STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 03/03/25 through 03/06/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KT6X11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/03/25 through 03/06/25. Event ID #KT6X11. The following intakes were investigated NC00225246, NC00227749, NC00225993, NC00227908, and NC00227921. 5 of the 18 complaint allegations resulted in 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, 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.	F 561		3/27/25

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

Electronically Signed | 03/27/2025

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F 561	Continued From page 1 §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 record reviews, and residents and staff interviews, the facility failed to honor residents' preferences for a shower for 3 of 3 residents reviewed for choices (Resident #32, Resident #77, and Resident# 24.) The findings included: 1a. Resident #32 was admitted to the facility on 2/16/22 with diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 1/8/25 assessed Resident #32 to be moderately cognitively impaired. The MDS assessed Resident #32 to require substantial assistance with showering/bathing. The MDS documented Resident #32 said it was very important to choose between a shower and a sponge bath. Review of the facility shower schedule revealed Resident #32 (who resided on the 200 hall) was scheduled for a shower on Tuesday and Friday. The Activities of Daily Living log for Resident #32 was reviewed and it was noted on Friday 2/28/25	F 561	F561 Self-Determination 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #32 was provided with their preferred type of bathing (shower) on 3/25/25. Resident #32 currently remains in the facility and is receiving preferred type of bath as scheduled. Resident #24 was provided with their preferred type of bath (shower) on 3/25/25. Resident #24 currently remains in the facility and is receiving preferred type of bath as scheduled. Resident #77 was provided with their preferred type of bath (shower) on 3/25/25. Resident #77 currently remains in the facility and is receiving preferred type of bath as scheduled. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:	

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F 561	Continued From page 2 she did not receive a shower. Resident #32 was interviewed on 3/3/25 at 2:23 PM and she reported she did not get a shower on 2/28/25 and this was upsetting to her. A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on 2/28/25. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #32. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #32 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #32 did not request a shower from her on 2/28/25. b. Resident #77 was admitted to the facility on 4/4/23 with diagnoses including asthma. The annual MDS dated 4/4/2024 documented Resident #77 said it was very important to choose between a shower and a sponge bath. The quarterly MDS dated 12/24/24 assessed Resident #77 to be moderately cognitively impaired and she required substantial assistance with showering/bathing. Review of the facility shower schedule revealed Resident #77 (who resided on the 200 hall) was scheduled for a shower on Tuesday and Friday.	F 561	Current residents have the potential to be affected. Current residents and/or responsible parties will be interviewed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) Nurse(s), Activities Director and/or designee to determine the resident□s/responsible party□s preferred type of bath for the resident by 4/3/25. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (NM), or designee will provide education to current agency nursing staff, facility nursing staff, and therapy staff noting residents are to be offered and receive their preferred type of bath as scheduled. If a resident refuses their preferred type of bath, the resident□s assigned nurse should document the refusal in the electronic health record. Education will be completed by 4/3/25. After 4/3/25, all contract agency and/or facility nursing staff that has not worked and received the education will complete upon their next scheduled shift. " Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will include education noting the same in general orientation for contract agency and facility nursing staff.	

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F 561	Continued From page 3 The Activities of Daily Living log for Resident #77 was reviewed and she did not receive a shower on 2/28/25. Resident #77 was interviewed on 3/5/25 at 10:25 AM and she reported she did not receive a shower on 2/28/25 and she wanted a shower. Resident #77 reported not receiving her shower was upsetting to her. A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on 2/28/25. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #77. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #77 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #77 did not request a shower from her on 2/28/25. c. Resident #24 was admitted to the facility 5/12/23 with diagnoses including heart disease. The annual MDS assessment dated 5/18/24 documented the staff assessment of daily and activity preferences that Resident #24 preferred to receive a shower or a bed bath. The quarterly Minimum Data Set (MDS) assessment dated 12/24/24 documented	F 561	4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will review documentation in the electronic health record to ensure residents are being offered and receiving their preferred type of bath as scheduled during clinical morning meeting. Documentation audits will be conducted 3 times per week x 12 weeks. Additionally, 5 residents with BIMS of 12 or higher will be interviewed weekly x 12 weeks to ensure they are being offered their preferred type of bath. The Administrator is responsible for the plan of correction and monitoring audits. The QAPI committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 4/3/25	

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Resident #24 was cognitively intact and she required moderate assistance with showering/bathing.

