STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

(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 3/3/25 through 3/6/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YFDW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/3/25 through 3/6/25. Event ID# YFDW11. The following intakes were investigated: NC00213073, NC00223997, NC00212459, NC00222986, NC00220227, NC00219606, NC00215801, NC00214049, NC00220722, NC00213036, NC00220103, and NC00219259. 2 of the 35 complaint allegations resulted in deficiency.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		3/29/25

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

Electronically Signed | 03/28/2025

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F 655	Continued From page 1 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to develop an accurate baseline care plan for a resident (Resident #303) when the care plan did not include the indwelling catheter that was present on admission for Resident #303. This deficient practice occurred for 1 of 2 residents reviewed for baseline care plans. Findings included:	F 655	1. The Baseline Care Plan to include the indwelling catheter for Resident # 303 was updated and completed on 3/7/2025 and reviewed with the Resident. 2. The Baseline Care Plans for Residents admitted withing the previous 30 days on were reviewed on 3/10/2025 and found to be complete. 3. The Director of Nursing/Designee	

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F 655	Continued From page 2 Resident #303 was admitted to the facility on 2/28/25. An admission nursing assessment dated 2/28/25 completed by Nurse #1 documented under the section genitourinary, a catheter was used. The admission Minimum Data Set assessment had not been completed yet. A baseline care plan dated 2/28/25 was not marked for an indwelling catheter. An observation was conducted on 3/3/25 at 11:20 AM of Resident #303 in her room in bed with an indwelling catheter draining to a bedside drainage bag. An order dated 3/4/25 read, [indwelling] urinary catheter 14 french with 10 milliliter (ml) balloon. An interview was conducted on 3/6/25 at 10:07 AM with Nurse #1. She recalled completing Resident #303's admission on 2/28/25 and that Resident #303 had an indwelling catheter on admission. Nurse #1 stated she should have put the indwelling catheter for Resident #303 on the baseline care plan but had missed it. An interview was conducted with the Minimum Data Set (MDS) Nurse on 3/6/25 at 9:57 AM. She explained baseline care plans were completed by the admitting nurse. The MDS Nurse stated an indwelling catheter should be included in the baseline care plan. She stated she did not typically review the baseline care plans. The MDS nurse was not sure what the process was for reviewing the baseline line care plan for completion and accuracy and deferred to the	F 655	provided education to the nurses on 3/10-3/11/2025 stressing the importance of the 48-hour time frame for developing the Baseline Care Plan and its importance to good outcomes for the Residents. Emphasis was placed on including indwelling catheters in the care plans as indicated. The education packet will be placed into the staff in-service education book and will be included in new hire orientation for nurses. The baseline care plan corrective action will be monitored by Nursing Leadership for new admissions weekly for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Director of Nursing/designee will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial compliance: 03/29/2025	

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F 655	Continued From page 3 Director of Nursing (DON). An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. She explained the baseline care plan was done by the admitting nurse on admission. She stated the indwelling catheter for Resident #303 should have been on the care plan but it was missed. The DON said after the baseline care plan was completed by the admitting nurse, the care plan went to medical records and was scanned into the resident's electronic medical record. The DON reported she did not review baseline care plans. The DON said there was not a current process for reviewing baseline care plans for completion and accuracy. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator stated the baseline care plan should have included Resident #303's indwelling catheter and that it had been missed.	F 655		
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	F 656		3/29/25

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F 656	Continued From page 4 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 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 accurate comprehensive care plan for a resident (Resident #10) when the care plan did not include a plan of care for pain. This deficient practice occurred for 1 of 1 resident reviewed for pain.	F 656	1. The Pain Management care plan for Resident #10 was completed on 3/6/2025. 2. Resident care plans were reviewed by the Director of Nursing/Designee on 03/12/2025 to ensure a comprehensive approach was initiated; the focus was on	

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F 656	Continued From page 5 Findings included: Resident #10 was admitted to the facility on 2/8/25 with the following diagnoses: unspecified fracture of shaft of left femur, unspecified fracture of upper end of left humerus. The admission Minimum Data Set (MDS) assessment dated 2/11/25 indicated Resident #10 was cognitively intact. The MDS documented that she had moderate pain, at a frequency of almost constantly, and she received as needed (PRN) pain medication. The MDS further documented that she received an opioid medication. The Care Area Assessment 2/11/25 revealed Resident #10 had triggered for pain and indicated she should be care planned for pain. A physician order dated 2/13/25 read, oxycodone (pain medication) 5 milligrams (mg) oral tablet, give 2.5 mg by mouth every eight hours as needed for pain. Resident #10's care plans last reviewed on 3/3/25 did not include a care area for pain. An interview was conducted with the Minimum Data Set (MDS) nurse on 3/6/25 at 9:57 AM. The MDS nurse said Resident #10's care plan should have included pain. She explained Resident #10 had triggered for pain on the Care Area Assessment when she had completed her admission MDS. The MDS nurse further explained she had started a care plan for pain for Resident #10 but had never clicked the finish button. The MDS nurse said it was an oversight, and it had been missed.	F 656	care plans specific to Pain Management as well as timely completion of the care plan. 3. The Regional Minimum Data Set Director provided education for the Minimum Data Set nurses on 3/17/2025. The education on care plans will be provided to new licensed staff as indicated. Residents needing a Pain Management Care plan as determined by the interdisciplinary team will be monitored weekly for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Regional Minimum Data Set Director/designee will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial compliance: 03/29/2025	

