4/25 at 10:33 AM and stated that she randomly went through the facility checking the residents' fingernails. She also stated that she would cut the nails of the residents who had diabetes if it was reported to her that it was needed since NAs could not cut their nails. She stated that the NAs were ultimately responsible for nail care, but that it was lacking lately.

The Director of Nursing was interviewed on 2/6/25 at 10:01 AM and stated the Nurse Aides normally do nail care during showers and AM care. She indicated that the IC nurse would assist with nail care sometimes as well for those residents diagnosed with diabetes. She stated that nail care should be done on shower days, and the residents should be checked daily for as needed care. She stated the NAs should report refusals of showers to the floor nurse.

4. Resident #51 was admitted to the facility on 01/13/25 with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness or paralysis on one side of the body), and aphasia (loss of ability to understand or speak).

Baseline care plan, dated 01/13/25, revealed Resident #51 required assistance with activities of daily living. He was dependent on staff for incontinence care, toileting hygiene, personal hygiene, shower/bath, and transfers.

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The admission Minimum Data Set (MDS) assessment dated 01/20/25 indicated Resident #51's cognition was severely impaired. He had no behavior and no rejection of care. He was dependent on staff for personal hygiene and shower/baths.

A review of Resident #51's nursing progress notes from 01/13/23 to 02/04/23 did not reveal refusals for showers or nail care.

An observation of Resident #51 was conducted on 02/02/25 at 11:20 AM. The observation revealed Resident #51's fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his fingertips and were jagged. Under the fingernails on the left and right hands was a brown/black substance.

An observation of Resident #51 was conducted on 02/03/25 at 11:08 AM. He was observed on a shower stretcher being taken to the shower room. The observation revealed Resident #51's fingernails were still long, jagged, and dirty.

An observation of Resident #51 was conducted on 02/03/25 at 12:08 PM. Resident #51 was observed sitting in his wheelchair with his family member rubbing his legs. The Resident's fingernails were still long, jagged, and dirty.

An observation and interview were conducted on 02/03/25 at 12:09 PM with Resident #51's family member. She stated she tried to keep Resident #51's nails clean and cut because they were long, and he had been scratching himself. She stated the staff had not cut or cleaned them since he was admitted to the facility, and she did not

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realize that was their responsibility.

An observation of Resident #51 was conducted on 02/04/25 at 9:14 AM. Resident #51's fingernails were still long, jagged, and dirty.

A phone interview was conducted on 02/04/25 at 1:12 PM with Nursing Assistant (NA) #7 which stated she provided showers to the residents that were scheduled for 02/03/25. She verified she gave Resident #51's shower on 02/03/25. She stated she did clean Resident #51's nails on 02/03/25 after his shower, however she did not cut or file them. She indicated she did not know why she did not cut or filed his nails.

An interview was conducted on 02/05/25 at 11:22 AM with Nursing Assistant (NA) #2. She verified she was the direct care NA for Resident #51 on 02/03/25. She stated she did not perform nail care to the residents on F Hall because she did not know the residents and did not know if they were diabetic. She also stated she did not think to ask the nurse. She explained that she normally performed nail care when she gave showers.

An observation and interview were conducted on 02/04/25 at 10:00 AM with the Director of Nursing (DON). She stated nail care was to be done any time it was needed. The Nursing Assistants normally did nail care during showers, morning care, and as needed. She observed Resident #51's nails and stated his nails needed to be cut and cleaned. She then stated there was no reason his nails had not been tended to.

An interview was conducted on 02/04/25 at 10:33 AM with the Infection Control (IC) Nurse. She stated that she randomly went through the facility

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checking fingernails. She also stated that Nursing Assistants were ultimately responsible for nail care, "but it's been lacking lately".

5. Resident #205 was admitted to the facility on 01/20/25 with diagnoses that included osteomyelitis of vertebra and type 2 diabetes mellitus.

Baseline care plan, dated 01/20/25, revealed Resident #205 required assistance with activities of daily living. He was dependent on staff for toileting hygiene, shower/bath, and transfers and required moderate assistance with personal hygiene.

The admission Minimum Data Set (MDS) assessment dated 01/27/25 indicated Resident #205's cognition was intact. He had no behavior and no rejection of care. He was dependent on staff for shower/baths and required moderate assistance with personal hygiene.

A review of Resident #205's nursing progress notes from 01/20/23 to 02/04/23 did not reveal refusals for showers or nail care.

An observation of Resident #205 was conducted on 02/02/25 at 11:30 AM. The observation revealed Resident #205's fingernails on his left and right hands extended approximately 1/4 of an inch beyond his fingertips and were jagged. Under the fingernails on the left and right hands was a brown/black substance.

An observation of Resident #205 was conducted on 02/03/25 at 2:19 PM. His fingernails were still noted to be long, jagged, and dirty.