Review of the shower schedule for Resident #24 (who resided on the 200 hall) revealed she was scheduled for a shower on Tuesday and Friday.

The Activities of Daily Living log for Resident #24 was reviewed and she did not receive a shower on 2/28/25.

Resident #24 was interviewed on 3/5/25 at 10:28 AM. Resident 24 reported she did not receive a shower on 2/28/25 and she wanted a shower. Resident #24 reported she thought she would be offered a shower later on that date, but no one offered her a shower, and this was upsetting to her.

A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on 2/28/25. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #24. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #24 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #24 did not request a shower from her on 2/28/25.

The Director of Nursing (DON) was interviewed

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F 561	Continued From page 5 on 3/6/25 at 9:37 AM. The DON reported NA #3 did not get accurate information from other staff members and Resident #32, Resident #77, and Resident #24 should have been offered a shower on 2/28/25. The DON reported she expected the bathing preferences of residents to be honored. The Administrator was interviewed on 3/6/25 at 2:01 PM and she reported she expected residents to receive showers on their scheduled days if they wanted a shower.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		3/27/25

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F 585	Continued From page 6	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 7 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and Responsible Party and staff interviews, the facility failed to make prompt efforts to resolve a grievance 1 of 3 residents reviewed for grievances (Resident #72). The findings included: The facility grievance policy dated 11/2016 and revised 8/2018 read, in part: "Upon receipt of an oral, written or anonymous grievance ... the	F 585	F585-483.10(j)(1)-(4)- Grievances Corrective Action for the Resident Affected On , the responsible party for resident #72 was contacted by the corporate office on March 18, 2025 to discuss their grievances. Per the responsible party, they prefer contact to be made concerning resident #72 via email. It was agreed	

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F 585	Continued From page 8 Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated; ...the Grievance Committee/Grievance Official shall complete an investigation of the resident's grievance. This may include a review of the facility processes, programs, and policies, as well as interview with staff, residents and visitors, as indicated; .... Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: the date the grievance was received, the summary of the statement of the resident' grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action that was or will be taken, and if corrective action was taken a summary of the corrective action ...the Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the grievance was resolved or will be resolved. A copy of the written grievance decision will be provided to the resident upon request." Resident #72 was admitted to the facility 6/29/22 with diagnoses including Parkinson's Disease. The quarterly Minimum Data Set assessment dated 12/2/24 assessed Resident #72 to be severely cognitively impaired. The Responsible Party provided an email dated 11/11/24 at 2:49 PM from the Responsible Party to Social Worker (SW) #1, read, "I received a very concerning call last night that (Resident #72) has no Parkinson's medications to take because	F 585	upon that email correspondences would be communicated per request via email. Corrective Action for the Residents Potentially Affected All residents have the potential to be affected. On March 27, the Administrator reviewed grievances. All of the grievances were resolved and proper communication was given to the resident and or responsible parties. Systemic Changes On March 27, 2025, the Administrator in-serviced the Interdisciplinary team (IDT) on the grievances process and the grievance/compliant form. The in-service included the process of completion of the grievance and proper communication with the person(s) filing the grievance in a timely manner. The Social Worker will in-service all staff on the grievance process and proper communication with the person(s) filing the grievance in a timely manner by 4/3. Any new hires will receive training during orientation. Staff on FMLA will receive training upon their next scheduled shift. Quality Assurance The Administrator and or the Social Worker will randomly select 3 completed grievances weekly times 4 weeks, then monthly utilizing the QA Monitoring Tool for grievances, to ensure that proper communication has occurred with the person(s) filing the grievance in a timely manner. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance & Performance Improvement (QAPI)	