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F 656	Continued From page 6 An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. She said Resident #10's care plan should have included pain and that it had been missed by the MDS nurse. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator stated Resident #10 should have been care planned for pain and it had just been missed.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and Wound Care Nurse Practitioner (NP) interviews, the facility failed to assess for and identify a pressure ulcer on the buttock before it was assessed as a stage III (full-thickness loss of skin) for 1 of 2 residents (Resident #10) reviewed for pressure ulcers.	F 686	1. Resident #10 had a skin assessment completed on 03/07/2025. 2. Current residents in the facility had skin assessments reviewed by the Director of Nursing for completeness on 03/19/2025.	3/29/25

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F 686	Continued From page 7 Findings included: The hospital discharge summary dated 2/7/25 indicated Resident #10 was admitted to the hospital with a left femur fracture and had a surgical procedure to repair her left femur fracture on 2/4/25. The discharge summary reported an x-ray was completed on 2/4/25 that showed a humerus fracture. The discharge summary indicated she had surgical incisions to her left lower extremity. The discharge summary did not mention any other wounds or skin abnormalities. Resident #10 was admitted to the facility on 2/8/25 with the following diagnoses: unspecified fracture of shaft of left femur, unspecified fracture of upper end of left humerus, and impaired mobility. The admission nursing assessment dated 2/8/25 documented a stage I pressure area to the coccyx and bruising to her left upper/ lower extremities. The treatment administration record (TAR) for February 2025 and revealed there were no treatment orders for a stage I pressure ulcer to the coccyx. A Braden scale assessment (assessment for predicting pressure ulcer risk) dated 2/9/25 indicated Resident #10 was low risk for developing pressure ulcers. The admission Minimum Data Set (MDS) assessment dated 2/11/25 indicated Resident #10 was cognitively intact. The MDS documented she was at risk of developing a pressure ulcer.	F 686	3. Upon admission/readmission, the Director of Nursing/designee will add the skin assessments to the MAR based on the UDA (user Defined Assessment) which will trigger the weekly skin assessments to be completed by the nursing staff. During the clinical team meeting, the Director of Nursing/designee will be reviewing the UDA for scheduling and completion of the skin assessments. The Director of Nursing/Designee provided education to the nurses and Certified Nursing Assistants on 3/10-3/11/2025 stressing the importance of the admission assessment as it pertains to skin and the importance of accurate wound location and description(s). Also, the Director of Nursing/Designee provided education on 3/10/2025-3/11/2025 to the nurses regarding the weekly skin assessments being on the MAR and the need for weekly skin assessments to be completed as written. The education packet(s) will be placed into the staff in-service education book and will be included in new hire orientation. The Director of Nursing/Designee will monitor weekly skin assessment scheduling and completion for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Director of Nursing/designee will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the	

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F 686	Continued From page 8 The MDS documented that she had a surgical wound but that she did not have a pressure ulcer. The MDS further documented that she was not receiving any skin or ulcer treatments. An order entered by Unit Manager (UM) #1 was dated 2/11/25 and read: weekly skin integrity review every evening shift every Tuesday, Friday for monitoring skin. A review of Resident #10's electronic medical record revealed weekly skin assessments had not been completed since her admission. There were no skin assessments documented for the weeks of 2/11/25, 2/18/25, or 2/25/25. An interview was conducted with UM #1 on 3/4/25 at 1:57 PM. UM#1 recalled she entered the order for Resident #10's weekly skin assessments. UM #1 reviewed the order and reported the order had been put in wrong. UM #1 explained because the order was put in wrong it would not pull to the medication administration record (MAR) for the nurses to see and the nurses would not know they needed do the skin assessment. UM #1 said weekly skin assessments were supposed to be completed weekly not twice weekly. She said Resident #10 had changed rooms and when she moved rooms the skin assessment day for the new room was added to the order, but the prior rooms skin assessment day was not removed from the order. A telephone interview was conducted with NA #3 on 3/5/25 at 3:37 PM. She recalled being assigned to care for Resident #10. She reported she remembered seeing a wound to Resident #10's buttocks. She said it was one of the days when she had been assigned to work on E hall,	F 686	plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial complaince:03/29/2025	

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where Resident #10 resided on 2/20/25 or 2/21/25. NA #3 remembered Resident #10 had a "skin tear" she thought it was on her right buttock cheek but said it could have been on the left side. She stated she had talked to the Wound Care Nurse about it. NA #3 explained the Wound Care Nurse had told her she already knew about the area and told her to "put zinc on it". NA #3 said she had gone into Resident #10's room with the Wound Care Nurse to roll Resident #10 so the Wound Care Nurse could look at the wound. NA #3 recalled she had also been working on 2/25/25 and had helped on E hall that day, but said it was before that day when she had reported the area to Resident #10's buttocks and had gone into Resident #10's room with the Wound Care Nurse to look at the wound with her.

