STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 03/05/2025

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BRUNSWICK REHABILITATION AND HEALTHCARE CENTER	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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E 000	Initial Comments The survey team entered the facility on 02/16/25 to conduct a recertification and complaint investigation survey and exited on 02/21/25. Additional information was obtained on 03/04/25 and 03/05/25. Therefore, the exit date was changed to 03/05/25. Event ID #ZNT411. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/16/25 to conduct a recertification and complaint investigation survey and exited on 02/21/25. Additional information was obtained on 03/04/25 and 03/05/25. Therefore, the exit date was changed to 03/05/25. Event ID# ZNT411. The following complaint intakes were investigated: NC00220621, NC00223508, NC00221554, NC00224879, and NC00225070. 9 of the 18 complaint allegations resulted in a deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		4/4/25

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

Electronically Signed | 03/21/2025

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F 561	Continued From page 1 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide a resident with their preferred number of showers a week for 1 of 1 residents reviewed for choices (Resident #38). The findings included: Resident # 38 was admitted to the facility on 12/06/24 with diagnoses that included spondylosis, muscle weakness, venous thrombosis, and anxiety. Resident #38's most recent Minimum Data Set (MDS) dated 02/07/25 revealed the resident had no cognitive impairments. Resident #38 needed extensive to total assistance with activities for daily living: bed mobility, transfers, eating, toilet use, dressing, personal hygiene, and bathing.	F 561	1. Resident #38 was asked about her preference for how many times a week they would prefer a shower on 3/19/25 by the Director of Nursing/ designee. Resident #38□s shower schedule was adjusted to include their preferences. 2. All residents have the potential to be affected by this deficient practice. All residents were asked what their preference for number of showers per week was (or their representative was asked when the resident was not able to be interviewed) by Nurse Manager/ designee on 3/19/25 and the residents shower schedule was adjusted per preference. 3. All nursing staff were inserviced on inquiring on preferences for number of showers per week to each resident/ responsible party by the Assistant Director	

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F 561	Continued From page 2 Resident #38's care plan dated 02/03/25 revealed Resident #38 was unable to participate in the usual daily routine and needed modified activities or some assistance when using her hands. Resident #38 had an Activities for Daily Living (ADL) self-care performance deficit related to diabetes, spondylosis with myelopathy, osteoarthritis, and muscle weakness. Resident #38 had limited physical mobility and required two-person total assistance utilizing a mechancial lift for transfers and showers. Review of the ADL record for January 2025 and February 2025 documented Resident #38 received one bath on 02/11/24 and no showers and was not noted to have refused a shower during those months. A review of Resident #38's electronic activities for daily living (ADL) bath/shower sheets from 01/21/24 through 02/18/25 revealed one bath on 02/11/25 and no showers during the 30-day look back period. Review of the shower schedule revealed Resident #38's was scheduled for a shower on Tuesdays. An interview and observation was conducted on 02/16/25 at 12:00 PM with Resident #38. She stated she had only received one shower since her admission on 12/06/24. She stated she would like to have 2 showers a week, but staff told her it took too much of their time to take her to the shower room and back, and they could not accommodate her request. Resident #38 was observed sitting up in bed, had a gown on, and her face and hair appeared oily.	F 561	of Nursing/ designee on 3/24/25. Any newly hired nursing staff will be inserviced on inquiring on shower preferences 4. A weekly audit of 5 residents and/ or resident representatives will be completed times twelve to ensure the resident□s preference for number of showers per week is honored and correct on the shower schedule by the nurse manager/ designee. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/ designee monthly times three.	

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F 561	Continued From page 3	F 561		

A follow-up interview was conducted on 02/17/25 at 12:00 PM with Resident #38. She stated since her admission she had only received one shower. Resident #38 stated she did not refuse showers and wanted 2 showers a week, but the NAs refused to give her one, with only a partial bed bath now and then. She said she let the nurses know, but still received no showers.

An interview was conducted on 02/17/25 at 9:15 AM with Nurse #1. Nurse #1 stated she did not know when Resident #38 last had a shower and that Resident #38 should be getting two showers a week or more if she wants them. Nurse #1 stated all residents should be scheduled for 2 showers per week and on the other days they should receive a bed bath. A review of Resident #38's shower calendar with Nurse #1 revealed Resident #38's shower day was Tuesday. Nurse #1 stated Resident #38 should have had 2 shower days posted per week on the calendar (Tuesday and Saturday), not Just Tuesday. When Nurse #1 checked the electronic shower/bath 30-day look back tracking log from 01/21/25 through 02/18/25, it revealed Resident #38 received no showers and one bath on 02/11/25 at 1:00 PM.

An interview was conducted on 02/17/25 at 9:20 AM with NA #1. NA #1 stated Resident #38 told her that she had only had one shower since her admission. NA #1 stated she never gave the resident a shower, and that Resident #38 needed 2 NAs with a mechanical lift to take her to and from the shower room, and that it was easier for the NAs to just to give the resident a bed bath.

An interview was conducted on 02/18/25 at 12:15 PM with the Director of Nursing (DON). The DON

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F 561	Continued From page 4 stated Resident #38 should be getting daily bed baths and 2 showers per week per her preference. But it was currently scheduled for one shower weekly on Tuesday, and she was not getting that and should have been. The DON revealed all residents should have a shower twice a week and whenever they request a shower. An interview was conducted on 02/17/25 at 10:35 AM with the Administrator. He stated he had not heard any complaints about residents not receiving showers.	F 561		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		4/4/25

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F 580	Continued From page 5 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Nurse Practitioner, and Physician interviews, the facility failed to notify the Physician, or the Nurse Practitioner of a resident's blood pressure medication Carvedilol 3.125 milligrams prescribed for hypertension and scheduled for administration twice a day was held 34 times during a period of 77 days or that Midodrine (prescribed to increase blood pressure) was being administered outside of the prescribed parameters. This occurred for 2 of 5 residents (Resident #54) reviewed for medication administration and notification to the physician.	F 580	1. Medication errors were documented for resident 54 and resident 43 regarding not following BP parameters on 3/17/25 by the Director of Nursing. Physician notified. Nurses involved were reinserviced regarding following physician orders for BP parameters and notification to physicians. 2. All residents that have BP parameters have the potential to be affected by this deficient practice. Nurse management/ designee audited all residents that have BP parameters on 3/21/25 to ensure they	

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F 580	Continued From page 6 Findings included. This tag is cross referenced to: F760: Based on record review, and staff, Physician, Nurse Practitioner, and the Consultant Pharmacist interviews the facility failed to 1.)administer the antihypertensive medication Carvedilol 3.125 milligrams prescribed twice a day for hypertension. Resident #54 experienced no significant outcome by not receiving the medication. 2.) hold the blood pressure medication Midodrine (prescribed to increase blood pressure) when the systolic blood pressure was greater than 130 millimeters of mercury (mmHg). Resident #43 experienced no significant outcome from receiving the additional doses. This occurred for 2 of 5 residents (Resident #54 and Resident #43) reviewed for medication administration.	F 580	were followed by physician orders and any concerns reported to the physician. Any issues were documented on medication error form with physician notification. 3. All licensed nurses/ CMAs were inserviced by the Director of Nursing/ designee on following physician orders for BP parameters and notification with any concerns reported to physician on 3/24/25. Any newly hired licensed nurse/ CMA will be inserviced on following physician orders for BP parameters and with any concerns reported to the physician during orientation by the Director of Nursing/ designee. Any agency licensed nurses or CMAs will receive education on following physician orders for BP parameters with any concerns reported to the physician prior to their first shift worked by the Director of nursing/ designee. 4. A medication administration pass will be completed three times per week times twelve weeks to ensure physician orders for BP Parameters are being followed with any concerns reported to the physician by the Nurse Managers/ designee. An audit of BP parameters on the MARs will also be checked by the Director of Nursing/ designee to ensure licensed nurses/ CMAs are following physician orders for BP parameters and any concerns reported to the physician weekly times twelve. Any concerns will be documented on medication error forms with physician notification by the Director of Nursing/ designee. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement	

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F 580	Continued From page 7	F 580	Committee by the Administrator/ designee monthly times three.	
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 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	F 584		4/4/25

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F 584	Continued From page 8 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 record review, observations, Administrator, and Maintenance Director interviews, the facility failed to remove the black greenish substance from the commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411), failed to repair resident's overhead lights that were non-functioning in resident rooms (202 and 411). These failures occurred on 3 of 5 hallways (200, 300, and 400 Halls) observed for a safe, clean, homelike environment and failed to maintain hot water temperatures in 2 of the 2 shower rooms on the 300-hall (Spa #1 and Spa #2) reviewed for hot water. Findings included: 1. An observation of the two 300-hall shower rooms was completed during a round on 02/17/25 which started at 9:45 AM with the Maintenance Director. The shower hot water temperature in Spa #1 fluctuated from 85 degrees Fahrenheit (F) to 89 degrees F, and the shower in Spa #2 hot water temperature fluctuated from 83 degrees F to 101 degrees F. Both shower water temperatures were obtained using the calibrated thermometer provided by the Maintenance Director and the temperatures were obtained after 5-minutes of continuous hot water monitoring in both shower rooms. The Maintenance Director stated during the	F 584	1. The caulking on the commode bases in room 200, 201, 205, 207, 208,209,305 and 411 was replaced on 3/18/25 by the maintenance director/designee. Overhead lights were fixed for room 202 and 411 and are operational on 3/25/25 by maintenance director/ designee. Hot water temperatures were obtained on the 300-hall (spa room 1 and 2) on 2/17/25 by the maintenance director/ designee. 2. All residents have the potential to be affected by this deficient practice. All resident commodes were checked on 3/21/25 by the maintenance director / designee to ensure the caulking was appropriate- if not it was replaced. All overhead lights were checked on 3/21/25 by the maintenance director/ designee to ensure they were in working order- if not they were fixed and operational. All Spa rooms/ showers in the facility were checked to ensure hot water temperatures were obtained on 2/17/25 by the maintenance director/ designee. 3. All maintenance staff were inserviced by the Administrator/ designee to ensure that rooms/ Spa rooms are checked frequently and specifically to look for caulking around commodes, overbed lights, and hot water temperatures in Spa rooms on 3/24/25. Any newly hired	

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F 584	Continued From page 9 observation the water was too cold for showers, which should have been around 114 degrees F. The Maintenance Director said he would try to adjust the faucets and mixing valve to bring the hot water temperature up to around 114 degrees F. An interview was conducted on 02/21/25 at 12:00 PM with the Administrator and he stated as of September 2024, their paper water temperature logs were no longer being used, since they updated to the electronic Maintenance TELS (The Equipment Lifecycle System) (an online system used to help manage maintenance in a facility). The Administrator explained he had their new electronic TELS water testing log did not include testing water temperatures in the shower rooms. The Administrator further explained he hired a new Maintenance Director and because the 3 shower rooms were inadvertently not added in the TELS water testing log, the Maintenance Director did not track the shower water temperatures which resulted in the 3 shower rooms water temperatures not being monitored. The Maintenance Director said another reason the water in the shower rooms might be cold was due to the hot water having to travel all the way from the boiler to the shower rooms and staff were not waiting 3-5 minutes for the water to heat up. 2. An observation on 02/18/25 at 12:00 PM revealed resident commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411), were noted to have black greenish substance located around the base of the commodes. An interview and observation were conducted on 02/18/25 at 1:30 PM with the Maintenance	F 584	maintenance staff will received this inservice during orientation by the Administrator/ designee. 4. The maintenance director/ designee will audit 5 resident rooms per week to ensure caulking around the commode is appropriate and overbed lights are functional times twelve weeks. The maintenance director/ designee will audit water temperatures in all Spa rooms weekly times twelve to ensure hot water is obtained. The results of both audits will be forwarded by the Administrator/ designee to the Quality Assurance and Performance Improvement Committee monthly times three.	

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F 584	Continued From page 10	F 584		

Director. He stated there were areas on the 200, 300, and 400 halls that needed to be addressed, repaired, or replaced. He stated he was new to the building and had no assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes commode base caulking in resident rooms (200, 201, 205, 207, 208, 209, 305, and 411). He said maintenance was responsible for repairing or replacing items in the facility, and that some of the commodes caulking needed to be replaced.

3. An observation on 02/18/25 starting at 12:15 PM revealed overhead lights that were non-functioning, in rooms (202 and 411). All four alert and oriented residents in the two rooms said they told their nurses about the non-functioning lights, but nothing had been done. They said they primarily use the lighting from the outside window and keep the hallway door open.

An interview was conducted on 02/18/25 at 1:30 PM with the Maintenance Director. He stated there were still areas on the 200, 300, and 400 halls that still needed to be addressed, repaired, or replaced. He said maintenance was responsible for repairing or replacing items in the facility, and that some of the overhead lights were not working and needed new ballasts.