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An observation and interview were conducted on 02/04/25 at 9:40 AM with Resident #205. He was observed lying in bed watching television. Resident #205's fingernails were observed to still be long, jagged, and dirty. He stated he asked a staff member to cut and clean his fingernail a week ago, the staff member said they would be back to do them but never returned.

An interview was conducted on 02/05/25 at 11:22 AM with Nursing Assistant (NA) #2. She verified she was the direct care NA for Resident #205 on 02/03/25. She stated she did not perform nail care to the residents on F Hall because she did not know the residents and did not know if they were diabetic. She also stated she did not think to ask the nurse. She explained that she normally performed nail care when she gave showers.

An interview was conducted on 02/05/25 at 12:48 PM Nurse #1/Wound Nurse. She verified she was Resident 205's direct care nurse on day shift for 02/02/25 and 02/03/25. She stated the Nursing Assistants should be performing nail care when they did showers and when they performed morning care. She stated she had not noticed that Resident 205's fingernails needed to be cut or cleaned, and NA #2 did not report to her that the nails were long and needed to be cut.

An observation and interview were conducted on 02/04/25 at 9:55 AM with the Director of Nursing (DON). She stated nail care was to be done any time it was needed. The Nursing Assistants (NAs) normally did nail care during showers, morning care, and as needed unless they were diabetic. If the resident was diabetic the NAs could clean the nails, but the nurse would have to cut the nails. She observed Resident #205's nails and stated

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his nails needed to be cut and cleaned. She then stated there was no reason his nails had not been tended to.

An interview was conducted on 02/04/25 at 10:33 AM with the Infection Control (IC) Nurse. She stated that she randomly went through the facility checking fingernails. She also stated that Nursing Assistants were ultimately responsible for nail care, "but it's been lacking lately".

6. Resident #1 was admitted to the facility on 04/05/24.

Resident #1's quarterly Minimum Data Set (MDS) dated 01/20/25 indicated her cognition was moderately impaired. She required moderate assistance with toileting hygiene, shower/bath, and dressing. She was occasionally incontinent with bowel and bladder.

An observation was conducted on 02/02/25 at 10:54 AM of Resident #1 sitting on the side of her bed with the bedside table in front of her. The surveyor observed her sheet with a very large wet area with a brown ring around it in the center. Resident #1 stated the staff did not put a pull-up on her or check on her last night and she saturated her clothes and bed. She explained that she wore pull-ups at night time and she needed assistance with incontinence care. The surveyor observed a note taped to the closet door that read, "I am incontinent and need help going to bathroom!!! (Even at night)". She indicated a nurse put the note on the door a while back because the NAs didn't assist her at night. Resident #1 also stated the note on the door did help some but there were still times that night shift didn't come in her room. She further

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explained that she did use her call bell for assistance, but the night staff would come in and turn it off without assisting her.

An interview was conducted on 02/04/25 at 6:10 AM with Nursing Assistant (NA) #1. She verified she did work the night of 02/01/25 and that she was Resident #1's direct care NA. She indicated she checked on Resident #1 at 6:00 AM on the morning of 02/02/25 and she was not soaked. She explained she put a pullup on Resident #1 and checked on her at 3:00 AM and about 6:00 AM.

An interview was conducted on 02/02/25 at 11:50 AM with Nursing Assistant (NA) #4. She verified she was the direct care NA for Resident #1. NA #4 stated Resident #1 and her bed were saturated this morning (02/02/25) when she entered the room. She explained she did not have a pull-up or brief on, so she provided incontinent care and removed the linens from her bed.

An observation was conducted on 02/03/25 at 8:35 AM of Resident #1's room. A strong smell of urine was present, the bed was without sheets, and the mattress appeared wet. Resident #1 was not in her room.

An interview was conducted on 02/03/25 at 8:50 AM with Nursing Assistant (NA) #4. She verified she worked full time on day shift and was normally the direct care NA for Resident #1. She stated Resident #1 did have a pullup on this morning (02/03/25) however, she and her bed were saturated with urine. She explained that she gave Resident #1 a shower and removed the linen from the bed. She then explained this was a

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reoccurring problem.

A follow-up interview was conducted on 02/04/25 at 12:35 PM with Resident #1. She stated that the staff on night shift do not assist her with putting on a pullup or incontinent care throughout the night. She explained she sometimes she reminds them, but they don't listen to her. She had not filed a grievance regarding the concern because she forgot to do it.

An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing. She stated she was unaware Resident #1 had not received incontinent care consistently on night shift. She also stated she expected all residents to be provided with incontinent care timely.

7. Resident #206 was admitted to the facility on 01/30/25.

Baseline care plan, dated 01/30/25, revealed Resident #206 required assistance with activities of daily living.

Resident #206's Minimum Data Set (MDS) assessment was "in progress".