A telephone interview was conducted with NA #2 on 3/5/25 at 3:44 PM. She recalled being assigned to care to Resident #10 on 2/16/25, 2/18/25 and 2/24/25 day shift (7a-3pm). She reported she did not remember seeing any wounds to her buttocks when she assisted her with incontinent care. She reported Resident #10 sometimes did not want to do things like get out of bed or turn/ reposition.

An interview was conducted with the Wound Care Nurse on 3/6/25 at 10:30 AM. The Wound Care Nurse reported a wound to Resident #10's buttocks was not reported to her by NA #3 on 2/20/25 or 2/21/25. She did not recall telling NA #3 to put zinc on a wound to Resident #10's buttocks. She said the wound to Resident #10's buttocks had been reported to her on 2/25/25 by the Physical Therapist.

The Physical Therapist was unavailable to be

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interviewed.

A change of condition situation background assessment and recommendations (SBAR) note completed by the Wound Care Nurse was dated 2/25/25. The note indicated Resident #10 had an open area to her buttocks.

An interview was conducted with the Wound Care Nurse on 3/4/25 at 1:54 PM. The Wound Care Nurse explained Resident #10's pressure ulcer was found last week on 2/25/25 and was a stage 3 pressure ulcer when it had been found. The Wound Care Nurse explained she thought skin assessments were supposed to be completed twice a week for residents. The Wound Care Nurse further explained there was an order entered into the electronic computer system for the resident's skin assessment so it would populate and pull to the MAR for the nurses to see. She stated the order was the trigger for nurses to know they needed to go and do the skin assessment. The Wound Care Nurse reviewed the order for Resident #10's skin assessment and said the order had been entered incorrectly. She said the order was not put in to pull to the MAR and because the order did not show up on the MAR the nurses would not have known they needed to do the skin assessment for Resident #10. The Wound Care Nurse reported the skin assessment was separate from the daily skilled nursing note and was not included in the daily skilled nursing note. The Wound Care Nurse verbalized the non-pressure ulcer skin condition assessment was a monitoring tool used to monitor wounds such as surgical wounds. The Wound Care Nurse reported Resident #10 was already being followed by the Wound Care NP for her surgical wound and that when the stage 3

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pressure ulcer had been found Resident #10 was seen by the Wound Care NP for evaluation of her pressure ulcer. The Wound Care Nurse recalled Resident #10 had a stage 1 pressure ulcer documented to her coccyx on the admission assessment but reported she had looked at Resident #10's skin to her buttocks a couple of days after her admission and had not seen a wound to her buttocks. She said, even if Resident #10 had a stage 1 pressure ulcer to her coccyx on admission that it would be different because her stage 3 pressure ulcer was to her left buttocks not her coccyx. The Wound Care Nurse stated she thought the pressure ulcer to Resident #10's buttocks would have probably been identified and found before it was a stage 3 pressure ulcer if weekly skin assessments had been completed.

A review of Resident #10's electronic medical record revealed she had an order dated 2/27/25 for an air mattress to promote offloading.

A care plan with an initiation date of 2/28/25 and last revised on 3/3/25 was present for potential for impairment to skin integrity related to incontinence, impaired bed mobility, and risk for skin breakdown. The care plan included Resident #10 had a stage 3 pressure wound to her left buttocks. The care plan interventions included: air mattress as ordered, assist to turn/ reposition in bed frequently, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, encourage good nutrition and hydration, incontinence care as ordered, monitor/ document location, size and treatment of skin injury.

An interview and observation was completed of

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Resident #10 on 3/3/25 at 2:17 PM. Resident #10 was observed sitting up in her wheelchair. A pressure reduction cushion was observed in the seat of her wheelchair and an air mattress was in place to her bed. Resident #10 said she had a wound to her buttocks that had developed after admission, she did not recall exactly when the wound had developed. She stated the facility was treating the wound to her buttocks and it was getting better. She reported that staff assisted her with turning/ repositioning frequently and assisted her with incontinent care when needed.

A progress note dated 3/4/25 by the by the Register Dietician (RD) indicated Resident #10 was seen on 3/4/25 and Prostat (protein supplement) 30 milliliters daily was added to aid wound healing. The RD note indicated her weights were being monitored and the RD would continue to follow her due to her wound.

An interview was conducted with Nurse #2 on 3/4/25 at 1:30 PM. Nurse #2 explained skin assessments for residents were supposed to be completed weekly. She further explained that the weekly skin assessment was separate and different than daily skill nursing notes and that a skin assessment was not part of the daily skilled nursing note. Nurse #2 reported she knew when she needed to complete a weekly skin assessment because it would pop up on the MAR to indicate the assessment needed to be completed. Nurse #1 said she only did assessments if the assessment was on the MAR to complete it. She explained if a weekly skin assessment did not show up on the MAR then she would not know it needed to be completed.