An interview was conducted with the Administrator on 02/18/25 at 1:50 PM. He revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. He said there were still areas in the facility that still needed to be addressed, and they were actively putting plans in place to address areas concern

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F 584	Continued From page 11 observed during the survey. The Administrator stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to protect a residents' right to be free from neglect when a nurse (Nurse#5) failed to perform the daily wound care to an infected Stage IV left heel pressure wound and an unstageable right heel pressure wound both of which were facility acquired. This failure occurred for 1 of 3 residents reviewed for neglect. Findings included. This tag is cross referenced to: F686: Based on observations, record review,	F 600	1. Resident #60 treatment was changed on 2/16/25. Nurse involved was reeducated by the Director of Nursing/ designee on 2/19/25. 2. All residents with treatment orders have the potential to be affected by this deficient practice. All treatments were audited on 3/21/25 by the nurse managers/ designee to ensure the treatments were changed timely and as ordered by the physician. 3. Licensed nursing staff were inserviced regarding timely completion of treatments as ordered by the physician by the	4/4/25

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F 600	Continued From page 12 staff, the Medical Director and the Wound Physician interviews, the facility failed to provide wound care according to the physician's order for a Stage IV pressure ulcer on the left heel and an unstageable deep tissue injury on the right heel. This occurred for 1 of 3 residents (Resident #60) reviewed for wound care.	F 600	Assistant Director of Nursing/ designee on 3/19/25. Any new licensed nurses hired will have this education during the orientation process. Any agency licensed nursing staff will have this completed prior to their first scheduled shift. 4. An audit of timely completion of treatments will be conducted twice a week by the nurse managers/ designee for twelve weeks on 5 residents. The results of these audits will be forwarded to the Quality Assurance and Process Improvement Committee by the Administrator/ designee monthly times three months.	
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 observations, record review, and staff interviews, the facility failed to provide bathing and showers (Resident #39, Resident #53, and Resident #60) and incontinence care (Resident #7) to residents who were dependent on staff assistance with activities of daily living (ADL). This occurred for 4 of 5 residents reviewed for ADL care. Findings included. 1a.) Resident #39 was admitted to the facility on 1/6/25 with diagnosis including Alzheimer's disease.	F 677	1. Residents #39, #53, and #60 received a shower/ bath on 2/18/25. Resident # 7 received incontinence care on 2/21/25. Staff involved with these four residents received education regarding requirements of ADL care regarding bathing/showers and incontinence care by the Director of Nursing/ designee on 2/21/25. 2. All residents have the potential to be affected by this deficient practice. All residents' requiring assistance with showers/ bathing and incontinence care were audited on 3/24/25 by the nurse	4/4/25

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F 677	Continued From page 13 The Minimum Data Set (MDS) admission assessment dated 1/16/25 revealed Resident #39 was severely cognitively impaired. She had no rejection of care. She had impaired range of motion in her bilateral upper and lower extremities and was dependent on staff for activities of daily living (ADL). A care plan dated 1/16/25 revealed Resident #39 had ADL self-care performance deficit related to her diagnosis of Alzheimer's disease, primary osteoarthritis, diabetes, and hypertension. Interventions included to encourage participation in tasks. During an interview on 2/16/25 at 5:00 PM Nurse #5 stated Resident #39 did not receive her scheduled shower last night on Saturday 2/15/25. She stated it was reported to her this morning when she came on duty by the night nurse and Resident #39 still had not had a shower as of now. She indicated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #39 was scheduled for showers to be given on night shift on Wednesday and Saturday nights. During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths. During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He	F 677	managers/ designee to ensure their assistance level was correct and listed on their kardex. 3. All nursing staff were inserviced on assistance needed with showers/ bathing and incontinence care of residents, where to find feeding assistance status- Kardex by the Assistant Director of Nursing/ designee on 3/21/25. All newly hired nursing staff will receive this education during orientation by the Assistant Director of Nursing/ designee. Any agency nursing staff member will receive this education prior to working their first shift by the Assistant Director of Nursing/designee. 4. An observation audit on two residents will be conducted by nurse managers/ designee five days a week times twelve weeks to ensure proper assistance is given for bathing/showers and incontinence care is given. The results of these audits will be forwarded to the Quality Assurance and Process Improvement Committee by the Administrator/ designee monthly times three.	

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stated he was an agency nurse aide, and he was made aware of who needed showers when he came on shift. He stated three residents were supposed to get showered that night but stated he was busy during the shift and just didn't get the showers done on any of the three residents which included Resident #39. He stated there were two nurse aides on duty and assigned to the locked unit along with the nurse on Saturday night from 7:00 PM until 7:00 AM which was the usual number of staff on the locked unit.

During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated the second Nurse Aide who was scheduled this shift called out this morning, so it was just her and the nurse until approximately 10:00 AM. She stated Resident #39 had not been given a bath today at this point because there was no time this morning to give baths.

b.) Resident #53 was admitted to the facility on 11/30/21 with diagnoses including dementia.

A care plan dated 11/25/24 revealed Resident #53 had an ADL self-care deficit related to dementia. Interventions included assistance by staff with bathing and showering.

The Minimum Data Set (MDS) quarterly assessment dated 1/6/25 revealed Resident #53 had severely impaired cognition. She required extensive assistance by staff with activities of daily living.

During an interview on 02/16/25 at 5:00 PM Nurse #5 stated Resident #53 did not receive her

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scheduled shower last night (Saturday 2/15/25). She stated that was reported to her this morning when she came on duty by the night nurse. She stated Resident #53 still had not had a shower as of now. She stated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #53 was scheduled for showers to be given on night shift on Wednesday and Saturday nights.

During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths.

During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He stated he was an agency nurse aide and stated he was made aware of who needed showers when he came on shift. He stated he was busy during the shift and just didn't get the showers done on any of the three residents who were scheduled which included Resident #53.

During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated Resident #53 had not been given a bath today at this point because there was no time this morning to give baths.

c.) Resident #60 was admitted to the facility on 3/27/24 with diagnoses including dementia.

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A care plan revised 11/25/24 revealed Resident #60 had an ADL self-care deficit related to dementia with agitation. Interventions included to encourage resident to participate to the fullest extent.

The Minimum Data Set (MDS) quarterly assessment dated 1/1/25 revealed Resident #60 had moderately impaired cognition. She required extensive assistance by staff with activities of daily living. She had no rejection of care.

During an interview on 02/16/25 at 5:00 PM Nurse #5 stated Resident #60 did not receive her scheduled shower last night (Saturday 2/15/25). She stated Resident #60 still had not had a shower as of now. She stated she did not know why the showers weren't done by the Nurse Aides. She stated Resident #60 was scheduled for showers to be given on night shift on Wednesday and Saturday nights.

During a phone interview on 3/4/25 at 8:30 PM Nurse Aide #9 stated he was the assigned Nurse Aide on 2/15/25 from 7:00 AM until 7:00 PM. He stated baths were not given to any residents during his shift on 2/15/25 because he was the only Nurse Aide assigned on the locked unit that day and there was no time to give baths.

During an interview on 2/18/24 at 3:00 PM Nurse Aide #7 stated he worked Saturday night 2/15/25 on the locked unit from 7:00 PM until 7:00 AM. He stated he was an agency nurse aide and stated he was made aware of who needed showers when he came on shift. He stated he was busy during the shift and just didn't get the showers done on either of the three residents who were scheduled which included Resident #60.

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During an interview on 2/16/25 at 2:51 PM Nurse Aide #5 stated she was the assigned Nurse Aide on the locked unit today and was scheduled to work from 7:00 AM until 7:00 PM. She stated Resident #60 had not been given a bath today at this point because there was no time this morning to give baths.

During a phone interview on 2/18/24 at 4:00 PM Nurse #7 stated she was the assigned nurse on the locked unit on Saturday night 2/15/25. She stated she was an agency nurse, and it was her very first night working in the facility. She indicated she was aware showers were scheduled on night shift but did not know why the nurse aides on duty Saturday night didn't do them. She indicated she reported this to the oncoming nurse the next morning.

During the survey three attempts were made to contact Nurse Aide #8 who was on duty in the locked unit from 7:00 PM until 7:00 AM on Saturday night 2/15/25. There was no response.

During an interview on 02/19/25 at 11:24 AM the Director of Nursing (DON) stated she was made aware of the three residents who did not get showered on their scheduled shower day on Saturday night 2/15/25. She stated she did confirm after talking with Nurse Aide #7 and Nurse Aide #8 who were the nurse aides on duty that showers weren't given. She stated they chose not to do the showers, and they received disciplinary action and were pulled from the locked unit. She stated they typically had two nurse aides assigned to each shift on the locked unit and there were two nurse aides on duty from 7:00 AM until 7:00 PM. She stated the showers

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should have been given.

2) Resident #7 was admitted to the facility on 12/18/23. Diagnoses included history of urinary tract infections, muscle wasting and atrophy, and need for assistance with personal care.

The Minimum Data Set (MDS) quarterly assessment dated 02/11/25 revealed Resident #7 was cognitively intact and was coded for impairments to both sides of upper and lower extremities and dependent with one staff physical assistance for ADL care. Resident #7 was always incontinent of bowel and bladder.

A care plan updated on 02/11/25 for Resident #7 revealed a plan of care was in place for incontinent care and required staff assistance with toileting and bowel and bladder incontinence. The goal of care was to receive the appropriate level of staff assistance for toileting and incontinence care. Interventions included providing one person assistance with toileting and incontinence care. A plan of care was in place for limited physical mobility related to weakness, impaired mobility and incontinence with a goal that resident would be free of complications related to immobility to include skin breakdown. Interventions included observing for any signs or symptoms of skin breakdown. A plan of care updated on 02/13/25 revealed the resident had a Stage IV pressure ulcer to her coccyx (a small bone at the base of the spinal column above the buttocks) related to immobility and incontinence with a goal that the pressure ulcer would show signs of healing and remain free from infection. Interventions included observing any changes in skin status.

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An observation and interview with Resident #7 on 02/16/25 at 10:30 AM revealed an alert and oriented resident lying in bed on her back. Resident #7 reported that her brief had not been changed since early this morning and stated it was well before breakfast. Resident #7 stated she was wet with urine at this time and wanted to be changed. Resident #7 stated she would ring her call bell to get assistance.

A follow up observation and interview was conducted with Resident #7 on 02/16/25 at 1:15 PM. Resident #7 stated she rang her call bell and told the Nurse Aide (NA) #2 that she needed her brief to be changed. The call light was not sounding upon entry to Resident #7's room. Resident #7 reported NA #2 stated she would be right back but she did not come back. Resident #7 stated she believed it was about 10:30 AM or so when she pressed her call bell, but she could not remember the actual time. Resident #7 stated she wanted her brief to be changed, but she did not want to keep bothering the nurse aide.

An interview was conducted with Nurse Aide (NA) #2 on 02/16/25 at 1:15 PM. NA #2 was asked when the last time was that she checked on and changed Resident #7's brief. NA #2 responded "I don't know, I don't keep track of that. I am so busy with the 18 residents on my hall." NA #2 stated she did not recall Resident #7 ringing her call bell to ask for assistance or telling Resident #7 she would be back. NA #2 stated she would check Resident #7 at this time.

An observation of NA #2 was conducted on 02/16/25 at 1:15 PM. NA #2 was noted to have checked Resident #7's brief and it was noted to

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F 677	Continued From page 20 be saturated with a significant amount urine. NA #2 was observed changing Resident #7's brief at this time. Resident #7's dressing to her coccyx was noted to be intact. A follow up interview was conducted with NA #2 on 02/16/25 at 1:45 PM. NA #2 stated she was doing the best the could with keeping up with changing her residents. NA #2 stated she tried to check her residents every 2 - 3 hours per the facility protocol to see if the residents needed to be changed, but that Resident #7 had gone over 4 hours before she was changed again. NA #2 stated she did not remember when she first changed Resident #7 but she thought it was at the start of her shift around 7:30 AM. NA #2 stated she should have checked her for incontinence again after 2-3 hours since she was one of her residents known to urinate a lot. An interview was conducted with the Administrator on 02/21/25 via phone at 1:35 PM. The Administrator stated he would have expected the nurse aides to check and change all residents on their assignment every 2 - 3 hours to ensure they were kept dry and clean to maintain the resident's skin integrity.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		4/4/25

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F 686	Continued From page 21 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 observations, record review, and staff, the Medical Director and the Wound Physician interviews, the facility failed to provide wound care according to the physician's order for a Stage IV pressure ulcer on the left heel and an unstageable deep tissue injury on the right heel. This occurred for 1 of 3 residents (Resident #60) reviewed for wound care. Findings included: Resident #60 was admitted to the facility on 3/27/24 with diagnoses including peripheral arterial disease, diabetes, hypertension, and dysphagia. A care plan dated 11/18/24 revealed Resident #60 had deep tissue injuries to her left and right heel and was at risk for further decline and infection. Interventions included in part to administer wound care treatments as ordered and monitor for effectiveness. The Minimum Data Set (MDS) quarterly assessment dated 1/1/25 revealed Resident #60 had moderately impaired cognition. She had two deep tissue injuries. She had no rejection of care. The wound physician's note dated 2/12/25 revealed Resident #60 was evaluated for Stage	F 686	1. Resident #60's treatment was changed on 2/16/25. Nurse involved was reeducated by the Director of Nursing/ designee on 2/19/25. 2. All residents with treatment orders have the potential to be affected by this deficient practice. All treatments were audited on 3/21/25 by the nurse managers/ designee to ensure the treatments were changed timely and as ordered by the physician. 3. Licensed nursing staff were inserviced regarding timely completion of treatments as ordered by the physician by the Assistant Director of Nursing/ designee on 3/19/25. Any new licensed nurses hired will have this education during the orientation process. Any agency licensed nursing staff will have this completed prior to their first scheduled shift. 4. An audit of timely completion of treatments will be conducted twice a week by the nurse managers/ designee for twelve weeks on 5 residents. The results of these audits will be forwarded to the Quality Assurance and Process Improvement Committee by the Administrator/ designee monthly times three months	

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IV pressure wound to the left heel. The wound measured 4.2 centimeters (cm) x 8 cm x 0.2 cm. The wound had 60% thick adherent devitalized necrotic tissue. The wound progress was not at goal. The treatment plan was Santyl (debriding ointment) daily for 16 days and alginate (absorbent protective dressing) daily for 23 days.