Admission/Readmission Data Collection, dated 01/30/25, revealed Resident #206 was alert and oriented to person, place, and time. She was frequently incontinent with bowel and bladder and wore briefs. She also required assistance from one staff member with activities of daily living.

An interview was conducted on 02/02/25 at 6:21 PM with Resident #206's and her family member. The family member stated on 02/01/25 at 5:10 PM when dinner trays were being served, he told

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the Nursing Assistant (NA) (did not know the NAs name) that the resident needed incontinence care to be provided because Resident #206 was wet. He also stated the NA told him she would be back, however, no one returned to change her. He indicated he turned the call bell on at 5:20 PM and at 5:40 PM a nurse and an NA (did not know their names) were in the hallway, he stopped them and told them Resident #206 needed incontinence care to be provided but they did not come into the room to assist. The family member stated he then put the call bell on again at 5:45 PM but no one responded. He explained that he walked up the hall, looked at the nurses' station and down all the halls but he did not see anyone at all. He stated by this time his mom and the bed were saturated with urine. At 6:30 PM a different NA came by the room, and he stopped her and asked if she could provide incontinent care to Resident #206, which she did. Resident #206 stated that what her son had stated was correct, they didn't come after being asked several times.

An interview was conducted on 02/04/25 at 2:20 PM with Resident #206. She stated the Nursing Assistant (NA) was good today and had provided incontinent care like she should. She then stated on 01/31/25 she waited 1 hour and 30 minutes for the NA to come and change her and on 02/01/25 she waited 1 hour and 20 minutes to be changed. She explained that her family member timed the occurrences because no one would answer her call bell or respond to her family member's request for assistance needed. She also explained that she did not know the NAs name that assisted her, only that it was an African American female.

Multiple unsuccessful attempts were made to

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contact the Nursing Assistant that worked from 4:00 PM until 7:00 PM on 01/31/25 and from 3:00 PM until 7:00 PM on 02/01/25.

8. Resident #33 was admitted to the facility on 8/23/24 with diagnoses that included muscle weakness, and diabetes type 2.

The active care plan, last reviewed 9/6/24, included a focus area for Activities of Daily Living (ADLs) self-care performance deficit related to activity intolerance, impaired balance and is at risk for further decline. The interventions included one person assistance for bathing/showering and personal hygiene. The care plan did not include any refusals of nail care.

A quarterly Minimum Data Set (MDS) assessment dated 11/30/24 indicated Resident #33 was cognitively intact and was dependent on staff for bathing and personal hygiene.

A review of Resident #33's nursing progress notes from 2/1/24 to 2/2/25 revealed no refusals of nail care documented.

A review of the Nurse Aide (NA) shower sheets for December 2024 to February 2025 revealed that nails were cleaned but not cut. A shower sheet dated 2/1/25 indicated that Resident #33's nails were cleaned.

On 2/2/25 at 11:10 AM, an interview and observation were conducted with Resident #33. A dark substance was present under the nails to both hands and jagged nails were observed to the third and fourth finger on the right hand. Resident #33 explained that he was not able to see very well and relied on others to care for his

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fingernails. He stated that occasionally a nurse came by to cut his fingernails.

An observation occurred on 2/3/25 at 11:33 AM while Resident #33 was lying in bed. A dark substance was present under the nails to both hands and jagged nails were observed on the third and fourth fingers of the right hand.

A phone interview occurred on 2/4/25 at 1:02 PM with NA #7. She was assigned to care for Resident #33 on 2/1/25 and had indicated on the shower sheet that she had cleaned his fingernails. NA #7 explained that she provided Resident #33 with his scheduled shower on 2/1/25 and had used the "stick" to clean under his nails. She stated she observed the jagged nails and indicated she could have filed them but didn't stating, "Maybe I'll try that next time I see they are jagged". She was unsure if she had let the nurse know of the jagged fingernails.

A phone interview with a family member for Resident #33 was completed on 2/4/25 at 4:23 PM. She indicated that nail care was a concern when she visited, and she would often let staff know when she identified a dark substance under his fingernails or if they needed to be trimmed.

On 2/5/25 at 9:49 AM, NA #2 was interviewed and indicated when she provided personal care to Resident #33, she would use a washcloth to clean his fingernails but didn't cut them. She could not recall if she had noticed the jagged nails to his right hand when she had cared for him on 2/3/25.

Attempts were made to contact NA #3 on 2/4/25 and 2/5/25, who was assigned to care for

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Resident #33 on 2/2/25 during the 7:00 AM to 7:00 PM shift but were unsuccessful.

The Director of Nursing (DON) was interviewed on 2/4/25 at 10:00 AM and explained the NAs were to complete nail care during showers/baths, personal care and as needed. For diabetic residents, the NAs were able to clean and file fingernails and if they needed to be trimmed would need to let the nurse know.