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F 585	Continued From page 9 (the medications) could not be found. This is obviously a very, very big deal, and I need to know exactly how this happened and what is the solution. From my understanding, she may have already been out of medications for a couple of days before I was notified. Can you please let me know the full details surrounding this situation? Thank you." A grievance dated 11/11/24 filed on behalf of Resident #72 by the Responsible Party documented the Responsible Party reported his concern to SW #1 and indicated he had concerns about medication administration for Resident #72. The concern was assigned to the Director of Nursing (DON) on 11/11/24 and the DON documented on the grievance "attempted to call (Responsible Party) time 3 to discuss medications and answer questions." At the bottom of the grievance form it was documented by the DON she had attempted to call the Responsible Party on 11/12/24 at 5:00 PM, 11/12/24 at 5:30 PM, and 11/13/24 at 11:30 AM. The resolution of the concern section of the grievance form had documentation that "no" the concern was not resolved because the Responsible Party was unable to be reached. The Responsible Party was interviewed by phone on 3/3/25 at 3:07 PM. The Responsible Party reported he had filed a grievance with the facility in November 2024 regarding his mother's medications and the facility had not contacted him regarding the grievance or a resolution. The Responsible Party explained that in addition to emailing SW #1, he had verbally expressed concerns to other staff members, including the floor nurse, and the care planner, and he had not received any resolution to those issues. The	F 585	Committee by the Social Worker for review by the IDT members monthly. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance:4/3/2025	

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Responsible Party explained that he was very busy, and he wanted communication by email so that he was better able to respond to the facility. The Responsible Party explained he had emailed several administrative staff members with his concerns, but no one had reached out to him.

SW #2 was interviewed on 3/6/25 at 1:25 PM. SW #2 reported she had been at the facility for 3 weeks and had not been handling the grievance process. SW #2 reported SW #1 had been at the facility when the Resident #72's Responsible Party filed the grievance.

SW #1 was not available for interview.

The DON was interviewed on 3/6/25 at 1:47 PM. The DON explained because SW #2 was new, she and the Administrator had taken over the Grievance Official responsibilities until SW #2 was ready to take on that responsibility. The DON reported she was told by SW #1 that Resident #72's Responsible Party had told SW #1 he would only accept email and not phone calls from the DON. The DON reported she attempted to contact the Responsible Party three times, and he did not return her calls, and she did not know what concerns he had regarding medication administration. The DON explained she was not aware the Responsible Party wanted email exchanges until after she attempted to call him, and she did not email the Responsible Party about his concerns. The DON reported she thought the Administrator was handling the grievance with Resident #72's Responsible Party and she did not reach out to him to get the details about his grievance filed on 11/11/24.

The Administrator was interviewed on 3/6/25 at

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F 585	Continued From page 11 2:01 PM and she reported Resident #72's Responsible Party was reporting his concerns to a former Nursing Assistant (NA) who no longer worked at the facility. The Administrator reported that when the NA left the facility, the Responsible Party had complaints that he was reporting to different staff, but when he put the grievance in writing, the DON was unable to contact him by phone to discuss the issues. The Administrator reported she did not feel that email was appropriate to discuss grievances, and the DON had not pursued the investigation because she had been unable to talk to the Responsible Party. The Administrator reported she had not attempted to call or email Resident #72's Responsible Party regarding the grievance he filed on 11/11/24.	F 585		
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 record review and staff interviews the	F 600	F-600 □ Free from Abuse and Neglect	3/27/25