An observation of Resident #10's wound was

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conducted on 3/5/25 at 9:30 AM with the Wound Care NP. The Stage III pressure ulcer to Resident #10's left buttocks was assessed and measured by the Wound Care NP. The wound measured 1.1 x 1.3 x 0.2 centimeters (cm), the wound bed was red/ pink in color with 60 % granulation (new tissue growth) and 40 % intact tissue, there was no odor, no slough (material that overlays the wound bed and can hinder healing), no drainage, and no signs/ symptoms of infection.

An interview was conducted with the Wound Care NP on 3/5/25 at 9:33 AM. The Wound Care NP explained Resident #10's wound had improved and was healing. She said Resident #10's pressure ulcer had been full thickness when she originally saw it. The Wound Care NP reported Resident #10 had areas of hyperpigmentation (discoloration) to her buttocks that was evidence she had prior wounds to other areas of her buttocks in the past and that there could have possibly been a prior wound to the area where the stage III pressure ulcer was located. The Wound Care NP explained she had no indication for sure that there was a prior wound to the area or what the wound was if there had been one there and so she had classified Resident #10's wound as a stage III pressure ulcer. She explained the wound to resident #10's left buttocks could not be the stage I area to the coccyx identified on the admission assessment, she said that it was a different location. The Wound Care NP said skin assessments were important to identify new skin impairments. She stated she could not say if Resident #10's pressure ulcer could have been identified earlier before it was a stage III because of evidence there may have been a wound prior to that area. The Wound Care NP verbalized she could not

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F 686	Continued From page 14 say how fast a stage III pressure ulcer wound could develop. She explained how fast a wound developed was individualized and based on risk factors such as age, debility, mobility, nutrition. She reported the Braden scale assessment was one of the most common standardized tools used to identify the risk of pressure ulcer development and that there was a correlation with individuals who developed pressure ulcers and the Braden score. An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. The DON said she was aware of Resident #10's left buttocks stage III pressure ulcer. The DON stated she was not aware Resident #10 had not had skin assessments completed since her admission. The DON reported skin assessments were supposed to be completed weekly. She explained the nurses would not have known to do the skin assessments for Resident #10 because the order had been put in wrong and did not pull to the MAR for them to see. The DON explained skin assessments were important to identify new skin issues. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator reported the purpose of skin assessments was to determine skin integrity. The Administrator stated Resident #10's skin assessments were probably missed because it did not show up on the MAR to trigger the nurses to do the assessment. .	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		3/29/25

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F 690	Continued From page 15 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 690	1. The indwelling catheter for Resident	

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F 690	Continued From page 16 and Nurse Practitioner (NP) interviews, the facility failed to ensure the resident had medical diagnoses to support an indwelling urinary catheter and to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 1 resident reviewed with a urinary catheter (Resident #303). Findings included: Resident #303 was admitted to the facility on 2/28/25 with diagnoses that included atrial fibrillation and chronic obstructive pulmonary disease (COPD). A discharge summary dated 2/28/25 did not include information or an indication for Resident #303's indwelling catheter. An admission nursing assessment dated 2/28/25 completed by Nurse #1 documented under the section genitourinary, a (urinary) catheter was used. The admission Minimum Data Set assessment had not been completed yet. A baseline care plan dated 2/28/25 was not marked for an indwelling catheter. An order dated 3/4/25 read, [indwelling] urinary catheter The order did not include a diagnosis or indication of use for the catheter. a. An interview was conducted on 3/3/20 at 11:20 AM with Resident #303. She stated she did not have an indwelling urinary catheter before she went to the hospital. She did not know why she had the indwelling urinary catheter.	F 690	#303 was removed on 3/25/25. Attempts were made to remove the catheter on 3/21/25 however the Resident refused the removal of the catheter. Resident had her catheter bag and tubing secured to the bed and not on the floor effective 03/06/2025. 2. Current residents were assessed for indwelling catheter(s) to include a supporting medical diagnosis for the indwelling catheter and to ensure the bag/tubing are not on the floor on 03/10/2025. 3. The Mock Survey teams and Grand Rounds team will monitor those Residents with an indwelling catheter to ensure placement of the catheter bag is not on the floor. Inconsistencies will be reported to the Director of Nursing/designee. The Director of Nursing/Designee provided education to the licensed nurses on obtaining a supporting medical diagnosis for indwelling catheter use on 03/10-3/11/2025. The Director of Nursing/Designee provided education to the licensed nurses and certified nursing assistances to ensure indwelling catheter bags and tubing are not touching the floor on 3/10-3/11/2025. The education packet will be placed into the staff in-service education book and will be included in new hire orientation. Newly admitted Residents and readmitted Residents will be monitored for indwelling catheters and supporting diagnosis(es) as well as catheter bag placement to ensure the catheter bag is not on the floor, weekly for	