On 2/4/25 at 10:33 AM, an interview occurred with the Infection Control nurse who explained that she randomly went throughout the facility checking fingernails and would clean, file and trim as needed at times. The Infection Control nurse stated that ultimately it was the responsibility of the NAs to perform nail care during personal care and baths.

On 2/4/25 at 10:39 AM, an observation was conducted of Resident #33's fingernails with the Infection Control Nurse. She confirmed they had a dark substance under the nails to both hands and there were 2 fingernails that were jagged on the right hand. Resident #33 agreed to let the nurse care for his fingernails.

Nurse #1 was interviewed on 2/4/25 at 12:50 PM. She worked in the facility as both the wound care nurse and a floor nurse when needed. She explained that nail care should be completed by the NAs during personal care and baths. They are to clean under the fingernails and file if uneven. If the resident was diabetic and needed their nails cut the NA would let the nurse know. She had not been made aware that Resident #33 had jagged fingernails on his right hand.

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F 677	Continued From page 52 Another interview was completed with the DON on 2/6/25 at 9:32 AM and stated Resident #33's jagged fingernails should have been reported to the nurse so they could have trimmed them. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.	F 677		
F 689 SS=D	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 observations, record review and staff interviews, the facility failed to maintain a safe environment as evidenced by a housekeeping staff member mopping the entire width of the F hallway (Rooms 135-146) which would have required residents, staff, and visitors to walk on the wet floor. This was for 1 out of 5 resident hallways. Findings included: A continuous observation was conducted on 02/03/25 from 10:30 AM until 10:35 AM of the Housekeeping Manager mopping the floor at the top of the F Hall and the hall area in front of the nurse's station. The Housekeeper Manager was actively mopping the area to the left then middle of hall. When asked if the floor was wet all the	F 689	1. Housekeeping Supervisor immediately educated the housekeeper who was mopping the floor in the hallway to only mop half of the hall to prevent falls and injuries then mop the other side when first half is dry applying wet floor signs to provide signage for wet floor on 2/3/25. 2. Housekeeping Supervisor will complete education on mopping the floor in the hallway to only mop half of the hall to prevent falls and injuries then mop the other side when first half is dry applying wet floor signs to provide signage for wet floor by 2/26/25. On 2/26/25, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee	3/5/25

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F 689	Continued From page 53 way across the hall, she stopped to let the surveyor walk through to the right side of the hall where there was a 2 foot area of dry floor. As soon as the surveyor walked through the area the Housekeeper Manager mopped the only dry area left. The total area was 4 foot (ft) x 10 ft. The floor was wet completely across the hall with the wet sign located in middle of walkway. An interview was conducted with the Housekeeping Manager on 02/03/25 at 10:40 AM. She stated she mops and assists with other housekeeping duties daily. She then stated she did mop completely across the hall/walk area but did not give a reason why. She explained that she normally mops half of the hall area at a time and will wait for that half to dry prior to mopping the other side. She further stated that waiting for the floor to completely dry before starting the other side prevents residents and staff from accidentally falling. An interview was conducted with Nurse #1 on 02/03/25 at 10:48 AM. She stated some housekeepers mop completely across the hall area and some only mop one side at a time. She verified the floor at the top of the F Hall and the hall area in front of the nurse's station were wet completely across. She explained that was why she walked around the other side of the nurse's station because she did not want to fall. An interview was conducted with the Housekeeping District Manager on 02/03/25 at 3:15 PM. He explained when housekeepers were mopping the halls they should be mopping half of the hall at a time. After one side was completely dry, they were to mop the opposite side. He stated this was to prevent anyone from falling. He	F 689	and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. 3. The Housekeeping Supervisor will educate any new employees the appropriate procedure when mopping floors by 2/26/25. The Executive Director will monitor housekeeping when mopping floors to ensure appropriate procedure is followed to prevent falls and injuries 3 times a week x 12 weeks. The Executive Director will review in QAPI monthly for 3 months. 4. The Executive Director will monitor housekeeping when mopping floors to ensure appropriate procedure is followed to prevent falls and injuries 3 times a week x 12 weeks. Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as indicated. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. 5. 03/05/2025	

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F 689	Continued From page 54 then stated all housekeeping staff have been educated and trained to mop the floors in that manner.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 2 residents reviewed for respiratory care (Resident #33). The findings included: Resident #33 was admitted to the facility on 8/23/24 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and congestive heart failure. Resident #33's active care plan, last reviewed 9/6/24, included a focus area for potential for altered respiratory status/difficulty breathing related to acute on chronic respiratory failure, COPD, history of bronchopneumonia and pleural effusion. One of the interventions included oxygen continuous at 4 liters per minute via nasal cannula.	F 695	1. The Unit Manager corrected the oxygen flow rate on the concentrator to 4 Liters as ordered by the Physician on 2/2/25 for resident #33. 2. The Director of Nursing and Unit Managers audited all residents who was ordered Oxygen to ensure it was being administered per Physicians orders on 2/2/25. There were no other deficiencies found. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice.	3/5/25