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F 600	Continued From page 12 facility failed to protect a resident's right to be free from staff to resident abuse. While Nurse Aide (NA) #6 and NA #7 were providing care for a cognitively impaired resident, the resident became agitated. NA #7 slapped the resident on the left upper thigh and NA #6 held the residents' hands during care while the resident was agitated and being combative. This deficient practice was found for 1 of 3 residents reviewed for abuse (Resident #3). The findings included: Resident #3 was admitted to the facility on 01/11/21 with diagnoses which included cerebral infarction, major depressive disorder, dementia, contracture right knee, and contracture to left knee. Review of Resident #3's annual Minimum Data Set (MDS) dated 01/30/25 revealed Resident #3 was severely cognitively impaired and required extensive assistance with two people assist for bed mobility and transfers. The MDS further revealed Resident #3 was not coded for any behaviors. Review of Resident #3's care plan revised on 02/13/25 revealed the resident was at risk of adjustment issues due to showing sign and symptoms of depression, anxiety, and psychosocial wellbeing issues. Resident #3 exhibited the following inappropriate behaviors, negative statements, and resistance of care. Resident #3 had the potential to be verbally aggressive, inappropriate, demonstrate physical behavior, wanders the facility, and depression. The goal was for Resident #3 to maintain comfort and dignity daily with calm relaxed manners,	F 600	Corrective Action for the Resident Affected On 3/2/25, the Administrator and unit manager performed a head-to-toe assessment on resident #3 and no injuries were noted. On 3/7, the Administrator, submitted a North Carolina Department of Health and Human Services, Health Care Personnel Registry, 24-hour Initial Report and initiated an internal investigation. Corrective Action for the Residents Potentially Affected All Residents have the potential to be affected. Staff performed a head-to-toes assessment on all residents with a BIMS score of 11 and below to ensure that no other resident had been affected were done March 3. None of the residents had any signs of injury. The Social Worker(s), interviewed residents that are alert and oriented to person, place and time and a BIMS score of 12 and above on March 3 and 4 asking them if they had been treated inappropriately. None stated they had not been injured. Systemic Changes An inservice was initiated March 3 and 5 to staff on Abuse, specifically that the residents have the right to be free from abuse, (mental, verbal, sexual and physical,) neglect, misappropriation of resident property and exploitation, and including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraints that is not required to treat the resident□s medical symptoms. Any staff that did not	

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F 600	Continued From page 13 clean appearance, positive decision making, maintain psychosocial wellbeing, positive expressions, positive body language. Resident #3 would be monitored and met with appropriate interventions. Interventions included for Resident #3 was to always approach in a calm and relaxed manner, encourage activity distraction, encourage resident to express needs, explain all procedures and care before beginning to assist, monitor and report and mood changes to nurse, and observe and report to the nurse any behavior issues. Review of the initial facility reported incident dated 03/25/25 at 8:00 AM revealed it was reported that an employee stated that they helped another employee with providing incontinence care and during the process the employee slapped the resident with her hand. The accused employee was told to leave the facility and removed from the schedule until the investigation was completed. It further revealed skin assessment did not show any findings. Review of the investigation completed by the Administrator related to Resident #3's incident revealed the following: -Nurse Aide (NA) #6 written statement dated 03/02/25 read in part, around 1:00 AM she and NA #7 went to put Resident #3 in bed. Resident #3 was lying on her left side and NA #6 was on her right side. Resident #3 started to be aggressive and started to hit and cuss and called NA #7 the "N Word". NA #7 stated "she was proud of her skin." NA #6 and NA #7 continued care and Resident #3 hit NA #6 a few times and as NA #6 was getting the other side of the brief out Resident #3 hit NA #7 and NA #7 let the	F 600	receive the in-service by 4/3 will be taken off the schedule until they receive the training. This in-service will be a part of the orientation process for newly hired staff. Quality Assurance The Social Worker(s) will randomly select 3 staff members, 3 times a week for 4 weeks, then 2 staff members weekly for 4 weeks then monthly, from different departments, example, Activities, Dietary, Nursing, Maintenance, Housekeeping/Laundry and or Rehab, to ensure that they understand the meaning of abuse and the different types or abuse and neglect, utilizing the QA monitoring tool for abuse, neglect and exploitation. The results of the interviews will be submitted to the Quality Assurance and Performance Improvement (QAPI) committee by the Social Worker. The Quality monitoring schedule modified based on findings. The QAPI committee to evaluate and modify monitoring as needed. Date of Compliance: 4/3/2025	

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resident down on the bed and hit her thigh. NA #6 was trying to hold Resident #3's hands trying to prevent but she had let go of hands. NA #6 and NA #7 finished care and left the room.