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F 690	Continued From page 17 Further review of Resident #303's medical record revealed there was no indication or diagnosis for her indwelling urinary catheter. An interview was conducted with the Nurse Practitioner (NP) on 3/6/25 at 10:50 AM. The NP reviewed Resident #303's electronic medical record and reported she did not see an indication for her indwelling urinary catheter. She stated there should be a diagnosis for an indwelling catheter to specify why it was needed. The NP explained indwelling catheters should be removed as soon as possible when there was not a clear indication for use. She further explained, an indwelling catheter was an indwelling device and increased the risk of developing an infection. An interview was conducted with the DON on 3/6/25 at 11:27 AM. The DON stated Resident #303 should have a diagnosis that supported why she needed an indwelling catheter. The DON explained Resident #303's catheter being reviewed to ensure there was a diagnosis, had been missed. The DON said an indwelling catheter being left in place increased the risk of infection. An interview was conducted with the Administrator on 3/6/25 at 4:55 PM. The Administrator said there should be an indication for an indwelling catheter, and catheters should be removed if there was not one. She said an indwelling catheter was an indwelling device and increased an individual's risk of developing an urinary tract infection b. An observation was conducted on 3/3/25 at 11:20 AM of Resident #303 in her room in bed.	F 690	12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Director of Nursing/Designee will present the monitoring plan to the Quality Assurance Committee on 03/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial compliance:03/29/2025	

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She was observed to have an indwelling urinary catheter draining to a bedside drainage bag. The bedside drainage bag and tubing was observed on the floor under the bed.

A follow up observation was conducted on 3/3/25 at 3:03 PM of Resident #303's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame.

An additional observation was conducted on 3/6/25 at 9:14 AM of Resident #303 in her room resting in bed. Her indwelling urinary catheter was observed draining to a bedside drainage bag. The urinary catheter drainage bag and tubing was resting on the floor under the bed.

An interview was conducted with Nurse #1 on 3/6/25 at 10:07 AM. She was not aware Resident #303's catheter drainage bag and tubing was on the floor. Nurse #1 said catheter bags and tubing should not be on the floor because of contamination and infection risk.

An interview was conducted with Nurse Aide (NA) #1 at 10:27 AM. NA #1 stated she had gone into Resident #303's room this morning to deliver her breakfast tray. She explained she had not seen the urinary catheter drainage bag or tubing on the floor. NA #1 reported catheter bags and tubing should not be on the floor because it was unsanitary and increased the risk of infection. NA #1 said catheter bags were supposed to be positioned below the level of the bladder and hung on the bed frame rail.

An interview was conducted with the Director of Nursing on 3/6/25 at 11:27 AM. The DON stated

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F 690	Continued From page 19 urinary catheter bags and tubing should be kept off the floor to prevent infection. The DON explained the urinary catheter bag should be hung on the side of the bed below the level of the bladder when a resident was in bed. An interview was conducted with the Administrator on 3/6/25 at 4:55 AM. The Administrator reported urinary catheter drainage bags and tubing should not be on the floor for infection control reasons, it could leak, or someone could step on it.	F 690		
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 observations, record review, and resident, and staff interviews, the facility failed to ensure that oxygen air filters were present, clean, and without dust for 2 of 3 residents reviewed for respiratory care (Resident #25 and Resident #78). The findings included: 1. Resident #25 was admitted to the facility on 04/16/2024 with diagnoses of chronic respiratory failure.	F 695	1. Oxygen concentrator for resident #25 was replaced on 03/07/2025. Oxygen concentrator air filter for resident #78 was replaced on 03/7/2025. 2. A audit was completed by the Director of Nursing to inspect that air filters were in-place and clean for current oxygen concentrators in use on 3/10/2025. 3. The task for monitoring and cleaning these filters has been added to the TELS	3/29/25

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F 695	Continued From page 20 Review of a significant change Minimum Data Set (MDS) assessment dated 02/18/2025 revealed that Resident #25's cognition was moderately impaired. A review of physician orders dated 03/03/2025 at 7:00 AM revealed an order for continuous oxygen at 2 liters per minute via nasal cannula every shift. An observation conducted on 03/03/2025 at 1:08 PM, Resident #25 was observed lying in bed with his head of bed elevated. His oxygen cannula was in place to both nostrils with an oxygen setting of 2 liters per minute. The oxygen concentrator had a place for an oxygen air filter, and it was noted that the filter was missing as was the filter cover. An observation conducted on 03/04/2025 at 10:10 AM, Resident #25 was lying in bed with his head of bed elevated. A nasal cannula was attached to an oxygen concentrator that did not have an oxygen air filter or filter cover, and the oxygen was set to deliver 2 liters per minute. An observation was conducted on 03/05/25 at 8:33 AM, Resident #25 was observed lying in bed with oxygen in use at 2 liters per minute. There was no oxygen air filter or filter cover observed on the resident's oxygen concentrator. An observation was conducted on 03/06/25 at 8:00 AM, Resident #25's was resting in bed with oxygen in use at 2 liters per minute. The oxygen concentrator was noted to have no oxygen air filter or filter cover.	F 695	monitoring system as a routine task to be completed monthly and as needed. The Executive Director provided education to the Maintenance Director and Central Supply Manager on 03/26/2025 with instructions to ensure air filters in-place and clean for current oxygen concentrators in use; The Director of Nursing provided education to the nursing staff on as well as the certified nursing assistants on 3/10/2025-3/11/2025, with instructions to ensure air filters in-place and clean for current oxygen concentrators in use. The education packet will be placed into the staff in-service education book and will be included in new hire orientation. The oxygen concentrators will be monitored weekly for 4 weeks, then monthly for 8 weeks to ensure cleanliness of the filter. The monitors will be presented to the Quality Assurance Committee each month. 4. The Executive Director and Maintenance Director will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set	