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F 695	Continued From page 55 Resident #33 was hospitalized from 10/3/24 to 10/11/24 for pneumonia. A review of the physician orders included an order dated 10/11/24 for oxygen continuously at 4 liters per minute for COPD. A quarterly Minimum Data Set (MDS) assessment dated 11/30/24 indicated Resident #33 was cognitively intact, displayed shortness of breath when lying flat and was coded with oxygen use. On 2/2/25 at 11:10 AM, Resident #33 was observed lying in bed with oxygen flowing via nasal cannula. The oxygen regulator on the concentrator was set at 3.5 liters flow when viewed horizontally at eye level. Resident #33 indicated he had very poor bad sight and relied on the nursing staff to ensure his oxygen was set at the correct amount. Resident #33 was observed lying in bed on 2/3/25 at 11:33 AM. The oxygen regulator on the concentrator was set at 3.5 liters flow by nasal cannula when viewed horizontally, eye level. The February 2025 Medication Administration Record (MAR) was reviewed and included Oxygen continuous at 4 liters per minutes every 12 hours to be checked at 9:00 AM and 9:00 PM. Staff had initialed Resident #33 as receiving oxygen as ordered on 2/2/25 and 2/3/25. An observation occurred of Resident #33 on 2/4/25 at 6:14 AM, which revealed the oxygen regulator on the concentrator was set at 3.5 liters flow by nasal cannula when viewed horizontally at eye level.	F 695	3. The Director of Nursing educated nursing staff to ensure oxygen is applied via nasal canula as ordered by the Physician on 2/2/25. The Director of Nursing will educate any new nurses upon hire on following Physicians orders when applying oxygen via nasal canula. The Director of Nursing and Unit Managers will audit all residents who have orders for Oxygen 3 times a week for 12 weeks to ensure the oxygen is being administered as ordered by the Physician. The Facility will review in QAPI monthly for 3 months. 4. The Director of Nursing and Unit Managers will audit all residents who have orders for Oxygen 3 times a week for 12 weeks to ensure the oxygen is being administered as ordered by the Physician. The Facility will bring to QAPI monthly for 3 months. The Facility will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	

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F 695	Continued From page 56 An observation was made with Nurse #1 of Resident #33's oxygen concentrator on 2/4/25 at 12:20 PM, who stated the oxygen regulator on the concentrator was set at 3.5 liters when viewed horizontally at eye level and looked to be set on 4 liters when standing over the concentrator. Nurse #1 adjusted the flow to administer 4 liters of oxygen. On 2/5/25 at 8:45 AM, Resident #33 was observed lying in his bed. The oxygen regulator on the concentrator was set at 3.5 liters flow by nasal cannula when viewed horizontally at eye level. The oxygen concentrator was not within reach of Resident #33. An observation was made with the Unit Manager on 2/5/25 at 11:33 AM of Resident #33's oxygen concentrator. She indicated that the oxygen regulator on the concentrator was set at 3.5 liters when viewed horizontally at eye level and looked to be set on 4 liters when standing over the concentrator. The Unit Manager adjusted the flow to administer 4 liters of oxygen and stated that staff should be setting the oxygen concentrators and ensuring they were on the ordered flow rate by looking at the oxygen regulator at eye level rather than standing over the concentrator. During an interview with the Director of Nursing on 2/6/25 at 9:32 AM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		3/5/25

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F 725	Continued From page 57 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, resident interviews, and resident family interviews, the facility failed to provide sufficient nursing staff to provide incontinence care in a manner to maintain the residents' dignity (Resident #1, #206, and #9) and failed to provide assistance with Activities of Daily Living (ADL) to residents who required extensive to total care with nail care and incontinence care (Residents #9, #32, #35, #51, #205, #1, #206, and #33). This affected 8 of 18 sampled residents reviewed for	F 725	1. All shifts will have adequate licensed and certified nursing coverage. Education was completed to nursing and administrative leadership to reinforce the importance of filling in for floor staff openings as licensure allows. The facility hired a full time staffing coordinator to be tasked with continuous responsibility for filling resident care needs sufficiently and adjusting as needs vary.	