- Nurse Aide (NA) #7 statement dated 03/02/25 read in part, on 03/02/25 NA #6 asked to assist to put Resident 33 in bed around 1:00 AM. NA #7 revealed taking off Resident #3's pants the resident began to hit, and NA #6 stated "she is going to try to hit you". Resident #3 tried to hit NA #6 and NA #6 told the resident not to hit her. Resident #3 began to call NA #7 a "ni**ger and monkey." NA #7 stated "I swear to god I never touched that lady". NA #7 indicated NA #6 never voiced any concerns during care. NA #7 revealed she had tried to leave during care, but NA #6 had begged her to stay and help finish the resident. After care was provided NA #6 and NA #7 went immediately to the nurses' station discussing how Resident #3 had been combative and had called NA #7 names. NA #7 revealed she finished her charting at the nurses' station and passed out ice and did not go back to Resident #3's room. Around 5:00 AM Nurse #7 told NA #7 she had to leave the facility, and she left.

- Nurse #7 written statement dated 03/02/25 read in part, Nurse #7 was not in the room of question. NA #6 reported "NA #7 hit resident on her left upper thigh. Resident #3 was also combative.

Review of NA #7's time sheet revealed she worked on 03/1/25 from 7:00 PM until 5:45 AM on 03/02/25.

A phone interview conducted with NA #7 on 03/05/25 at 12:30 PM revealed NA #6 had asked her to assist with Resident #3 to complete

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incontinence care. NA #7 indicated she had cared for Resident #3 before, and the resident could be combative and resistive to care at time. NA#7 further revealed NA #6 and NA #7 began care and Resident #3 became combative and hit NA #6. NA #7 revealed NA #6 stated, "You don't need to hit us were just trying to help you". NA #7 indicated she wanted to stop and walk away from assisting the resident, but NA#6 wanted to complete care due to Resident #3 having a bowel movement. NA #7 stated Resident #3 continued to call her a "ni**ger and a monkey", and she replied that "she was proud to be a nig**er." NA #7 revealed Resident #3 was combative while she cleaned her. NA #6 held Resident #3's hands for an estimated time of 5 minutes so that she could not hit the NAs during care. NA #7 revealed Resident #3 attempted to hit her but never made contact. NA #7 denied being aggressive or slapping Resident #3.

A phone interview conducted with NA #6 on 03/04/25 at 6:40 PM revealed on 03/02/25 she and NA #7 went into Resident #3's room to give incontinence care. NA #6 revealed she had cared for Resident #3 before and was sometimes combative and resistive to care. NA #6 indicated Resident #3 was not cognitively intact and was hard to understand. NA #6 revealed she and NA #7 had used a mechanical lift and got Resident #3 undressed with no issues. It was further revealed when Resident #3 was rolled on her right side she became combative and hit NA #6 in the arm. NA #6 stated she told Resident #3, "we don't hit, and everything was okay." NA #6 revealed she and NA #7 continued care and rolled Resident #3 back to her back that Resident #3 was attempting to punch and grab at both NA's. NA #6 stated Resident #3 hit her in the arm

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again. NA #6 indicated Resident #3 started to grab at herself and she took Resident #3's hands and held them for 2-3 minutes while Resident #3 continued to be combative. NA #6 and NA #7 rolled Resident #3 onto her left hip as NA #6 continued to hold Resident #3's hands. NA #6 indicated Resident #3 fell loose from NA #6's grip and struck at NA #7 hitting her in the arm. NA #6 stated at this time NA #7 laid the residents' leg back down from cleaning her and slapped her on her right upper thigh with an open hand. NA #6 revealed she was in shock and did not say anything to NA #7. NA #6 indicated Resident #3's behavior remained combative throughout care and seemed agitated. NA #6 stated she had been educated to walk away if residents were combative but did not with Resident #3 due to wanting to ensure, she was clean from her bowel movement. NA #6 revealed she and NA #7 completed care on Resident #3 and she did not report until around 5:00 AM to Nurse #7 due to being busy on the floor with residents. NA #6 indicated NA #7 worked the rest of the shift with residents answering call lights.