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F 695	Continued From page 21 An observation on 03/06/2025 at 2:20 PM, Resident #25 was observed with oxygen at 2 liters per minute via nasal cannula while lying in bed. The oxygen concentrator did not have an oxygen air filter or filter cover. An observation was conducted on 03/06/25 at 2:29 PM with Unit Manager #2 of Resident #25's oxygen concentrator. Unit Manager #2 acknowledged that the oxygen concentrator was missing the oxygen air filter and cover but did not comment on the issue. The Director of Nursing (DON) was notified on 03/06/25 at 3:15 PM of Resident #25's missing oxygen air filter and cover and did not comment on the issue. The Administrator was interviewed at 4:52 PM on 03/06/2025 and stated that Resident #25's oxygen concentrator should have the required oxygen air filter with cover. 2. Resident #78 was admitted on 05/16/2024 with diagnosis of Chronic Obstructive Pulmonary Disease. Review of a quarterly Minimum Data Set (MDS) dated 01/30/2025 revealed that Resident #78's cognition was intact and received oxygen therapy. A review of the physician orders revealed that continuous oxygen was order at 2 liters per minute via nasal cannula on 12/17/2024. Upon observation at 11:02 AM on 03/03/2025, Resident #78 was sitting in her wheelchair at bedside with a nasal cannula attached to an oxygen concentrator set to deliver 2 liters per	F 695	Nurse and one direct Caregiver. 5. Date of substantial compliance:03/29/2025	

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minute. The filter on the oxygen concentrator had a grayish/white material covering the filter.

Unit Manager #2 entered Resident #78's room at 2:27 PM on 03/03/2025 and when interviewed stated that she noted the dirty air filter on the concentrator.

At 9:52 AM on 03/04/2025 Resident #78 was sitting in a wheelchair wearing a nasal cannula and receiving Oxygen at 2 liters per minute via oxygen concentrator with a filter that had gray matter covering it.

On 03/05/2025 at 9:20 AM while sitting in her wheelchair, Resident #78 was receiving oxygen at 2 liters per minute via nasal cannula attached to an oxygen concentrator with a filter that had a large amount of gray substance on it.

An observation at 03/06/2025 at 7:59 AM revealed that Resident #78 was sitting on her bedside receiving oxygen at 2 liter per minute via nasal cannula by oxygen concentrator. There was caked dust on the outside of the filter on the concentrator.

Upon interview at 7:59 AM on 03/06/2025, Resident #78 stated that she didn't know when the filter had been changed or cleaned and didn't realize the machine had one.

An interview was conducted with both Unit Manager #1 and Unit Manager #2 at 3:05 PM on 03/06/2025, the findings at 2:27 PM of Resident #78's dirty air filter on the concentrator were revealed, neither manager made a comment.

An observation and interview were conducted

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 23 with the Director of Nursing (DON) on 03/06/25 at 3:15 PM. The DON was informed that Resident #78's oxygen filter was covered with grey/white dust, and she stated "some oxygen concentrators had internal filters" but did not comment on the gray/white dust on the filter. The Administrator was interviewed at 4:52 PM on 03/06/2025 and stated that the air filters on oxygen concentrators such as Resident #78's should be cleaned and that it was not appropriate to be dirty with dust. She revealed that an air filter should be used with an oxygen concentrator such as with Resident #78.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		3/29/25

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F 756	Continued From page 24 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Nurse Practitioner (NP), and Consultant Pharmacist interviews, the facility failed to act on a pharmacy recommendation to add a stop date for a PRN antipsychotic medication (Resident #17). This deficient practice occurred for 1 of 5 residents reviewed for pharmacy recommendations. Findings included: Resident #17 was admitted on 11/29/24 was diagnosis that included post-traumatic stress disorder (PTSD), schizophrenia and bipolar disorder. A review of Resident #17's physicians orders found an active order dated 12/1/24 for Haloperidol injection solution inject 5 milligrams (MG) intramuscularly every 4 hours as needed (PRN) for agitation.	F 756	1. Resident #17 as needed (PRN) antipsychotic medication was discontinued on 03/05/2025. 2. On 03/12/2025 the Director of Nursing/Designee completed an audit of pharmacy recommendations for as needed (PRN) antipsychotic medications to ensure recommendations were followed as ordered. 3. The Regional Director of Clinical Services provided education to the Director of Nursing, Assistant Director of Nursing and Unit Managers about following up on pharmacy recommendations within 21 days on 03/25/2025. The education packet will be placed into the staff in-service education book and will be included in new hire orientation. Pharmacy recommendations	