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F 725	Continued From page 58 sufficient staffing. The findings included: This tag is cross-referred to: 1. F550: Based on record review, observations, resident, resident family, and staff interviews, the facility failed to provide incontinence care in a manner to maintain the residents' dignity for 3 of 5 residents reviewed for dignity (Residents #1, #206 ,and #9). 2. F677: Based on record reviews, observations, and family, resident, and staff interviews, the facility failed to provide nail care and/or incontinence care for 8 of 13 residents dependent on staff for activities of daily living (ADL) (Residents #9, #32, #35, #51, #205, #1, #206, and #33). Review of staff posting, assignment sheets, and the time cards revealed: On 01/12/25 there was 1 Nursing Assistant (NA) providing resident care from 3:40 PM until 7:00 PM for a census of 50 residents. On 01/27/25 there was 1 NA providing resident care from 4:00 PM until 7:00 PM for a census of 52 residents. On 01/30/25 there was no NA working the floor from 4:00 PM until 7:00 PM and 1 NA providing resident care from 7:00 PM until 11:00 PM for a census of 54 residents. On 01/31/25 there was 1 NA providing resident care from 4:00 PM until 11:00 PM and from 11:00	F 725	2. All residents have the potential to be affected by the deficient practice. Staffing was reviewed for all other days since 2/26/25 by the Executive Director and Director of Clinical Services, no other days were found to be without the appropriate licensed and certified nursing staff. All clinical staff re-educated on 2/24/25 regarding expectations for not leaving until replacement has arrived, and who to contact for call offs. On 2/24/25 the Social Worker conducted an interview with all residents with BIMS score of 13 and above concerning their care and staffing no complaints were made. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. The schedule is to be reviewed daily by the Executive Director, staffing coordinator and Director of Clinical Services to ensure adequate licensed nurses and certified nursing assistants coverage is available. A master schedule was created to ensure needs are being anticipated 2 weeks to a month in advance. The executive director will notify regional leadership in the event, there are unusual circumstances or fluctuations with staffing needs. Supplemental staffing, and bonuses will be made available to address staff shortages and management who are required to fill in for open availability. A wage analysis was also completed to ensure wages are competitive to retain	

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F 725	Continued From page 59 PM until 7:00 AM for a census of 54 residents. On 02/01/25 there was 1 NA providing resident care from 3:00 PM until 7:00 PM for a census of 54 residents. On 02/02/25 there was 1 NA providing resident care from 3:00 PM until 7:00 PM for a census of 54 residents. A phone interview was conducted on 02/05/25 at 10:40am with Nurse #2. She stated she hadn't been at the facility working for about a month. She explained when she started working at the facility it was on day shift however, about a month later she went to night shift because she was overwhelmed on day shift due to not having enough Nursing Assistants (NA) working. She further explained she was no longer a full-time employee, she only worked "as needed" because of her concerns with staffing. She went on to say when she worked 7:00 PM-7:00 AM there were nights, and could not recall how many, she would come in and there wouldn't be an NA until 11:00 PM. She indicated she would be over a medication aide, have her own medication cart to pass out medications, do blood sugars, and there were times the residents received incontinent care and/or were assisted to bed later than they should have. She went on to say she felt like there needed to be a plan in place when an NA wasn't coming to work, but the facility didn't have a plan when an NA was not going to come to work. She then stated the nurses assisted as much as they could, but they were trying to pass out medications. A phone interview was conducted on 02/05/25 at	F 725	and hire staff. Nurse managers will ensure nursing shifts are covered in the event of call off by following established protocol. The Director of Clinical Services has hired Certified Nursing Assistants and Medication Aides for day shift, 7a-7p and night shift, 7p-7a. Education was provided to the staff regarding call offs and how it affects the facility, the residents□, and their peers by the Director of Clinical Services on 2/24/25. The nursing staff was provided in-service on 2/18/25, 2/24/25, and 2/25/25 by the Infection Preventionist regarding providing effective incontinence care. Finally, department heads will be required to do room rounds every morning prior to the morning meeting as part of the audit process. Each assigned manager will be required to check into those rooms physically and ensure that residents had been cared for the day before. Any concerns will be brought to the morning meeting and addressed through the grievance process. Any trends will be brough to the monthly QAPI meeting for 3 months. 4. The executive director, and DCS will monitor performance through the daily morning meeting. They will discuss daily staff needs, fluctuations and schedule changes. Daily schedules will be reviewed, and staff will be assigned based on census needs. Management will fill in for any gaps to ensure resident care	

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F 725	Continued From page 60 06:09 PM Nursing Assistant (NA) #8. She stated she normally worked 7:00 PM-7:00 AM and she had to work the whole building by herself two to three times a week. She also stated it was not possible to keep every person dry when working by herself or conduct routine rounds and provide incontinent care at least every two hours. She further explained some nurses would assist, and some wouldn't. She concluded the interview by stating, you just can't operate a building like that. An interview was conducted on 02/06/25 at 9:01 AM with Nursing Assistant (NA) #6. She stated she had worked at the facility for 9 years and she had never seen staffing as bad as it was over the past three to four months. She explained she worked all shifts but at times when she would come in at 11:00 PM there would not be any NAs in the building, and she would normally have to work by herself on the night shift. She indicated there was one nurse, a med aide and herself on night shift. She further explained there was no way to keep all of the residents dry and do all of the required tasks when there were only 2 NAs on first shift or 1 NA at any time. She went on to say the census was normally above 50 residents. An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing (DON). She stated staffing was hard, she had requested to use an agency, and to give bonuses to the staff that did come in and work extra. However, she explained both requests had to be approved by corporate and they had not approved the facility to use agency. She explained qualified department heads would assist the NAs when they were short staffed to ensure the residents	F 725	needs are being met. Finally, the results of the daily room rounds audits will be discussed during that meeting and resident care concerns can be addressed immediately, with the overseeing department head present. In addition to the daily room round audit for dept heads, the Administrator will audit 3 random alert and oriented residents weekly x 4 weeks and monthly x 3 months to ensure they are being cared for. Any findings will be reviewed during monthly QAPI meeting for 3 months 5. 03/05/2025	