The wound physician note dated 2/12/25 revealed Resident #60 was evaluated for an unstageable full thickness wound to the right heel. The wound measured 2.6 centimeters (cm) x 5.2 cm x 0.1 cm. The wound had 40% thick adherent black necrotic tissue (eschar). The wound progress was not at goal. The treatment plan was Santyl (debriding ointment) daily for 23 days and alginate (absorbent protective dressing) daily for 23 days.

A physician's order dated 2/13/25 for Resident #60 revealed Santyl ointment 250 units per gram. Apply to left heel daily. Cleanse with normal saline, pat dry. Apply Santyl to wound bed, apply oil emulsion to wound bed, and apply calcium alginate and cover with gauze daily.

A physician's order dated 2/13/25 for Resident #60 revealed Santyl ointment 250 units per gram. Apply to right heel daily. Cleanse with normal saline, pat dry. Apply Santyl to wound bed, then apply calcium alginate to wound bed and cover with gauze daily.

A physician's order dated 2/13/25 for Resident #60 revealed Doxycycline (antibiotic) oral tablets 100 milligrams (mg). Give 1 tablet by mouth two times a day for wound infection for 10 days.

A care plan dated 2/14/25 revealed Resident #60

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had a Stage 4 pressure ulcer on her left heel and was at risk for further decline in skin integrity and infection. Interventions included in part to administer wound care treatments as ordered and monitor for effectiveness.

Review of the Treatment Administration Record (TAR) dated February 2025 for Resident #60 revealed the daily wound treatment of Santyl to bilateral heels was not signed off as administered on 2/15/25.

During an observation on 02/16/25 at 4:50 PM Resident #60 was sitting up in her wheelchair in the common area of the locked dementia unit. She was not oriented to person, place, or time. Heel protector boots were in place on both feet. Nurse #5 removed the heel protector boots which revealed bilateral soiled dressings on the heels that were falling off. The dressings on both heels were dated 2/14/25.

During an interview on 2/16/25 at 4:50 PM Nurse #5 stated she worked Saturday 2/15/25 from 7:00 AM until 7:00 PM and today Sunday 2/16/25 from 7:00 AM until 7:00 PM. She stated Resident #60 had a Stage IV left heel wound and an unstageable wound to her right heel and had orders to receive daily dressing changes. When asked if the wound care had been completed over the weekend, Nurse #5 stated no she did not complete the wound treatment on Saturday because she was going to have the night shift nurse (Nurse #7) change the dressing during Resident #60's shower which was scheduled to be given Saturday night. She stated when she returned to work Sunday morning at 7:00 AM she discovered Resident #60's wound care had not been completed during the night. Nurse #5 stated

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the wound care to Resident #60's heels had not been done since day shift Friday 2/14/25 when the wound nurse did the treatment. When Nurse #5 was asked why the dressings had not been changed today and it was near the end of her shift and had been over 48 hours since the last dressing change, she stated she had been busy and just had not done them yet.

Review of the Treatment Administration Record (TAR) on 2/17/25 for Resident #60 revealed the wound treatment of Santyl to bilateral heels was signed off as administered after 6:00 PM on 2/16/25.

A phone interview was conducted on 2/17/25 at 3:00 PM with Nurse #7 the night shift nurse who worked 7:00 PM on 2/15/25 until 7:00 AM on 2/16/25. She stated she was an agency nurse and 2/15/25 was the first night she had ever worked in the facility. She stated it was not reported to her that Resident #60's wound care had not been completed on day shift on 2/15/25. She stated it did not populate in the electronic medical record for her to complete a dressing change for Resident #60 during her shift.

During an interview on 2/17/25 at 10:00 AM the Wound Nurse stated she completed Resident #60's wound care to her bilateral heels early on Friday 2/14/25. She indicated it was before 12:00 PM. She stated the assigned nurse was responsible for wound care over the weekends when she was off. She was not aware that the heel dressings were not changed on 2/15/25 and not until late in the day on 2/16/25. She stated Resident #60 was followed by the wound care physician and had orders for daily dressing changes. She stated Resident #60's wound care

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was scheduled to be completed on day shift. She stated she was also currently receiving antibiotics beginning 2/13/25 due to a wound infection.

During an interview on 2/18/25 at 2:00 PM the Medical Director stated Resident #60 had chronic wounds and was followed weekly by the wound care physician. She stated wound care should be completed according to the physician orders.

During an interview on 02/19/25 at 03:13 PM the Wound Care Physician stated Resident #60's wounds were evaluated by her weekly. She stated Resident #60 had bilateral heel wounds and orders to complete daily dressing changes using Santyl to both heels. She stated Resident #60 had poor vasculature which impacted her wound healing and potentially causing the wounds to take longer to heal. She stated she was currently receiving the antibiotic Doxycycline for wound infection of the Stage IV on the left heel. She stated she was made aware that Resident #60 missed the wound care treatment over the weekend. She stated the wound had not deteriorated due to not getting the treatment done on 2/15/25. She indicated that it was important for daily wound care to be completed to promote healing and reduce the risk for further infection.

During an interview on 2/20/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware that Resident #60's wound care was not completed by Nurse #5 on Saturday 2/15/25. She stated the wound care populated in the electronic medical record to be completed during day shift and she expected the day shift nurse to complete the treatment. She stated when Nurse #5 returned to work Sunday 2/16/25 and realized the dressing change had not been completed since

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F 686	Continued From page 26 Friday 2/14/25 the nurse should have completed the dressing change sooner than later. She indicted going over 48 hours between daily dressing changes was not acceptable especially since the wound was being treated for infection. She stated education would be provided to staff. During a phone interview on 3/4/25 at 2:00 PM the Medical Director stated Resident #60 was admitted to the facility in March 2024. When she came in, she was frail and in need of a higher level of care. Over the course of a few months, she had weight loss. Labs were done during that time which showed no acute findings. She was also diabetic, and they tried to adjust some of her diabetic medications. She stated overall during the course of several months Resident #60 started to decline due to advanced dementia, and weight loss. When she developed the deep tissue injuries (DTIs) on her heels they ordered a doppler ultrasound (imaging studies to determine blood flow). The doppler study showed severe peripheral arterial disease (narrowed arteries causing reduced blood flow to the arms or legs). She stated Resident #60's multiple comorbidities contributed to her wound development. She stated her overall decline could not have been avoided. She indicated that due to her overall decline in health along with severe peripheral arterial disease these wounds were not avoidable.	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		4/4/25

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F 692	Continued From page 27 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Registered Dietician and Physician interviews, the facility failed to provide a nutritional supplement ordered twice a day for 30 days for wound healing to a resident who was at risk for malnutrition and had a facility acquired unstageable deep tissue injury of the right heel and a deep tissue injury to the left heel that developed into a Stage IV pressure wound. This occurred to 1 of 10 residents (Resident #60) reviewed for nutrition. Findings included. Resident #60 was admitted to the facility on 3/27/24 with diagnoses including muscle wasting with atrophy, dysphagia, and dementia. A wound physician's report dated 11/20/24 revealed Resident #60 had bilateral deep tissue injuries to her left and right heels.	F 692	1. Resident #60's dietitian recommendation for supplement were ordered and initiated on 3/5/25. 2. Any resident with dietitian recommendations for supplements has the potential to be affected by this deficient practice. All dietitian recommendations from 2/20/25 to 3/20/25 were audited by the Director of Nursing/ designee to ensure proper/ timely follow through with on 3/24/25. 3. All licensed nursing staff were educated on proper/ timely follow through dietary recommendations by the Assistant Director of Nursing/Designee on 3/24/25. Any newly hired licensed nursing staff will be educated on proper/ timely follow through of dietitian recommendations by	

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F 692	Continued From page 28 A care plan revised 11/25/24 revealed Resident #60 was at nutritional risk due to cognitive decline associated with dementia, dysphagia with a modified diet order, age-related physiological decline and debility, skin breakdown, diabetes, and aphasia. She was at risk for malnutrition, and for hydration alterations and weight fluctuations secondary to diuretic use. Interventions included in part: to observe for signs of malnutrition and provide and serve supplements as ordered. The Registered Dietician will evaluate and make diet change recommendations as needed. The Registered Dietician review note dated 12/17/24 revealed that she evaluated Resident #60. The head-to-toe skin review indicated that Resident #60 had a suspected deep tissue injury on the right and left heel. The current weight on 12/4/24 was 111 pounds, which was up over the past month. The Registered Dietician recommended for wound healing Arginaid twice a day for 30 days. (Arginaid is a nutritional supplement in a powder or drink mix that contains arginine. Arginine is an amino acid that's essential for wound healing. It stimulates the release of growth hormone and insulin-like growth factor, which can improve wound healing.) Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated December 2024 revealed no documentation that Arginaid nutritional supplement was administered to Resident #60. Review of Resident #60's progress notes from 12/17/24 through 12/31/24 revealed no documentation as to why Arginaid was not administered.	F 692	the Assistant Director of Nursing/designee during orientation. Any agency licensed nursing staff will be educated on proper/ timely follow through of dietitian recommendations by the Assistant Director of Nursing/ designee prior to the start of their first shift. 4. An audit will be completed weekly times twelve by the Director of Nursing/ designee to ensure dietitian recommendations are properly and timely followed through with. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/ designee monthly times three.	

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Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated January 2025 revealed no documentation that Arginaid nutritional supplement was administered to Resident #60.

Review of Resident #60's progress notes from 1/1/25 through 1/17/25 revealed no documentation as to why Arginaid was not administered.

The Minimum Data Set (MDS) quarterly assessment dated 1/1/25 revealed Resident #60 had moderately impaired cognition. She had two deep tissue injuries. She had no rejection of care.

A wound physician's report dated 2/12/25 for Resident #60 revealed the deep tissue injury to the left heel had now revealed itself to be a Stage IV pressure injury. The right heel wound remained unstageable due to necrosis.

The Registered Dietician review note dated 2/13/25 revealed that she evaluated Resident #60 for pressure areas and weight loss. The wound report indicated Resident #60 had wounds to the left and right heel. The Registered Dietician recommended for wound healing and weight stability Arginaid twice a day for 90 days.

Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated February 2025 revealed no documentation that Arginaid was administered to Resident #60.

Review of Resident #60's progress notes from 2/1/25 through 2/28/25 revealed no

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documentation as to why Arginaid was not administered.

Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated March 2025 revealed no documentation that Arginaid was administered to Resident #60 as of 3/5/25.

During an interview on 2/17/25 at 2:30 PM Nurse #8 stated she was consistently assigned to care for Resident #60. She stated Resident #60 had pressure wounds, but she did not recall Resident #60 receiving Arginaid at any time since December 2024. She stated she did not see the order on the MAR or the TAR for Arginaid for Resident #60 in December 2024, or January 2025 or through today 2/17/25.

During an interview on 02/18/25 at 2:44 PM the Registered Dietician stated she last evaluated Resident #60 on 2/13/25. The progress notes indicated Resident #60 continued with deep tissue injuries and Stage III and Stage IV pressure wounds. She stated she was not aware that the Arginaid recommendation for wound healing was not implemented in December 2024, but a new recommendation was made for Arginaid on 2/13/25. She stated she did not enter her recommendations as orders. She stated when she wrote the recommendations, she emailed them to the Director of Nursing, then the physician would sign off on the order then the nursing staff would enter it into the resident's electronic medical record to be implemented.

During an interview on 02/20/25 at 1:04 PM the Director of Nursing (DON) stated that when the Registered Dietician made recommendations

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following her evaluations, she emailed the recommendations to her. She stated she would then forward the email to the Unit Manager to complete the order process. She indicated that she gave the recommendations made by the Registered Dietician to Unit Manager #1 following the December 2024 evaluation of Resident #60.

During a phone interview on 02/21/25 at 2:05 PM Unit Manager #1 stated she gets the Registered Dietician recommendations from the DON. She stated once she gets the recommendation, she sends it to the Nurse Practitioner or the Physician to be signed off, then she would enter the order into the electronic medical record, and it would flow to the Medication Administration Record. She stated she looked back for the recommendation for Resident #60 from December 2024 for Arginaid and she could not find where the recommendation was sent to her. She indicated it was missed and was never implemented.