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F 756	Continued From page 25 A December pharmacy recommendation dated 12/2/24 read in part Resident #17 had an order for Haloperidol without a stop date. The review wrote PRN antipsychotic orders were only good for a maximum of 14 days. The recommendation was signed by the NP on 3/5/25 and agreed to stop the PRN medication. A review of Resident #17's quarterly minimum data set (MDS) dated 12/6/24 had her coded for severe cognitive impairment. She was coded yes for taking an anti-psychotic medication. The Director of Nursing (DON) was interviewed on 3/06/25 at 1:11 PM. The DON stated the PRN antipsychotic medications needed a 14-day stop date. The DON said after 14 days, the medication needed to have a new order from the physician. Resident #17 was ordered the antipsychotic medication by an on-call provider for agitation and a 14 day stop date was not placed on the order. The DON stated Resident #17's December 2024 pharmacy recommendation was not signed off by the new psychiatry provider. The new psychiatry provider had not added Resident #17 as a patient at that time and didn't sign the recommendation. The DON stated the Pharmacy recommendation was misplaced and was signed on 3/5/25 by the psychiatry provider and the PRN medication was stopped. The Consultant Pharmacist was interviewed via phone on 3/06/25 at 4:22 PM. He said he completed pharmacy reviews each month. He stated he did not indicate any pharmacy recommendations for Resident #17 after the initial recommendation, but he did speak with the DON when he completed monthly reviews and told her about the needed 14-day PRN stop date.	F 756	will be monitored weekly for 4 weeks, then monthly for 8 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Director of Nursing/Designee will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial compliance: 03/29/2025	

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F 756	Continued From page 26 The Nurse Practitioner (NP) was interviewed on 3/6/25 at 1:41 PM. The NP stated she was not aware PRN antipsychotic medications required a 14 day stop date. The NP said she reviewed resident medications and if they had an antipsychotic medication, she reviewed the history but did not usually stop the medication because that was not her specialty. The NP stated she referred to psychiatry to evaluate antipsychotic medications.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		3/29/25

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F 758	Continued From page 27 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Pharmacy Representative, and Nurse Practitioner (NP) interviews, the facility the facility failed to include a 14- day stop date with an order for a PRN antipsychotic medication (Resident #17). This deficient practice occurred for 1 of 5 residents reviewed for pharmacy recommendations. Findings included: Resident #17 was admitted on 11/29/24 was diagnosis that included post-traumatic stress disorder (PTSD) and schizophrenia bipolar disorder.	F 758	1. Resident #17 as needed (PRN) antipsychotic medication was discontinued on 03/05/2025. 2. On 03/12/2025 PRN (as needed) psychotropic medication orders were reviewed by the Director of Nursing/Designee to ensure the orders were written correctly and the order included a stop date of no more than fourteen (14) days. 3. The Director of Nursing/designee will review PRN (as needed) orders during the clinical team meeting to ensure the orders	

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F 758	Continued From page 28 A review of Resident #17's physicians orders found an active order dated 12/1/24 for injection solution, inject 5 milligrams (MG) intramuscularly every 4 hours as needed (PRN) for agitation. A review of Resident #17's quarterly minimum data set (MDS) dated 12/6/24 had coded her as severely cognitive impaired. She was coded yes for taking an anti-psychotic medication. The Director of Nursing (DON) was interviewed on 3/06/25 at 1:11 PM. The DON stated the PRN antipsychotic medications needed a 14-day stop date. The DON said after 14 days, the medication needed to have a new order from the Physician. Resident #17 was ordered the antipsychotic medication by an on-call provider for agitation and a 14 day stop date was not placed on the order. The DON stated the PRN medication was stopped. The Nurse Practitioner (NP) was interviewed on 3/6/25 at 1:41 PM. The NP stated she was not aware PRN antipsychotic medications required a 14 day stop date. The NP said she reviewed resident medications and if they had an antipsychotic medication, she reviewed the history but did not usually stop the medication because that was not her specialty. The NP stated she referred to psychiatry to evaluate antipsychotic medications. A Pharmacy Representative was interviewed on 3/6/25 at 2:44 PM. The representative stated PRN antipsychotic medications require a 14-day stop date when ordered by a provider. The Administrator stated on 3/6/25 at 4:48 PM PRN antipsychotic medications needed to have a	F 758	are written correctly to include a stop date of less than or equal to fourteen (14) days. The Regional Director of Clinical Services provided education to the nurses and medical staff on 3/10/2025-3/11/2025 regarding the correct format to order PRN (as needed) psychotropic medications. The medical staff was instructed to include a stop date of 14 days for PRN (as needed) medications; nursing staff was instructed to contact the medical staff to obtain a corrected order in the event an order for a PRN (as needed) medication was received without a stop date. The education packet will be placed into the staff in-service education book and will be included in new hire orientation. New PRN (as needed) psychotropic medication orders will be reviewed 3X per week for 4 weeks; then weekly for 8 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Director of Nursing/designee will present the monitoring plan to the Quality Assurance Committee on 3/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver.	