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F 725	Continued From page 61 were fed and provided with incontinent care. She also stated she expected all residents to be fed and provided incontinent care timely. She explained on the day shifts when there were 2 NAs scheduled it was not possible to complete all showers and tasks. She verified the staffing numbers on 01/12/25, 01/27/25, 01/30/25, 01/31/25, 02/01/25, and 02/02/25 were correct.	F 725		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, and staff, and family interviews and record review, the facility failed to serve the lunch meal at the posted time on 2/2/25 as well as failed to serve the breakfast meal at the posted time on 2/3/25 for 2 of 5 meal	F 809	1. The Regional Dietary Manager educated the dietary staff on appropriate mealtimes on 2/2/25 to ensure meals are served timely and consistent.	3/5/25

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F 809	Continued From page 62 observations. This practice had the potential to affect other residents for meal delivery. The findings included: An observation was completed on 2/2/25 at 11:30 AM of the area outside of the main dining room. A meal schedule was posted as follows: -Breakfast 7:15 AM to 8:10 AM -Lunch 12:00 PM to 12:45 PM -Dinner 5:15 PM to 6:10 PM 1. On 2/2/25 at 12:30 PM four residents were observed waiting in the dining room for their lunch to be served. The Administrator was noted to be walking around the area assuring the residents their meals were due out soon. Lunch trays were served to the residents in the dining room beginning at 1:28 PM. On 2/2/25 at 12:45 PM the Regional Dietary Manager provided a copy of the facility's meal delivery log. The meal delivery log indicated that lunch was scheduled to be served in the dining room at 12:00 PM. a. Resident #206 was admitted to the facility on 1/30/25. The quarterly Minimum Data Set was in progress. Family member #1 was interviewed on 2/2/25 at 12:50 PM, and he stated that one of Resident #206's family members was always at the facility for mealtimes. He stated supper was served 1.5 hours late on 1/31/25 and lunch was served late on 2/2/25. He stated it was hard to encourage Resident #206 to eat without knowing when meals would be delivered.	F 809	2. The Director of Nursing audited breakfast, lunch, and dinner times for 3 days to ensure meals were provided timely by 2/6/25. There were no other deficiencies found. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. All dietary staff was educated on 2/2/25 the appropriate mealtimes. Any new dietary staff will be educated on hire the appropriate meals times. Any new dietary staff will be educated on hire the appropriate meals times. The Executive Director will monitor 3 meals a week x 12 weeks to ensure meals are served timely. The Executive Director will review in QAPI monthly for 3 months. 4. The Executive Director will monitor 3 meals a week x 12 weeks to ensure meals are served timely. The Facility will bring to QAPI monthly for 3 months. The Facility will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated.	

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F 809	Continued From page 63 On 2/2/25 at 1:00 PM Resident #206's Family Member #1 was heard in the hallway asking staff why the resident's lunch tray had not been delivered yet. He stated Resident #206 had waited a long time for her meal, and she was hungry. Staff stated that trays were due to come out soon. The first cart to leave the kitchen for lunch service on 2/2/25 was 1:28 PM. The meal cart was observed to be delivered to the F hall where Resident #206 resided at 2:00 PM. Lunch was scheduled to be delivered to the F hall by 12:45 PM. The Regional Dietary Manager was interviewed on 2/2/25 at 2:35 PM. He indicated that a staff member called out that day without letting the manager know. He further stated that one of the meals got dropped during lunch service and had to be redone causing a delay. According to Dietary Aide #1 who was interviewed on 2/2/25 at 2:43 PM, the dietary staff was not usually behind with meal delivery. She indicated that lunch trays were typically out by 11:30 AM. She stated that the State surveyors being in the kitchen delayed them that day. Dietary Aide #1 stated the kitchen was short staffed due to a call out that morning. She stated that they typically have three staff members in the mornings to help with meal service. She further stated that a tray had been dropped causing the staff to prepare a new entrée for lunch. On 2/2/25 at 2:47 PM the new Dietary Manager was interviewed. She stated that the dietary staff called her that morning to let her know she	F 809	5. 03/05/2025	

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F 809	Continued From page 64	F 809		

needed to buy bread. She stated that when she arrived at the facility, she then had to redo the meal tickets, and that threw the kitchen off on meal delivery.