During a phone interview on 3/4/25 at 2:00 PM the Physician stated Resident #60 had an unstageable deep tissue injury on her right heel and a Stage IV pressure wound on her left heel. She stated Resident #60 had multiple comorbidities that contributed to her wound development and the wounds were unavoidable. She stated she was made aware of the Arginaid order not getting entered for Resident #60 following the onsite survey period. She stated Arginaid had not been used in the facility for several years, however if it was recommended by the Registered Dietician then she would have signed off on the recommendation and expected the order to be entered and administered to the resident.

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F 692	Continued From page 32 A phone interview was conducted on 3/5/25 at 2:00 PM with the Registered Dietician, along with the Administrator and the Corporate Nurse. The Registered Dietician stated her recommendations had to have approval by the Physician before they were entered as an order. She stated she made another recommendation for Arginaid for Resident #60 during her last evaluation on 2/13/25 to aid in wound healing. The Corporate Nurse stated there had been an issue with the Registered Dieticians emails getting transmitted to the DON. The Administrator stated they just ordered the Arginaid for Resident #60, and it arrived at the facility on Monday 3/3/25. He stated Resident #60 would get the Argnaid by tomorrow 3/6/25.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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	F 725		4/4/25

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F 725	Continued From page 33 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 review, staff, and resident interviews the facility failed to provide sufficient nursing staff to provide incontinence care to a dependent resident (Resident #7). Nurse Aide #2 reported she changed Resident #7's brief at approximately at 7:30 AM and had not checked the resident for incontinence needs again until 1:15 PM. This occurred for 1 of 24 residents reviewed for sufficient staffing. Findings included: Resident #7 was admitted to the facility on 12/18/23. Diagnoses included history of urinary tract infections, muscle wasting and atrophy, and need for assistance with personal care. The Minimum Data Set (MDS) quarterly assessment dated 02/11/25 revealed Resident #7 was cognitively intact and was coded for impairments to both sides of upper and lower extremities and dependent with one staff physical assistance for ADL care. Resident #7 was always incontinent of bowel and bladder. A review of the staffing assignment sheet on 02/16/25 revealed there was one nurse aide assigned to each of the 100 hall, 200 hall, 300, and 400 hall from 7:00 AM to 7:00 PM, one nurse	F 725	1. Resident #7 had incontinence care performed on 2/21/25 by Nurse Aide #2. 2. All incontinent residents have the potential to be affected by this deficient practice. All incontinent residents were audited on 3/24/25 to ensure nursing staff were providing incontinent care every two hours and as needed by the nurse managers/ designee. The staffing sheets/ hours were reviewed from 2/20/25 through 3/20/25 to ensure sufficient staff were working. 3. All nursing staff were inserviced on timely incontinent care required to be given every two hours and as needed by the Assistant Director of Nursing/ designee on3/21/25. Any new staff will be inserviced on incontinence care being timely and offered every two hours and as needed by the Assistant Director of Nursing/ designee. Any agency staff will receive this inservice prior to the first shift they work by the Assistant Director of Nursing/ designee. 4. An observation audit will be completed on two residents 5 days a	

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F 725	Continued From page 34 aide on the 500 hall (locked unit) due to a call out, and 2 nurse aides from 10:00 AM until 7:00 PM. The facility census (number of residents residing in the facility) posting on 02/16/25 was 81 residents. The staffing assignment sheets on 02/16/25 revealed the following: Nurse Aide #2 assigned to the 100 Hall with 16 residents Nurse Aide #3 assigned to the 200 Hall with 15 residents Nurse Aide #4 assigned to the 300 Hall with 17 residents Nurse Aide #1 assigned to the 400 Hall with 17 residents Nurse Aide #5 and Nurse Aide #6 assigned to the 500 hall with 16 residents The total number of nurse aides working on 02/16/25 during the 7:00 AM to 7:00 PM was 6. There was a medication aide who was not working as a nurse aide who was administering medications on the 200 hall. An observation and interview with Resident #7 on 02/16/25 at 10:30 AM revealed an alert and oriented resident lying in bed on her back. Resident #7 reported that her brief had not been changed since early this morning and stated it was well before breakfast. Resident #7 stated she was wet with urine at this time and wanted to be changed. Resident #7 stated she would ring her call bell to get assistance. A follow up observation and interview was conducted with Resident #7 on 02/16/25 at 1:15	F 725	week times twelve weeks to ensure they are receiving timely incontinence care by the nurse managers/ designee. The results of these audits will be forwarded to the Quality Assurance and Process Improvement Committee by the Administrator/ designee monthly times three.	

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PM. Resident #7 stated she rang her call bell and told Nurse Aide (NA) #2 that she needed her brief to be changed. The call light was not sounding upon entry to Resident #7's room. Resident #7 reported NA #2 stated she would be right back but she did not come back. Resident #7 stated she believed it was about 10:30 AM or so when she pressed her call bell, but she could not remember the actual time. Resident #7 stated she wanted her brief to be changed, but she did not want to keep bothering the nurse aide.

An observation of NA #2 was conducted on 02/16/25 at 1:15 PM. NA #2 was noted to have checked Resident #7's brief and it was noted to be saturated with a significant amount urine. NA #2 was observed changing Resident #7's brief at this time.

An interview was conducted with NA #2 on 02/16/25 at 1:15 PM. NA #2 was asked when she last checked and changed Resident #7's brief. NA #2 responded "I don't know, I don't keep track of that. I am so busy with the 18 residents on my hall." NA #2 stated she did not recall Resident #7 ringing her call bell to ask for assistance or telling Resident #7 she would be back. NA #2 stated she had 18 residents and it was very difficult to meet all the needs of the residents, and she was not always able to meet their needs during her shift. NA #2 stated she was working from 7:00 AM to 7:00 PM on this hall. She stated she could not always find a staff member to assist her because the other aides were busy too. She stated 18 residents on the 100 hall were a lot of residents to care for during the day and evening shift and it was difficult to do it alone and provide the care needed.

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A follow up interview was conducted with NA #2 on 02/16/25 at 1:45 PM. NA #2 stated she was doing the best she could with keeping up with changing her residents. NA #2 stated she tried to check her residents every 2 - 3 hours per the facility protocol to see if the residents needed to be changed, but that Resident #7 had gone over 4 hours before she was changed again. NA #2 stated she did not remember when she first changed Resident #7 but she thought it was at the start of her shift around 7:30 AM. NA #2 stated she should have checked her for incontinence again after 2-3 hours since she was one of her residents known to urinate a lot. At this time, the actual number of residents she was assigned was confirmed by Nurse Aide to be 16 residents on 02/16/25. NA #2 stated 16 residents on day shift was a lot of care to provide with one nurse aide.

An interview with the Scheduler on 02/18/25 at 1:30 PM revealed on day shift (7:00 AM until 7:00 PM) she was allocated to have 7 nurse aides. The scheduler stated if a staff member called off, they had to try and replace the call out. She stated normal scheduling was based on the facility census and with the census being 81, she would schedule 7 nurse aides but someone almost always called out.

During an interview on 02/18/25 at 11:55 AM Nurse Aide #1 stated it was difficult for her to get all of her care done for the residents when she worked the 400 hall by herself. Nurse Aide #1 stated she usually had at least 17 residents on day shift on her assignment. Nurse Aide #1 stated a lot of her residents on the 400 hall required two person assistance or the need for a

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F 725	Continued From page 37 mechanical lift and it was not easy to find the second person to help. Nurse Aide #1 stated she would ask the upper management staff to assist, but they were not always available to assist. Nurse Aide #1 stated she would then not be able to get the residents out of bed until she found help. During a phone interview on 03/04/25 at 8:00 PM Nurse Aide #14 stated they needed more Nurse Aides assigned to all the halls. NA #14 stated care to the residents was not always getting done such as incontinence care when there was not enough staff. NA #14 stated he had worked each hall and it was always staffed with the bare minimum (1 nurse aide per hall) and it was hard to get care done for the residents. A phone interview was conducted with the Administrator on 02/21/25 at 1:35 PM. The Administrator stated the census on 02/16/25 was 81 and he had scheduled 7 Nurse Aides. He stated they were allocated 7 Nurse Aides on day shift, and they scheduled seven but that included a Medication Aide as well. He stated the 7th person was a Nurse Aide/Medication Aide and was assigned to a medication cart on the 02/16/25 which left only 6 Nurse Aides for 81 residents. The Administrator stated he did not feel it was a concern and that one Nurse Aide to 16 - 17 residents was a manageable assignment. The Administrator stated the assignment was tough but doable.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		4/4/25

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F 727	Continued From page 38 paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 13 of 275 days reviewed for staffing (04/6/24, 04/20/24, 04/21/24, 07/13/24, 07/27/24, 08/17/24, 09/07/24, 09/08/24, 09/28/24, 09/29/24, 10/05/24, 10/28/24, and 12/03/24). Findings included: The PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 1, 2024 (October 1 - December 31) documented the facility had no RN Coverage on 10/08/24, 11/19/24, 12/03/24, and 12/31/24. In addition, the PBJ Staffing Data Report Fiscal Year - Quarter 3, 2024 (April 1 - June 30) documented the facility had no RN Coverage on 04/06/24, 04/07/24, 04/20/24, and 04/21/24. In an interview with the Human Resources Director on 02/18/25 at 1:50 PM she stated she verified by reviewing the daily employee timecard punches that an Agency RN had worked 8 hours on the following dates: 04/07/24,10/08/24,	F 727	1. Eight hours of RN Coverage has been achieved since 3/18/25 by the Administrator/ designee. 2. All residents have the potential to be affected by this deficient practice. The staffing sheets/ hours were reviewed from 2/20/25 through 3/20/25 to ensure the facility had 8 hours of RN Coverage by the Administrator/ designee on 3/21/25. 3. All facility staff involved with staffing were inserviced on the need for 8 hours of RN coverage daily by the Administrator/ designee on 3/24/25. Any newly hired facility staff involved in staffing will receive this education during orientation. 4. A 5 day a week audit will be completed by the Administrator/ designee to ensure 8 hours of RN coverage is achieved daily for twelve weeks. The results of these audits will be brought by the Administrator/ designee to the Quality Assurance and Performance	

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F 727	Continued From page 39 11/19/24, 12/31/24. She could not explain why the PBJ report did not recognize the hours worked by the Agency RN because she did punch the time clock. The Human Resources Director verified by reviewing the timecard punches that the facility did not have 8 hours of RN coverage on the following dates: 04/06/24, 04/20/24, 04/21/24, 07/13/24, 07/27/24, 08/17/24, 09/07/24, 09/08/24, 09/28/24, 09/29/24, 10/05/24, 10/28/24, and 12/03/24. She explained the facility advertised through the internet and social media, participated in local college skills fairs, and placed a sign in facility yard in an effort to hire RN's. In an interview with the Administrator on 02/20/25 at 9:56 AM he explained the facility had a hard time hiring RNs and the Agency also had trouble supplying licensed RNs for the facility. He felt the facility offered a competitive wage. He noted a new scheduler had been hired on 12/06/24 and the scheduling had improved.	F 727	Improvement Committee monthly times three.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		4/4/25

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F 732	Continued From page 40 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document the Daily Nursing Hours' postings on 4 of 324 days reviewed (6/8/24, 6/9/24, 8/17/24 and 12/3/24). Findings included: Review of the Daily Nursing Hours Report from 4/1/24 through 2/18/25 revealed the following: a. On 6/8/24 the report was blank. b. On 6/9/24 the report was blank. c. On 08/17/24 the report had no data recorded	F 732	1. The daily staffing sheet has been accurate and filled out completely as of 3/18/25 by the Administrator/ designee. 2. All residents have the potential to be affected by this deficient practice. The staff posting from 2/20/25 through 3/20/25 were audited by the Administrator/ designee to ensure they were accurate, filled out completely and had 8 hours of RN coverage listed. 3. All staff involved in scheduling were inserviced by the Administrator/ designee on ensuring the daily staff posting is	

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F 732	Continued From page 41 for third shift (11:00 pm-7:00 am). d. On 12/03/24 the posting documented 8 hours of RN (Registered Nurse) coverage when there was none for that 24 hour period. In an interview with the Human Resources Director on 02/18/25 at 1:50 PM she verified by reviewing the employee timecard punches that there had been no RN coverage in the building on 12/03/24 and that the Daily Nursing Hours posting was incorrect. In an interview with the Administrator on 02/20/25 at 9:56 AM he stated there was no excuse for the two postings that were blank. He explained he had assigned himself to review the daily postings to ensure accuracy but had quit checking them 3 or 4 months after their last recertification survey. He noted he spent 2 weeks training a new scheduler that had been hired on 12/06/24 and there had been no errors on the Daily Nursing Hours Report since then.	F 732	accurately and completely filled out to include RN hours on 3/24/25. All newly hired scheduling staff will receive this inservice during orientation. 4. A 5 day a week audit will be conducted by for twelve weeks by the Admnistrator/ designee to ensure the staff posting sheet is completely filled out, accurate and includes RN 8hours coverage. The results of these audits will be forwarded by the Administrator/ designee to the Quality Assurance and Performance Improvement Committee monthly times three	
F 756 SS=E	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.	F 756		4/4/25