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F 758	Continued From page 29 stop date of 14 days when ordered.	F 758	5. Date of substantial compliance 03/29/2025	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide drinks consistent with the resident's thickened liquid needs for 1 of 1 sampled resident (Resident #73) reviewed for drinks available to meet resident needs. Findings included: Resident #73 was admitted on 9/4/24 with diagnoses that included dementia and dysphagia. Resident #73's quarterly Minimum Data Set (MDS) dated 12/13/24 was reviewed. Resident #73 was coded for severe cognitive impairment. Resident #73 was also coded for receiving a mechanically altered diet. Resident #73 had a physician's order dated 12/4/24 for regular diet, dysphagia puree texture with honey thickened fluids. On 3/6/25 at 12:25 PM in the locked unit dining room, the Speech Therapist notified the surveyor	F 807	F 807 □ Drinks available to meet needs/preferences/hydration 1. Resident #73□s drinks were replaced with the correct consistency on 03/06/2025. 2. Resident charts were reviewed by the District Food Services Manager on 3/26/2025 to determine those Residents needing thickened liquids. The Residents□ meal tickets were highlighted based on the needed consistency and to ensure accuracy. 3. The meal tickets for Residents needing thickened liquids are now highlighted to provide a visual aid to the line staff serving meals. Each consistency is highlighted in a different color based on the liquids order for the Resident. The District Manager for HealthCare Services Group provided the kitchen staff with education on 3/7/2025 thru 3/27/225 regarding the importance of providing the	4/2/25

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F 807	Continued From page 30 Resident #73 received thin liquids on his meal tray. The Speech Therapist said Resident #73 needed honey thickened liquids for safe swallowing, and it was written on the meal ticket. Resident #73 was observed sitting at a table with a family member who was assisting the resident with the meal. Resident #73 had not drunk any of the thin liquid. The thin liquid beverage was removed from the tray and replaced with a honey thickened beverage by the Speech Therapist. Resident #73's meal ticket read, "regular, dysphagia puree, honey thick liquids". During the observation, the Regional Dietary Consultant stated the honey thick liquid was overlooked on the tray line. The Administrator stated on 3/6/25 at 4:48 PM the meal trays needed to be double checked on the tray line to ensure the residents received the correct liquid consistency.	F 807	Residents with fluids at each meal in addition to serving fluids of the correct consistency for those Residents with swallowing difficulties. Newly hired staff will be provided with the learning module prior to serving on tray line duty. The nursing staff was educated by the Assistant Director of Nursing on 3/31/2025-04/01/2025 regarding tray ticket inspection for accurate liquid consistency. Inconsistencies will be reported to the Food Service Director and/or Director of Nursing/designee. Newly hired staff will be provided with the learning module(s). The plan of correction will be monitored by the Food Services Director/designee five (5) times per week for four (4) weeks and then three (3) times per week for eight (8) weeks. Nursing staff will report any inconsistencies to the Food Services Director/designee. The monitors will be presented to the Quality Assurance Committee each month. 4. The Food Services Director/Designee will present the monitoring plan to the Quality Assurance Committee on 03/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver.	

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F 807	Continued From page 31	F 807	5. DAte of substantial complaince 04/02/2025	
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 date opened containers of thickened liquids and clean 1 of 1 reach-in refrigerators. The facility also failed to remove expired chocolate milk from a nourishment room (the Secured Unit nourishment room). These practices had the potential to affect food served to the residents. Findings included:	F 812	1. All expired and undated food items were removed and discarded on 3/06/2025. There were no Residents affected by the alleged deficient practice. 2. The kitchen and nourishment room were inspected on 03/7/2025 by the HealthCare Services Group District Manager to ensure food items were labeled with the open date, stored properly and any expired food products	4/2/25

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F 812	Continued From page 32 a. On 3/3/25 at 9:51 AM an observation of the reach-in refrigerator in the kitchen found 3 containers of thickened liquid that were opened and did not contain an open date. The Dietary Manager (DM) stated during the observation he thought the thickened liquids were used for breakfast, but should have been dated before storing in the refrigerator. On 3/3/25 at 9:54 AM the bottom of the reach-in refrigerator was observed with a sticky to touch residue. The bottom of the refrigerator also contained food debris spread around the bottom of the refrigerator. The DM stated during the observation that he was unsure when the refrigerator was last cleaned. The DM stated he started working as the facility's DM the previous week and was still learning the kitchen cleaning schedules. b. On 3/6/25 at 2:49 PM an observation of the locked resident unit's refrigerator found 4 cartons of unopened chocolate milk with an expiration date of 3/5/25. The DM stated during the observation that the expired milk was not in the refrigerator when he checked it earlier in the day and was unsure who had placed the milk in the refrigerator. The Administrator stated on 3/6/25 at 4:48 PM the kitchen and all food storage areas should be cleaned and maintained. The Administrator said expired food items should be removed and disposed of and the opened thickened liquids should have been dated when opened.	F 812	were discarded. The reach-in refrigerator was cleaned on 3/4/2025. 3. The District Manager for Healthcare Services Group provided the kitchen staff with education on 3/3/2025-3/27/2025 to discuss the importance of correctly labeling opened products, proper storage of food products as well as discarding expired food items. The staff was also trained on inspecting the refrigeration appliances for cleanliness on 3/31/2025-4/1/2025. Newly hired staff will be provided with the learning module during orientation. The plan of correction will be monitored by the Food Services Director five (5) times per week for four (4) weeks and then three (3) times per week for eight (8) weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Food Services Director/Designee will present the monitoring plan to the Quality Assurance Committee on 03/27/2025. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Date of substantial compliance:	

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F 812	Continued From page 33	F 812	4/2/2025	