2. An observation of the breakfast meal service on 2/3/25 beginning at 7:15 AM revealed the Dietary Manager (DM) was recording the temperature of food items. The pureed eggs and ground sausage were below the holding temperature, and the DM had to place the food back in the oven to bring to up to serving temperature. The plating of food by dietary staff did not begin until 7:40 AM. The first meal cart left the kitchen at 7:50 AM. Breakfast trays were scheduled to be delivered beginning at 7:15 AM.

An interview was completed on 2/3/25 at 8:35 AM with the Dietary Manager. She stated that breakfast service was late that morning in part because of training a new cook as well as having one staff member call out. She indicated that due to some foods not being at the proper temperature for serving, the ground sausage and pureed eggs, she had to put them back in the warming oven to get the food to the correct temperature causing a further delay in serving breakfast. The Dietary Manager stated staff will say they will work then fail to show up for work.

An interview was completed on 2/3/25 at 2:46 PM with the District Dietary Manager. He stated that due to the former Dietary Manager walking out on 1/31/25 and staff calling out that mealtimes were delayed on 2/2/25 and 2/3/25. He stated that the new Dietary Manager began working on 2/3/25 as well as a new dietary staff member, and he felt the service would improve with additional staff on board.

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F 809	Continued From page 65 The Director of Nursing was interviewed on 2/6/25 at 10:01 AM. She stated that dietary had hired new staff, and she expected mealtimes to get better.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, date and remove expired food items stored for use and remove food with signs of spoilage from 1 of 1 walk-in refrigerator and failed to ensure frozen food items were dated and not stored open to air with signs of freezer burn in 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents.	F 812	1. The food that was not labeled properly, the out-of-date food, the food with signs of spoilage, frozen food items that were not dated and food that was stored open to air that had signs of freezer burn were all removed from the walk-in freezer on 2/2/25.	3/5/25

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F 812	Continued From page 66 The findings included: Accompanied by Dietary Aide #1, an observation was made of the walk-in refrigerator on 2/2/25 at 10:46 AM. The following items were stored in the refrigerator: -One undated box of butter that was open and partially used -One undated bag of mozzarella cheese that was open and partially used -One undated box of mozzarella cheese that was open and partially used -One open and partially used container of sour cream dated 12/31/24 -One box of parmesan cheese opened and dated 12/31/24 -One undated metal baking pan of gelatin dessert covered with aluminum foil with a frozen white substance on top of the foil -One box of 12 cucumbers with white fuzzy spots -One plastic container of honey opened and undated -One bottle of lemon juice opened and undated An observation of the walk-in freezer revealed the following stored items: -One box of frozen carrots opened and undated -One bag of shrimp undated -One bag of toast undated -One box western style beef patties unwrapped and open to air with ice crystals on them On 2/2/25 at 10:46 AM Dietary Aide #1 was interviewed. She stated that the former Dietary Manager (DM) walked out without notice this past Friday, 1/31/25. She indicated that the DM was the one responsible for dating food and disposing of outdated food kept in storage. Dietary Aide #1 stated a new DM would begin working on 2/3/24.	F 812	2. All dietary staff was educated on 2/2/25 the policy and procedure on how to store food, when to remove food from the walk-in freezer, and labeling food before placing in walk in freezer by the Regional Dietary Manager. Any new dietary staff will be educated on hire the regulations to store food, label food, how long to keep food in the walk-in freezer, and when to remove food from the walk-in freezer. The Dietary Manager audited all food in the walk-in freezer on 2/2/25. There were no other deficiencies found. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/26/25 to formulate and approve a plan of correction for the deficient practice. 3. Any new dietary staff will be educated on hire the regulations to store food, label food, how long to keep food in the walk-in freezer, and when to remove food from the walk-in freezer. All dietary staff was educated on policy and procedure how to store food and properly label and date food on 2/2/25. The Executive Director will audit walk in freezer weekly to ensure all food is labeled, dated, not expired, and there is no freezer burned food for 12 weeks. The Executive Director will review in QAPI monthly for 3 months.	

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F 812	Continued From page 67 Cook #1 was also interviewed on 2/2/25 at 11:15 AM. He stated that the dietary department was short staffed that day due to a call out. He stated that the Dietary Manager usually made sure the food was dated and stored correctly. The District Dietary Manager was interviewed on 2/2/25 at 12:45 PM. He stated that the former Dietary Manager had walked out this past Friday, 1/31/25. He indicated that he had spoken with the dietary staff this past Friday, 1/31/25, regarding the need to date food.	F 812	4. The Executive Director will audit walk in freezer weekly to ensure all food is labeled, dated, not expired, and there is no freezer burned food for 12 weeks. The Facility will bring to QAPI monthly for 3 months. The Facility will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated. 5. 03/05/2025	