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F 756	Continued From page 42 (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, 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 Physician and Consultant Pharmacist's interviews, the Pharmacist failed to identify and address during the monthly medication regimen review that a residents Carvedilol 3.125 milligrams prescribed for hypertension was held 17 out of 31 days during December 2024. This occurred for 1 of 5 residents (Resident #54) reviewed for medication administration. Findings included.	F 756	1. Resident #54 had no ill effect. 2. All residents have the potential to be affected by this deficient practice. All pharmacy recommendations for the month of December 2024 were reaudited to ensure BP parameters were addressed by a different pharmacy consultant to ensure any concerns were identified and corrected as needed on 3/25/25. 3. The pharmacy consultant was	

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F 756	Continued From page 43 Resident #54 was admitted to the facility on 6/28/23 with diagnoses to include hypertension. A physician's order dated 6/10/24 for Resident #54 revealed Carvedilol (antihypertensive) 3.125 milligram tablets. Give one tablet orally two times a day for hypertension. There were no parameters on the order to hold the medication. Review of the Medication Administration Record (MAR) dated December 2024 for Resident #54 revealed Carvedilol 3.125 milligram tablets. Give one tablet orally two times a day for hypertension to be administered at 8:00 AM and 8:00 PM. There were no parameters on the MAR to hold the medication. The medication was signed off on the following dates and times with either a chart code of 4 meaning vital signs were outside of the parameters or a chart code of 5 meaning the medication was held: 12/3/24 at 8:00 AM the blood pressure was 120/51 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/6/24 at 8:00 AM the blood pressure was 103/57 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/7/24 at 8:00 AM the blood pressure was 108/63 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/8/24 at 8:00 AM the blood pressure was 108/63 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/8/24 at 8:00 PM the blood pressure was 105/50 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11. 12/11/24 at 8:00 AM the blood pressure was 110/51 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5.	F 756	reeducated by the chief pharmacy consultant regarding pharmacy recommendations related to blood pressure parameters on 3/19/25. Any newly hired pharmacy consultants will receive this inservice by the chief pharmacy consultant/ designee during orientation. 4. A monthly audit times three of all pharmacy recommendations will be completed by the chief pharmacy consultant/ designee to ensure BP parameters were addressed as needed. The results of these audits will be forwarded by the chief pharmacy consultant/ designee to the Quality Assurance and Performance Improvement Committee monthly times three	

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12/11/24 at 8:00 PM the blood pressure was 105/57 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11.
12/12/24 at 8:00 AM the blood pressure was 100/55 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
12/14/24 at 8:00 PM the blood pressure was 110/70 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
12/16/24 at 8:00 AM the blood pressure was 108/78 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
12/19/24 at 8:00 PM the blood pressure was 118/60 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
12/23/24 at 8:00 AM the blood pressure was 128/60 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
12/23/24 at 8:00 PM the blood pressure was 104/64 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
12/24/24 at 8:00 AM the blood pressure was 110/56 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
12/25/24 at 8:00 AM the blood pressure was 105/93 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5.
12/26/24 at 8:00 AM the blood pressure was 116/54 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
12/30/24 at 8:00 PM the blood pressure was 106/90 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11.

Review of the monthly Pharmacy medication regimen review for January 2025 revealed no recommendations to address Resident #54's Carvedilol 3.125 milligrams being held 17 times during the previous month of December 2024.

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F 756	Continued From page 45 During a phone interview on 2/21/25 at 10:00 AM the Physician stated she was not aware that Resident #54's Carvedilol was being held so many times. She stated she did not usually put hold parameters on blood pressure medications. She stated Resident #54 has had no significant outcome from not receiving the medication. During a phone interview on 02/21/25 at 11:54 AM the Consultant Pharmacist stated the facility made her aware of the medication error today regarding the Carvedilol. She indicated the medication should not have been held unless the resident was symptomatic. She stated the physician should have been notified after the first held dose since there were no parameters and there was enough concern to hold the medication. She indicated she did not realize the number of times the Carvedilol was held during the month of December 2024 and didn't make recommendations to address Resident #54's Carvedilol being held frequently during the January 2025 monthly medication review.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain a medication error rate of less than 5%. There were 3 medication errors observed out of 25	F 759	1. Resident # 79 and resident # 66 had medication error forms completed with physician notification. Nurse #6 and MA#1 had medication passes completed	4/4/25

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F 759	Continued From page 46 opportunities which resulted in a medication error rate of 12%. This occurred for 2 of 4 residents reviewed during a medication pass observation (Resident #79 and #66). Findings included: 1). A medication pass observation on 02/19/25 a 8:30 AM with Nurse #6 revealed Resident #79 was administered Metoprolol (medication to treat high blood pressure) 25 milligrams (mg). Nurse #6 was not observed obtaining Resident #79's blood pressure prior to administering the Metoprolol 25 mg tablet. Nurse #6 stated she completed her medication pass for Resident #79 at 8:45 AM on 02/19/25. The medication reconciliation on 02/19/25 of Resident #79's medications revealed Resident #79 had an order for Metoprolol 25 mg with an order to hold the blood pressure medication if the systolic blood pressure (SBP) was less than 110 mm/Hg (millimeters of mercury). An interview was conducted with Nurse #6 on 02/19/25 at 10:35 AM. Nurse #6 stated she had not obtained a blood pressure from Resident #79. Nurse #6 reviewed the medication administration record and confirmed the order indicated to hold the Metoprolol 25 mg if the SBP was less than 110 mm/Hg. Nurse #6 stated she overlooked that portion of the order and did not obtain a blood pressure as ordered. Nurse #6 took Resident 79's blood pressure at this time and it was noted to be 126/72 mm/Hg. 2). A medication pass observation on 02/19/25 at 9:25 AM with Medication Aide (MA) #1 revealed MA #1 dispensed the following medications for	F 759	with the Assistant Director of nursing/ designee by 3/24/25. 2. All residents have the potential to be affected by this deficient practice. All Certified Medication Aides and Licensed Nurses will have a medication pass completed by nurse managers/ designee to ensure there are no issues by March 25th, 2025. 3. All licensed nurses and Certified Medication Aides received an inservice on taking vitals prior to giving medicines requiring, and to ensure all medicines are given (not omitted) as ordered by the physician order by the Assistant Director of Nursing/ designee on 3/19/25. Any newly hired licensed nurse or Certified Medication Aide will receive this inservice during orientation by the Assistant Director of Nursing/ designee. Any new agency will receive this education prior to their first shift worked by the Assistant Director of Nursing/designee. 4. A medication administration audit will be completed on 1 nurse or CMA 3 times a week times twelve weeks by the Director of Nursing/ designee to ensure blood pressure medications are followed and medicine are not omitted. The results of these audits will be forwarded by the Director of Nursing/ designee to the Quality Assurance and Performance Improvement Committee monthly times three.	

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Resident #66 into a medication cup: Vitamin D12 (supplement) 25 micrograms (mcg) 1000 international units (IU) 2 tablets, Folic Acid (supplement) 1 milligram (mg) one tablet, Isosorbide (medication to treat high blood pressure) 30 mg one tablet, Flomax (medication to treat enlarged prostate) 0.4 mg one tablet, Thiamin BI (supplement) 100 mg one and ½ tablet. MA #1 removed the Losartan (medication to high blood pressure) 25 mg medication card from the medication cart and then returned it back to the cart without dispensing the medication into the medication cup and she also removed the Multivitamin bottle from the medication cart and returned it back to the cart without dispensing any of the medication into the medication cup.

An interview with MA #1 on 02/19/25 at 9:28 AM revealed MA #1 stated she was completed with putting all of the ordered medications in the medication dispensing cup and entered Resident #66's room. MA #1 proceeded to administer Resident #66's medications. MA #1 was asked if she had all of Resident #66's medications to be administered and she replied "Yes." MA #1 went back to her medication cart and realized she omitted two medications: Losartan 25 mg one tablet and Multivitamin 1 tablet. MA #1 added the two medications she had omitted to the medication cup and stated she missed the two pills because she was nervous. MA #1 administered all the ordered medications to Resident #66.

The medication reconciliation on 02/19/25 of Resident #66's medications revealed Resident #66 had an order for Vitamin D12 50 mcg 2000 IUs daily, Folic Acid 1 mg one tablet daily,

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F 759	Continued From page 48 Isosorbide 30 mg one tablet daily, Flomax 0.4 mg one tablet daily, Thiamin BI (supplement) 150 mg one and ½ tablet daily, Losartan 25 mg one tablet daily and Multivitamin 1 tablet daily. An interview was conducted with the Administrator via phone on 02/21/25 at 1:30 PM. The Administrator stated he expected his nursing staff to administer the medications as ordered and to read the orders carefully for any further direction. The Administrator stated the parameters for the blood pressure were in place to monitor the resident's blood pressure to ensure the resident was not receiving the medication when the blood pressure was below the parameters.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, Nurse Practitioner, and the Consultant Pharmacist interviews the facility failed to 1.)administer the antihypertensive medication Carvedilol 3.125 milligrams prescribed twice a day for hypertension. Resident #54 experienced no significant outcome by not receiving the medication. 2.) hold the blood pressure medication Midodrine (prescribed to increase blood pressure) when the systolic blood pressure was greater than 130 millimeters of mercury (mmHg). Resident #43 experienced no significant outcome from receiving the additional doses. This occurred for 2 of 5 residents (Resident #54 and	F 760	1. Medication errors were documented for resident 54 and resident 43 regarding not following BP parameters. Physician notified. Nurses involved were reinserviced regarding following on 3/21/25 physician orders for BP parameters. 2. All residents that have BP parameters have the potential to be affected by this deficient practice. Nurse management/ designee audited all residents that have BP parameters on 3/21/25 to ensure they were followed by physician orders and any	4/4/25

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F 760	Continued From page 49 Resident #43) reviewed for medication administration. Findings included. 1.) Resident #54 was admitted to the facility on 6/28/23 with diagnoses to include hypertension. A physician's order dated 6/10/24 for Resident #54 revealed Carvedilol (antihypertensive) 3.125 milligram tablets. Give one tablet orally two times a day for hypertension. There were no parameters on the order to hold the medication. Review of the Medication Administration Record (MAR) dated December 2024 for Resident #54 revealed Carvedilol 3.125 milligram tablets. Give one tablet orally two times a day for hypertension to be administered at 8:00 AM and 8:00 PM. There were no parameters on the MAR to hold the medication. The medication was signed off on the following dates and times with either a chart code of 4 meaning vital signs were outside of the parameters or a chart code of 5 meaning the medication was held: 12/3/24 at 8:00 AM the blood pressure was 120/51 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/6/24 at 8:00 AM the blood pressure was 103/57 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/7/24 at 8:00 AM the blood pressure was 108/63 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/8/24 at 8:00 AM the blood pressure was 108/63 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/8/24 at 8:00 PM the blood pressure was	F 760	concerns were reported to the physician. Any issues were documented on medication error form with physician notification. 3. All licensed nurses/ CMAs were inserviced by the Director of Nursing/ designee on following physician orders for BP parameters and any concerns should be reported to the physician. Any newly hired licensed nurse/ CMA will be inserviced on following physician orders for BP parameters and any concerns reported to the physician during orientation by the Director of Nursing/ designee. Any agency licensed nurses or CMAs will receive education on following physician orders for BP parameters with any concerns reported to the physician prior to their first shift worked by the Director of nursing/ designee by 3/25/25. 4. A medication administration pass will be completed on 1 Nurse or CMA three times per week times twelve weeks to ensure physician orders for BP Parameters are being followed and any concerns are reported to the physician by the Nurse Managers/ designee. An audit of BP parameters on the MARs will also be checked by the Director of Nursing/ designee to ensure licensed nurses/ CMAs are following physician orders for BP parameters and any concerns reported to the physician weekly times twelve. Any concerns will be documented on medication error forms with physician notification by the Director of Nursing/ designee. The results of these audits will	

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F 760	Continued From page 50 105/50 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11. 12/11/24 at 8:00 AM the blood pressure was 110/51 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/11/24 at 8:00 PM the blood pressure was 105/57 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11. 12/12/24 at 8:00 AM the blood pressure was 100/55 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/14/24 at 8:00 PM the blood pressure was 110/70 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8. 12/16/24 at 8:00 AM the blood pressure was 108/78 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/19/24 at 8:00 PM the blood pressure was 118/60 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8. 12/23/24 at 8:00 AM the blood pressure was 128/60 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8. 12/23/24 at 8:00 PM the blood pressure was 104/64 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8. 12/24/24 at 8:00 AM the blood pressure was 110/56 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8. 12/25/24 at 8:00 AM the blood pressure was 105/93 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5. 12/26/24 at 8:00 AM the blood pressure was 116/54 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5. 12/30/24 at 8:00 PM the blood pressure was 106/90 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #11.	F 760	be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/ designee monthly times three.	

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Review of the progress notes for Resident #54 from 12/1/24 through 12/31/24 revealed no documentation as to why the Carvedilol was held or that the physician was notified that the medication was held.

Review of the Medication Administration Record (MAR) dated January 2025 for Resident #54 revealed Carvedilol 3.125 milligram tablets. Give one tablet orally two times a day for hypertension to be administered at 8:00 AM and 8:00 PM. The medication was signed off on the following dates and times with either a chart code of 4 meaning vital signs were outside of the parameters or a chart code of 5 meaning the medication was held:

1/3/25 at 8:00 PM the blood pressure was 100/60 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
1/12/25 at 8:00 AM the blood pressure was 128/58 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #8.
1/14/25 at 8:00 AM the blood pressure was 108/54 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5.
1/18/25 at 8:00 AM the blood pressure was 112/58 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
1/19/25 at 8:00 AM the blood pressure was 108/59 millimeters of mercury (mmHg) and signed off with chart code of 5 by Nurse #5.
1/21/25 at 8:00 AM the blood pressure was 112/58 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
1/22/25 at 8:00 AM the blood pressure was 108/54 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.

Review of the progress notes for Resident #54

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from 1/1/25 through 1/31/25 revealed no documentation as to why the Carvedilol was held or that the physician was notified with the exception of 1/5/25.

A progress note dated 1/5/25 during the day shift, Nurse #5 documented Carvedilol 3.125 milligrams was held, and the Nurse Practitioner was notified. There was no documentation that Resident #54 was symptomatic.

Review of the Medication Administration Record (MAR) dated February 2025 for Resident #54 revealed Carvedilol 3.125 milligram tablets. Give one tablet orally two times a day for hypertension to be administered at 8:00 AM and 8:00 PM. The medication was signed off on the following dates and times with either a chart code of 4 meaning vital signs were outside of the parameters or a chart code of 5 meaning the medication was held:

2/5/25 at 8:00 AM the blood pressure was 94/54 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/7/25 at 8:00 AM the blood pressure was 112/56 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/9/25 at 8:00 AM the blood pressure was 104/62 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/10/25 at 8:00 PM the blood pressure was 107/56 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/11/25 at 8:00 AM the blood pressure was 90/52 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/12/25 at 8:00 AM the blood pressure was 120/52 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.

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2/14/25 at 8:00 AM the blood pressure was 104/66 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/15/25 at 8:00 AM the blood pressure was 92/58 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/17/25 at 8:00 AM the blood pressure was 108/64 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.
2/18/25 at 8:00 AM the blood pressure was 114/58 millimeters of mercury (mmHg) and signed off with chart code of 4 by Nurse #5.

Review of the progress notes for Resident #54 from 2/1/25 through 2/18/25 revealed no documentation as to why the Carvedilol was held or that the physician was notified of the medication being held.

During an interview on 2/20/25 at 2:00 PM Nurse #5 stated Resident #54 had an order for Carvedilol twice a day. She stated she did hold the medication if his blood pressure was low. She stated there were no parameters on the MAR to hold the medication if the blood pressure was low but thought it was the right thing to do. She stated she thought she did notify the Nurse Practitioner once or twice that she had held Resident #54's Carvedilol but that was over a month ago. She indicated she should not have held the Carvedilol without parameters to hold it without notifying the Nurse Practitioner or the Physician for instructions on whether to hold it or administer the medication.

During an interview on 2/20/25 at 12:27 PM the Nurse Practitioner indicated there were no hold parameters on the Carvedilol for Resident #54. She stated she was not aware the medication

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had been held so frequently. She stated Resident #54 had no outcome due to the medication not being administered and had not been symptomatic for low blood pressure. She stated she would have expected to be notified after one or two doses of the medication being held.

During a phone interview on 2/21/25 at 10:30 AM Nurse #8 stated she would hold Resident #54's Carvedilol if his blood pressure was low. She stated she was not sure if there were hold parameters on the order or not. She stated she didn't recall Resident #54 being symptomatic, such as weakness or lethargy. She stated she did not notify the physician when the residents' blood pressure was low to get orders on whether or not to give the medication or hold it.

During a phone interview on 2/21/25 at 1:40 PM Nurse #11 stated she has held Resident #54's Carvedilol if his blood pressure was low. She stated she did not call the physician to get further instructions to hold it or give the medication.

During an interview on 2/20/25 at 3:00 PM the Director of Nursing (DON) stated she was not aware the Carvedilol was held so frequently by the nurses. She stated if there were no hold parameters on the order then the physician should have been notified that the medication was held so that further instruction or orders could have been given. She stated there was no protocol as to when to call the physician if medications were being held. She stated education would be provided.

During a phone interview on 2/21/25 at 10:00 AM the Physician stated she was not aware that Resident #54's Carvedilol was being held so

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many times. She stated she did not usually put hold parameters on blood pressure medications. She stated Resident #54 has had no significant outcome from not receiving the medication. The Physician stated she should have been notified that the medication was being held so frequently.

During a phone interview on 02/21/25 at 11:54 AM the Consultant Pharmacist stated the facility made her aware of the medication error today regarding the Carvedilol. She indicated the medication should not have been held unless the resident was symptomatic. She indicated the physician should have been notified after the first held dose since there were no parameters and there was enough concern to hold the medication. She indicated typically there were no parameters on Carvedilol unless the resident was symptomatic.

2.) Resident #43 was admitted to the facility on 12/12/24 with diagnosis including hypotension and end stage renal disease.

A physician's order dated 1/3/25 for Resident #43 revealed Midodrine Hydrochloride oral tablet 5 milligrams (mg). Give 1 tablet by mouth two times a day for hypotension. Hold for systolic blood pressure greater than 130 mmHg.

Review of the Medication Administration Record (MAR) dated January 2025 for Resident #43 revealed Midodrine 5 mgs with instructions to hold for systolic blood pressure greater than 130 mm/Hg was administered on the following dates and times when the systolic blood pressure was greater than 130 mmHg.

1/06/25 at 8:00 AM blood pressure 146/82

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(systolic/diastolic) administered by Nurse #8
1/09/25 at 8:00 PM blood pressure 140/70 administered by Nurse #11
1/10/25 at 8:00 AM blood pressure 146/88 administered by Nurse #8
1/11/25 at 8:00 PM blood pressure 132/76 administered by Nurse #10
1/15/25 at 8:00 AM blood pressure 140/86 administered by Nurse #8
1/16/25 at 8:00 AM blood pressure 146/82 administered by Nurse #8
1/16/25 at 8:00 PM blood pressure 140/80 administered by Nurse #10
1/19/25 at 8:00 AM blood pressure 142/89 administered by Nurse#5
1/19/25 at 8:00 PM blood pressure 142/89 administered by Nurse#11
1/20/25 at 8:00 AM blood pressure 138/92 administered by Nurse#8
1/20/25 at 8:00 PM blood pressure 142/78 administered by Nurse#10
1/21/25 at 8:00 AM blood pressure 142/88 administered by Nurse#8
1/21/25 at 8:00 PM blood pressure 140/80 administered by Nurse#10
1/22/25 at 8:00 AM blood pressure 142/86 administered by Nurse#5
1/23/25 at 8:00 AM blood pressure 150/88 administered by Nurse#5
1/24/25 at 8:00 AM blood pressure 144/88 administered by Nurse#8
1/24/25 at 8:00 PM blood pressure 136/80 administered by Nurse#10
1/25/25 at 8:00 AM blood pressure 138/84 administered by Nurse#8
1/26/25 at 8:00 AM blood pressure 144/84 administered by Nurse#8
1/26/25 at 8:00 PM blood pressure 132/82 administered by Nurse#10

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1/27/25 at 8:00 AM blood pressure 135/85 administered by Nurse#5
1/29/25 at 8:00 AM blood pressure 162/86 administered by Nurse#8
1/30/25 at 8:00 AM blood pressure 144/84 administered by Nurse#8
1/30/25 at 8:00 PM blood pressure 138/78 administered by Nurse#10

Review of the Medication Administration Record (MAR) dated February 2025 for Resident #43 revealed Midodrine was administered on the following dates and times when the systolic blood pressure was greater than 130 mmHg.

2/2/25 at 8:00 PM blood pressure 140/72 administered by Nurse #11
2/9/25 at 8:00 PM blood pressure 140/78 administered by Nurse#10

A physician's order dated 2/13/25 for Resident #43 revealed to discontinue Midodrine Hydrochloride oral tablet 5 milligrams (mg). Give 1 tablet by mouth two times a day for hypotension. Hold for systolic blood pressure greater than 130 mmHg.

Review of the progress notes from 1/6/25 through 2/9/25 for Resident #43 revealed no documentation as to why the Midodrine was administered outside of the prescribed parameters or that the Physician was notified.

During an interview on 2/18/25 at 11:28 AM Nurse #8 stated Resident #43 received dialysis three times a week. He was prescribed Midodrine for low blood pressure. She stated if she signed off on the MAR that the medication was administered

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then she did give it. She reported it was done in error.

During an interview on 2/19/25 at 11:00 AM Nurse #5 stated she was aware that there were hold parameters on the Midodrine. She stated if she signed off that the Midodrine was administered to Resident #43 then it was given in error.

During a phone interview on 2/19/25 at 12:50 PM Nurse #10 stated she was aware there were hold parameters on the Midodrine. She stated if she signed off that Midodrine was administered to Resident #43 outside of the parameters then it was administered in error.

During a phone interview on 2/19/25 at 4:00 PM Nurse #11 stated if she signed off on the MAR that she administered Midodrine to Resident #43 outside of the parameters then it was given in error.

During an interview on 2/18/25 at 3:36 PM the Physician stated she was not aware that the Midodrine was not being held according to the prescribed parameters. She stated Resident #43 received dialysis three times a week and has had no significant outcome from receiving the medication. The Physician stated staff should follow the physician orders. She indicated that she had not been notified when the Midodrine was given outside of the parameters.

During an interview on 2/20/25 at 12:27 PM the Nurse Practitioner stated Resident #43 has had no effects of receiving the Midodrine outside of the parameters. She stated she was made aware of the medication error on 2/13/25 and the Midodrine was discontinued. She indicated staff

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F 760	Continued From page 59 should follow the hold parameters according to the order. During an interview on 2/20/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the medication error regarding Resident #43 and medication parameters should be followed. She stated education would be provided. During a phone interview on 02/21/25 at 11:54 AM the Consultant Pharmacist stated the facility made her aware today of the medication error regarding the Midodrine for Resident #43. She stated the medication was discontinued on 2/13/25 by the time she completed the monthly medication regimen review so therefore no recommendations were made. She stated that receiving an antihypotensive medication when it was not needed would increase the blood pressure unnecessarily. She stated they had planned for in-service education with nursing staff in March 2025 and would review medication administration.	F 760		
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	F 812		4/4/25

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F 812	Continued From page 60 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 ensure that food items that were stored for use in 1 of 1 walk-in refrigerator, 1 of 1 reach-in refrigerator and the dry goods storage pantry were labeled, dated, or discarded when expired. This deficient practice had the potential to affect food served to residents. Findings included: An observation on 02/16/25 at 10:20 AM of the kitchen's walk-in refrigerator with the Dietary Manager in training revealed: a. (2) small glasses of nectar orange juice with no opened date b. (1) partially used plastic bucket of pears with no opened date c. (4) hot dogs in a zip lock bag with an expiration date of 02/11/25 d. (1) partially used container of apple juice with an open date of 01/29/25 (expired on 02/04/25) e. (1) tub of chocolate pudding partially used with no opened date f. (1) pitcher of partially used fruit punch with an expiration date of 02/07/25 g. (1) partially used container of thickened sweet tea with lemon with no opened date h. (1) partially used small bowel of apple sauce with no opened date	F 812	1. Expired/ Unlabeled foods were removed from the kitchen on 2/16/25. 2. All residents have the potential to be affected by this deficient practice. All food items in dietary were audited on 2/17/25 by the dietary manager/designee to ensure there were no other food items expired. 3. All dietary staff were inserviced by the regional director of dietary services/designee on ensuring all food items are not expired, labelled once opened as specified in food procurement policies on 3/19/25. Any newly hired dietary staff will receive this education during orientation by the dietary manager/ designee. 4. An observation audit will be conducted by the Administrator/ designee three times per week to ensure there are no expired food products or unlabeled food items weekly times twelve. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/designee monthly times	

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F 812	Continued From page 61 i. (1) partially used bowl of pudding with no opened date j. (1) white tubular package of thawed ground meat with no label and no opened date. k. (3) bowls of mixed fruit with no opened date l. (1) bowl of green Jello with no opened date Additionally, an observation of the reach in refrigerator revealed (1) partially used tub of pimento spread with an expiration date of 01/21/25. An observation of the dry storage pantry on 02/16/25 at 11:00 AM revealed: a. (1) partially used container labeled "yellow cake mix" with no expiration date b. (1) partially used zip lock bag labeled "breadcrumbs" with no expiration date In an interview with the Dietary Manager in training on 02/16/25 at 11:10 AM she stated it was her first day as the Dietary Manager. She could not explain why foods had not been labeled and expired foods had not been discarded. She stated the kitchen staff were supposed to inventory all food storage areas daily to ensure food was properly labeled and expired foods were discarded. In an interview with the Certified District Manager on 02/16/25 at 12:10 PM he stated that all stored foods were to be labeled, dated, and discarded when expired. He explained the current CDM had resigned (effective 02/18/25) and that he would be working full time at the facility until the Dietary Manager in training completed the food safety course and became certified. In an interview with the Administrator on 02/20/25	F 812	three.	

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F 812	Continued From page 62 at 9:56 AM he stated he did not know why foods were stored with no labels and expired foods had not been discarded. He expected all foods to be properly labeled and expired foods to be discarded daily.	F 812		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Nurse Practitioner, Rehabilitation Director, and Registered Dietician interviews, the facility failed to implement a written order for occupational therapy evaluation for 1 of 10 residents (Resident #7) reviewed for nutrition. Findings included:	F 825	1. Resident # 7 received an Occupational Therapy evaluation on 2/19/25 by the Occupational Therapist. 2. All residents that have orders for Physical Therapy, Occupational Therapy or Speech Therapy have the potential to be affected by this deficient practice. All	4/4/25

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F 825	Continued From page 63 Resident #7 was admitted to the facility on 12/18/23. Diagnoses included history of diabetes, protein calorie malnutrition, gastrostomy (the insertion of a feeding tube via the stomach) and need for assistance with personal care. The Minimum Data Set quarterly assessment dated 01/07/25 revealed Resident #7 was cognitively intact and had impairments to both sides to upper and lower extremities. She was required to be set up with clean up assistance with meals. Resident #7 had a feeding tube and was on a mechanically altered diet and therapeutic diet. Resident #7 was receiving 51% or more through the feeding tube and 501 milliliters (ml) per day of fluid through the feeding tube. A care plan review updated on 01/07/25 revealed a plan of care was in place for at risk for nutrition due to dysphagia (difficulty with swallowing) and diabetes. Resident #7 was on a modified diet in order to facilitate oral intake, adult failure to thrive, history of weight loss and risk for malnutrition with a goal that Resident's intake would meet her nutritional needs. Interventions included, in part, observe for signs or symptoms of dysphagia, pocketing food, choking, coughing, drooling, holding food in mouth, or refusing to eat, and provide and serve diet with adaptive feeding equipment as ordered and monitor weight per protocol. Review of Resident #7's weight record revealed her weight was stable for the last 6 months (August 5, 2024, thru February 06, 2025) fluctuating between 192 pounds and 199 pounds.	F 825	residents who had orders for Physical Therapy, Occupational Therapy or Speech Therapy from 2/20/25 through 3/20/25 were audited to ensure therapy was received timely by the Rehabilitation Director/ designee on 3/24/25. 3. All therapy staff and nursing staff were inserviced on proper communication and timely completion of therapy orders by the Administrator/ designee on 3/25/25. Any newly hired therapy or nursing staff will be inserviced on proper communication and timely completion of therapy orders during orientation by the Administrator/ designee. Any agency therapy or nursing staff will be educated on proper communication and timely completion of therapy orders prior to their first shift worked by the Administrator/ designee. 4. An audit will be completed weekly times twelve to ensure all therapy orders are properly communicated to therapy and timely completed by the Director of Rehabilitation/ designee. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/ designee monthly times three.	

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A physician's order written by the Nurse Practitioner (NP) on 01/30/25 revealed an order for Occupational Therapy (OT) to evaluate and treat and an order for Enteral (provide nutrition via a tube) feeding three times a day via a bolus (a single portion of feeding given all at once) of Jevity 1.5 calorie/250 milliliters (ml) with 60 milliliters of water flushes before and after bolus and with meals for diet. Hold bolus feed if resident consumes over 50% of meal.

A review of the resident's electronic medical record revealed there were no occupational therapy notes to indicate Resident #7 had been evaluated on 01/30/25.

An observation and interview with Resident #7 on 02/16/25 at 1:20 PM revealed resident was attempting to eat her meal with a regular fork that was provided from the kitchen and had bilaterally contracted hands where her fingers were fixed in an extended position pointing upwards. Resident was unable to bend her fingers. Resident #7 stated she was able to eat independently and did not like to use the adaptive equipment because it was too heavy.

An interview with Nurse Aide #2 on 02/16/24 at 1:30 AM revealed Resident #7 was able to eat independently with her meals once she was set up to include opening any containers, placing the meal tray in front of her and making sure she had her eating utensils. NA #2 stated she did not use her adaptive equipment which included a fork and spoon because she did not like them. NA #2 stated Resident #7 would usually eat about 25 - 50% of her meal.

An observation of Resident #7 on 02/18/25 at

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12:30 PM revealed resident had her mechanical soft meal tray in front of her which included a fruit bowl, and on the plate included ground protein, string beans and mashed potato with a covered gravy bowl on the side. Resident #7 was observed using a regular spoon (not adaptive) while eating her fruit with some difficulty noted. Resident #7 attempted to eat the mashed potatoes which was placed a little further than the fruit cup but was unable to get the food on the spoon. Resident #7 was unable to open the gravy bowl provided.

During the observation on 02/18/25 at 12:45 PM, Nurse Aide (NA) #1 entered the room and was observing Resident #7. NA #1 was asked if Resident #7 needed assistance with eating. NA #1 replied she seemed to need assistance with her meals. NA #1 stated that she was a new nurse aide at the facility and she was told by other nurse aides that Resident #7 could eat with set up assistance only. NA #1 assisted Resident #7 at this time with her meal tray.

An interview with NA #1 on 02/18/25 at 1:10 PM revealed Resident #7 ate all of her fruit cup and bites of the mashed potatoes only while she was assisting her and she stated she did not want anymore. Nurse Aide #1 stated she would let the nurse know that Resident #7 needed assistance with her meals.

An interview with the Occupational Therapist on 02/18/25 at 3:30 PM revealed she was not aware of an order for occupational therapy evaluation for Resident #7 and that Resident #7 was not currently being followed by occupational therapy.

An interview was conducted with the

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Rehabilitation Director on 02/18/25 at 4:00 PM. The Rehabilitation Director stated if there was a decline in a resident, it was up to nursing to notify the doctor and get a therapy order. The Rehabilitation Director revealed he was responsible for the therapy orders but that he was not aware of the order. He stated he would usually get a "Hey Therapy" form or a verbal order to let him know that there was an order for therapy. The Rehabilitation Director stated the "Hey Therapy" form was a two part form that consisted of a white page and a yellow page titled "Hey Therapy." He stated the nursing staff would complete the 2 part form and send the white page to the Therapy Department and maintain the yellow page for their records.

An interview with Nurse #4 on 02/18/25 at 4:17 PM revealed she was not aware that Resident #7 needing assistance with eating until she was told today by the Nurse Aide. Nurse #4 stated Resident #7 usually would eat on her own once her food tray was set up. Nurse #4 stated Resident #7 had an order if she ate more than 50% of her meal to hold her bolus tube feeding and the resident received her bolus tube feeding today because she was told by the Nurse Aide the resident ate less than 50%. Nurse #4 stated if a resident had a change that required therapy she would just tell the therapy department verbally and let the physician know and then an order would be put in the electronic record. Nurse #4 stated she did not say anything to the facility therapy department regarding Resident #7 at this time. Nurse #4 stated she was not aware of what a "Hey Therapy" form was and never heard of it.

A follow up interview with the Rehabilitation

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Director on 02/19/25 at 11:15 AM revealed he did not review the physician orders to see if any orders were written for therapy. He stated he would have go patient by patient to check orders. He stated the process that was in place for a therapy order was that nursing would write an order and communicate the order to the facility via a "Hey Therapy" form. He stated if the nursing staff do not relay this order to him verbally or via a "Hey Therapy," the order would get missed.

An interview with the Registered Dietician (RD) on 02/19/25 at 2:54 PM revealed Resident #7's weight had been stable for last 6 months. The RD stated staff should be encouraging the resident to eat first and if she consumes less than 50% to administer the tube feeding bolus. The RD stated she had only been at the facility for 2 months and was not aware of Resident's history but stated due to her contractures she needed supervision and cueing after setting up the tray, and to monitor to make sure she got started and continued to eat. The RD stated she was not aware of the occupational order to evaluate and treat on 01/30/25 and she was not aware resident was requiring more assistance to eat.

An interview with the Nurse Practitioner (NP) on 02/20/25 at 12:26 PM. The NP stated she put the order in the electronic record on 01/30/25 because she observed Resident #7 needing assistance with eating and felt she needed to be evaluated. The NP stated that usually after putting in the order, nursing would ensure that the therapy department was aware of the order, but added, that also the therapy department had access to the physician orders and should have seen the order for the occupational therapy

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evaluation.

An interview with Unit Manager #1 on 02/20/25 at 12:35 PM revealed if there was an order for therapy written by the provider, the nurses were to complete a "Hey Therapy" form and bring the form to the Therapy Department. She stated most of the time therapy would already know the order because it was in the electronic record. Unit Manger #1 stated she was the nurse who noted the order and she believed she completed the "Hey Therapy" form which was a two part form. Unit Manager #1 stated nursing would keep the yellow copy and bring the white copy to therapy. The Unit Manager #1 was unable to provide the yellow copy of the "Hey Therapy" form for 01/30/25.

A follow up interview was conducted with the Occupational Therapist on 02/19/25 at 11:42 AM. The OT stated she evaluated Resident #7 during her breakfast on 02/19/25 and brought in several different adaptive utensils such as a built up spoon and a smaller spoon than what was provided ordinarily from the kitchen. The OT stated the built up spoon was too heavy, and that Resident #7 did well with the smaller spoon. The OT stated Resident #7 took 3 bites at the beginning of her meal by herself but required assistance after that as she fatigued easily and required the OT's assistance. The OT stated Resident #7 was able to take 3 bites by herself at the end of the meal after being assisted with feeding. The OT stated after she completed the evaluation, she determined Resident #7 would be added to the therapy case load for strengthening her upper extremities and working with gross and fine motor coordination with a goal to improve her ability to feed herself at least 50% to 75% of her

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F 825	Continued From page 69 meal and to give her increased independence. The OT stated Resident #7 would be getting therapy 3 to 5 times per week as she required assistance from OT in order to have sufficient intake due to the fatigue. The OT stated she would let the nursing staff know that Resident #7 would be dependent with feeding at this point because Resident #7 was fatiguing too quickly and oral intake would not be adequate. An interview with the Administrator on 02/21/25 via phone at 1:30 PM revealed if there was an order in place to evaluate and treat for occupational therapy he would have expected the order to be followed through on. The Administrator stated he would have expected the order to be addressed to avoid any further decline for the resident that may have affected her nutrition.	F 825		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		4/4/25

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F 867	Continued From page 70 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

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F 867	Continued From page 71	F 867		

level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 72 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program established and implemented effective systems to monitor and evaluate action plans previously developed to correct identified deficiencies. This failure resulted in the facility being unable to sustain compliance at F584, F677, F727, F732, and F812. During a complaint investigation and follow up survey of 02/04/23, the facility failed to maintain hot water temperatures in a shower room used by residents (F584). During a complaint investigation survey of 01/25/24, the facility failed to provide incontinent care to dependent residents (F677). During a recertification and complaint investigation survey of 03/27/24, failed to provide 8 hours of a Registered Nurse (RN) coverage (F727), accurately document the Daily Nursing Hours staff postings (F732), and ensure that food items that were stored for use were labeled (F812). On the current recertification and complaint	F 867	Safe Clean comfortable Environment 1. The caulking on the commode bases in room 200, 201, 205, 207, 208,209,305 and 411 was replaced on 3/18/25 by the maintenance director/designee. Overhead lights were fixed for room 202 and 411 and are operational on 3/21/25 by maintenance director/ designee. Hot water temperatures were obtained on the 300-hall (spa room 1 and 2) on 2/17/25 by the maintenance director/ designee. Residents #39, #53, and #60 were received a shower/ bath on 2/18/25. Resident # 7 received incontinence care on 2/21/25. Staff involved with these four residents received education regarding requirements of ADL care regarding bathing/showers and incontinence care by the Director of Nursing/ designee on 2/21/25. Eight hours of RN Coverage has been achieved since 3/18/25 by the Administrator/ designee. The daily	

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F 867	Continued From page 73 investigation survey these identical deficient practices were repeated. The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: a. On the current recertification and complaint investigation survey the facility failed to maintain hot water temperatures in two shower rooms used by residents. During the complaint investigation and follow up survey of 02/24/23 the facility failed to maintain hot water temperatures in a shower room used by residents. An interview was conducted on 02/21/25 at 12:00 PM with the Administrator. The Administrator confirmed he was responsible for providing a safe and homelike environment for all residents, and for making sure the plan of correction (POC) that was in place for the cold shower citation of F584 was effective for sustaining compliance. The Administrator stated both he and the Maintenance Director were responsible for reassessing the POC for F584 to see if the plan that was implemented was working. The Administrator stated he believed the POC was not working because as of September 2024, their paper water temperature logs were no longer being used since they updated to the electronic maintenance system and hired a new Maintenance Director who was not tracking the shower water temperatures. The Administrator added that their new electronic maintenance water testing log did not include testing water temperatures in the shower rooms which resulted in the shower room water temperatures not being monitored and, because of this, they inadvertently	F 867	staffing sheet has been accurate and filled out completely as of 3/18/25 by the Administrator/ designee. Expired/ Unlabelled foods were removed from the kitchen on 2/17/25. 2. All residents have the potential to be affected by this deficient practice. All resident commodes were checked on 3/18/25 by the maintenance director / designee to ensure the caulking was appropriate- if not it was replaced. All overhead lights were checked on 3/21/25 by the maintenance director/ designee to ensure they were in working order- if not they were fixed and operational. All Spa rooms/ showers in the facility were checked to ensure hot water temperatures were obtained on 2/17/25 by the maintenance director/ designee. . All residents' requiring assistance with showers/ bathing and incontinence care were audited on 3/24/25 by the nurse managers/ designee to ensure their assistance level was correct and listed on their kardex. The staffing sheets/ hours were reviewed from 2/20/25 through 3/20/25 to ensure the facility had 8 hours of RN Coverage by the Administrator/ designee on 3/21/25. The staff posting from 2/20/25 through 3/20/25 were audited by the Administrator/ designee to ensure they were accurate, filled out completely and had 8 hours of RN coverage listed. All food items in dietary were audited on 2/17/25 by the dietary manager/designee to ensure there were no other food items expired.	

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F 867	Continued From page 74 forgot to add the 3 shower rooms to the electronic maintenance weekly water temperature testing form. He stated once they realized the water temperatures in the showers were not monitored during this recertification survey, they added shower rooms #1, #2, and #3 onto the electronic water temperature tracking form on 02/18/25 to document shower room water temperatures. The Administrator stated they were not aware of the cold-water concerns in the showers. b. On the current recertification and complaint investigation survey the facility failed to provide incontinence care to a resident who required assistance with activities of daily living (ADLs). During the complaint investigation survey of 01/25/24 the facility failed to provide incontinence care to 4 residents who were unable to carry out activities of daily living without staff assistance that were reviewed for needing assistance with ADLs. An interview with the Administrator conducted via phone on 02/21/25 at 1:30 PM revealed the Director of Nursing was responsible for making sure rounds were being completed to ensure residents were being changed if they were incontinent as part of the plan of correction (POC) that was written for F677. The Administrator stated he was responsible for reviewing the results of the audits to ensure the care was being provided and that the audits may have needed to be in place for a longer period of time. The Administrator stated after the initial audits were completed for the previous citation, there was no further assessing done to see if the plan of correction for providing incontinence care was working. He indicated there should have been further assessing. The Administrator stated he	F 867	3. All maintenance staff were inserviced by the Administrator/ designee to ensure that rooms/ Spa rooms are checked frequently and specifically to look for caulking around commodes, overbed lights, and hot water temperatures in Spa rooms. Any newly hired maintenance staff will received this inservice during orientation by the Administrator/ designee. All nursing staff were inserviced on assistance needed with showers/ bathing and incontinence care of residents, where to find feeding assistance status- Kardex by the Assistant Director of Nursing/ designee on 3/24/25. All newly hired nursing staff will receive this education during orientation by the Assistant Director of Nursing/ designee. Any agency nursing staff member will receive this education prior to working their first shift by the Assistant Director of Nursing/ designee. All facility staff involved with staffing will be educated on the need for 8 hours of RN coverage daily by the Administrator/ designee. Any newly hired facility staff involved in staffing will receive this education during orientation. All staff involved in scheduling were inserviced by the Administrator/ designee on ensuring the daily staff posting is accurately and completely filled out to include RN hours. All newly hired scheduling staff will receive this inservice during orientation. All dietary staff were inserviced by the regional director of dietary services/designee on ensuring all food items are not expired, labelled once opened as specified in food procurement policies on 3/19/25. Any newly hired dietary staff will receive this	

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F 867	Continued From page 75 was not aware that incontinence care was delayed for a resident. The Director of Nursing was not available for an interview on 02/21/25. c. On the current recertification and complaint investigation survey the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 13 of 275 days reviewed. During the recertification and complaint investigation survey of 03/27/24 the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 28 of 45 days reviewed. An interview with the Administrator on 02/20/25 at 9:56 AM revealed that the facility had a hard time hiring full and part time RN's and the Agency they used also had trouble providing licensed RNs for the facility. Additionally, the Administrator stated that the facility had several "as needed" (PRN) RNs but those nurses were not scheduling any days to work. The Administrator stated he was not sure why there were days in April 2024 that had no RN coverage because the new POC was in effect and the schedule was being reviewed every morning in the daily staff meeting. The Administrator stated when it was discovered that there was no RN on the schedule, himself and the DON should have been notified immediately, but they were not. The Administrator added, he and the DON even reviewed the weekend schedules every Friday in the morning meeting to ensure there was an RN on the schedule and discussed that in the event of a last minute call out, himself and the DON should have been notified immediately. The Administrator stated he could not understand how this continued to happen because the schedule was also scrutinized daily to ensure they were within the	F 867	education during orientation by the dietary manager/ designee. 4. The maintenance director/ designee will audit 5 resident rooms per week to ensure caulking around the commode is appropriate and overbed lights are functional times twelve weeks. The maintenance director/ designee will audit water temperatures in all Spa rooms weekly times twelve to ensure hot water is obtained. An observation audit on two residents will be conducted by nurse managers/ designee five days a week times twelve weeks to ensure proper assistance is given for bathing/showers and incontinence care is given. A 5 day a week audit will be completed by the Administrator/ designee to ensure 8 hours of RN coverage is achieved daily for twelve weeks. A 5 day a week audit will be conducted by for twelve weeks by the Admnistrator/ designee to ensure the staff posting sheet is completely filled out, accurate and includes RN 8hours coverage. An observation audit will be conducted by the Administrator/ designee three times per week to ensure there are no expired food products or unlabeled food items weekly times twelve. The results of all audits will be forwarded by the Administrator/ designee to the Quality Assurance and Performance Improvement Committee monthly times three.	

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F 867	Continued From page 76	F 867		

budget and stated that a RN weekend supervisor was hired on 10/23/24 and this had helped.

d. On the current recertification and complaint investigation survey the facility failed to accurately document the Daily Nursing Hours postings on 4 of 324 days reviewed. During the recertification and complaint investigation survey of 03/27/24 the facility failed to accurately document the Daily Nursing Hours staff postings for 2 days.

An interview with the Administrator on 02/20/25 at 9:56 AM revealed that he stated there was no excuse for the two postings that were blank. The Administrator explained he had assigned himself to review the daily postings to ensure accuracy but had quit checking them 3 or 4 months after their last recertification survey. The Administrator stated he had not done his due diligence as the reviewer and needed to do better to fix the problem. The Administrator added he spent 2 weeks training a new scheduler that was hired on 12/06/24 and there had been no errors on the Daily Nursing Hours Report since then.

e. On the current recertification and complaint investigation survey the facility failed to ensure that food items that were stored for use in a walk-in refrigerator, a reach-in refrigerator and the dry goods storage pantry were labeled, dated, or discarded when expired. During the recertification and complaint investigation survey completed on 03/27/24 the facility failed to ensure refrigerated food items that were stored for use in the walk-in refrigerator were dated and sealed.

An interview with the Administrator on 02/20/25 at 9:56 AM revealed that the Dietary Manager was

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F 867	Continued From page 77 responsible for visually inspecting the kitchen freezer and cooler for open, undated items twice daily, 5 days per week Monday through Friday. He stated the Dietary Manager had quit abruptly giving him less than a week's notice. The Administrator stated the previous plan of correction was not working and he believed it was due to poor leadership in the kitchen.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		4/4/25

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F 880	Continued From page 78 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 880	1. Nurse #5, Nurse Aide #1, and Nurse	

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F 880	Continued From page 79 interviews, the facility failed to implement the facility's infection control policy and procedures for Enhanced Barrier Precautions (EBP) when 1.) Nurse #5 provided direct care for Resident #60's Stage IV and unstageable chronic foot wounds without applying the necessary personal protective equipment (PPE) and; 2.) when two nurse aides (Nurse Aide #1 and Nurse Aide #2) provided care to Resident #7 without applying the necessary PPE who had a stage IV pressure ulcer and tube feeding port. This occurred for 3 of 3 staff (Nurse #5, Nurse Aide #1 and Nurse Aide #2) observed for infection control practices. Findings included: Review of the facility's policy for Enhanced Barrier Precautions updated October 2024 revealed "Enhanced Barrier Precautions (EBP) requires the use of gown and gloves only for high contact resident care activities. High contact resident care activities in the residents' rooms included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central lines, urinary catheters, feeding tubes, tracheostomy/ventilator use, and wound care." 1.) During an observation on 02/16/25 at 4:50 PM Resident #60 was observed sitting up in her wheelchair in the common area of the locked dementia unit. Resident #60 was not oriented to person, place, or time. Heel protector boots were in place on both feet. Nurse #5 sat down on the floor in the common area and removed the bilateral heel boots from Resident #60's feet. The gauze dressing on both feet were observed not intact and hanging from the wounds. The wounds	F 880	Aide #2 were reeducated regarding Enhanced Barrier Precautions and the required PPE to be utilized on 3/12/25. 2. All residents that have Enhanced Barrier Precautions have the potential to be affected by this deficient practice. All residents were audited to see if Enhanced Barrier Precautions were to be ordered based on the resident's medical conditions/ diagnosis by the Director of Nursing on 3/24/25 to ensure all residents requiring Enhanced Barrier Precautions had an order. 3. All staff were educated on Enhanced Barrier Precautions and what necessary PPE is needed when entering a resident's room by the Assistant Director of Nursing/ designee on 3/24/25. Any newly hired staff will be inserviced on Enhanced Barrier Precautions and what PPE is to be utilized by the Assistant Director of Nursing/ designee during orientation. Any agency staff will be inserviced on Enhanced Barrier Precautions and what PPE is to be utilized prior to the start of their first shift by the Assistant Director of Nursing/ designee. 4. An observation audit on two staff members will be completed 5 times a week times twelve weeks to ensure staff entering Enhanced Barrier Precaution rooms utilize the appropriate PPE by the Nurse Managers/ designee. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the	

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F 880	Continued From page 80 to her bilateral heels were not completely covered and revealed a Stage IV wound on the left heel and unstageable wound on the right heel. Nurse #5 lifted the left heel and removed part of the soiled dressing with her bare hand. She lifted the right heel and removed part of the soiled dressing with her bare hand. The surveyor stopped Nurse #5 at that point and told her that she needed to wear gloves while handling soiled dressings, and that gowns were also to be worn when providing direct care to a wound. Nurse #5 stopped and stated she would apply gloves and gown before removing more of the soiled dressing and proceeding with her wound care. During an interview on 2/16/25 at 4:50 PM Nurse #5 stated she was aware that Resident #60 had a chronic Stage IV wound, and an unstageable heel wound to her feet. She stated that she thought that she was only going to look at the wounds and not complete the dressing change and that was why she did not apply gloves or a gown prior to handling the wounds. She stated once she removed the heel protectors and saw that the dressing was soiled and falling off, she should have applied gloves and gown prior to removing part of the dressing on Resident #60's feet. She stated she had received infection control training and was aware of the requirement for Enhanced Barrier Precautions. During an interview on 2/20/25 at 1:00 PM the Infection Control Preventionist Nurse stated staff had been trained on Enhanced Barrier Precautions and were aware that gloves and gown were to be applied prior to providing direct care to residents with chronic wounds. During an interview on 2/20/25 at 2:00 PM the	F 880	Administrator/ designee monthly times three.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 03/05/2025

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F 880	Continued From page 81	F 880		

Director of Nursing (DON) stated Resident #60 had chronic heel wounds. She stated staff were aware that gloves and gown were to be worn when providing direct care to a resident with chronic wounds. She stated education would be provided to all nursing staff including Nurse #5.

2a) An observation of Resident #7's room door revealed a sign posted on the front of the door "Enhanced Barrier Precautions." Additionally, a storage cart was located outside the resident's room beside her door containing PPE to include gloves and gowns.

An observation of Nurse Aide (NA) #2 was conducted on 02/16/25 at 1:15 PM. NA #2 was noted to apply gloves and no gown upon entering the resident's room. NA #2 proceeded to remove Resident #7's brief and began to provide incontinence care. The brief was noted to be saturated with a significant amount urine. NA #2 was observed changing Resident #7's brief at this time with the use of gloves only.

An interview with NA #2 on 02/16/25 at 1:25 PM revealed she thought she was only suppose to wear gloves. She stated she did not think she had to wear a gown. NA #2 read the sign on the door and stated she knew Resident #7 had a wound and had a g-tube (gastrectomy tube inserted in the abdomen to provide nutrition). NA #2 stated she would wear the appropriate PPE to include gown and gloves whenever she entered the room from now on.

2b) An observation of NA #1 was conducted on 02/18/25 at 11:30 AM. NA #1 was observed completing incontinence care for Resident #7 while she secured the resident's brief and

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F 880	Continued From page 82	F 880		

disposed of the soiled brief and was noted to have on gloves only.

An interview was conducted with NA #1 on 02/18/25 at 11:30 AM. NA #1 was asked if she wore a gown while she provided incontinence care to Resident #7 and she stated "No, I thought I was only suppose to wear gloves." NA #1 stated she was aware that Resident #7 had a pressure ulcer and a g-tube (gastrectomy tube inserted in the abdomen to provide nutrition).

An interview was conducted with the Administrator via phone on 02/21/25 at 1:30 PM. The Administrator stated all staff needed to follow the policy and the signage on the door for residents with Enhanced Barrier Precautions in order to protect themselves and other residents from the potential of getting an infection. He stated education was given to every staff member regarding EBP upon hire and when the EPB was first initiated, but that more education was needed to be provided regarding enhanced barrier precautions.