A phone interview conducted with Nurse #7 on 03/05/25 at 11:15 AM revealed on 03/02/25 around 5:00 AM NA #6 reported to her that Resident #3 was combative during care and had called NA #7 a "ni**er," and hit the resident on her thigh. Nurse #7 further revealed NA #6 had stated the incident occurred between 1 and 1:30 AM. Nurse #7 stated she conducted a skin assessment on Resident #3 and found no new skin marks or issues. Nurse #7 indicated both NAs had been educated on walking away from residents if they are combative during care. Nurse #7 Indicated Resident #3 could sometimes be combative and resistive during care.

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F 600	Continued From page 17 An interview conducted with the Director of Nursing (DON) and the Administrator 03/05/25 at 12:00 PM revealed on 03/02/25 at 5:30 PM they were notified NA #6 had observed NA #7 hitting Resident #7 on the upper left thigh. The Administrator and DON were not aware NA #6 had restrained resident #3 during care by holding hands to prevent her from hitting the NA's. The DON further revealed she advised Nurse #7 to take NA #7 off the floor immediately sent her home. The DON revealed that NAs had cared for Resident #3 and the resident could be combative and resistive with care.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		3/27/25

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F 607	Continued From page 18 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow and implement abuse policies in the area of identification, protection and reporting for 1 of 3 residents reviewed for abuse (Resident #3). While Resident # 3 was being abused, Nurse Aide (NA) #6 did not intervene, stop, or report NA #7 when she slapped Resident #3 on the thigh. Also, NA #7 did not intervene or report immediately NA #6 for restraining Resident #3's hands during care when NA #6 held onto Resident #3's hands with her hands. As a result, NA #6 and NA #7 worked the rest of their shift, putting other residents at risk for abuse. The findings included: Review of the facility policy and procedure titled "North Carolina Resident Abuse Policy", with a revised date of 07/11/24, read in part 1.) Under Protect the Resident, "If the resident is injured. If the resident is injured as a result of the alleged or suspected incident, the facility should take immediate action to treat the resident. Under part a.) Staff should report all incidents immediately to their direct supervisors. Addressed under part 2.) If a staff member is accused or suspected, "If a staff member is accused or suspected of abuse, neglect, mistreatment, exploitation, involuntary	F 607	F-607 - Develop /Implement Abuse/Neglect Policies Corrective Action for the Resident Affected On 3/7/25, NA #7 was terminated for inappropriate approach with Resident #3 while performing Activities of Daily Living (ADL□s,) and for failure to immediately report NA #6 for perceived allegations. On 3/7/25, NA #6 was terminated for failure to report Resident #3□s hands while NA #7 was performing ADLs, and failure to immediately report NA #7. On 3/2, the administrator and unit nurse performed a head-to-toe assessment on resident #3 to ensure there was no injuries noted with negative results. Corrective Action for the Residents Potentially Affected All Residents have the potential to be affected. Staff performed a head-to-toes assessment on all residents with a BIMS score of 11 and below on March 3 to assure that no other resident had been affected. None of the residents in the facility had any signs of injury. The Social Worker(s), interviewed residents that are alert and oriented to person, place and time and a BIMS score	

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F 607	Continued From page 19 seclusion and/or misappropriation of property, the Facility immediately remove staff member from resident care area and request a written statement from accused staff member." Under definitions it reads in part, "restraints (physical or chemical) may only be used per MD order in compliance with regulations and guidelines." Review of the investigation completed by the Administrator related to Resident #3's incident revealed the following: -Nurse Aide (NA) #6 written statement dated 03/02/25 read in part, around 1:00 AM she and NA #7 went to put Resident #3 in bed. Resident #3 was lying on her left side and NA #6 was on her right side. Resident #3 started to be aggressive and started to hit and cuss and called NA #7 the "N Word." NA #7 stated, "She was proud of her skin." NA #6 and NA #7 continued care and Resident #3 hit NA #6 a few times and as NA #6 was getting the other side of the brief out during care Resident #3 hit NA #7 and NA #7 let the resident down on the bed and hit her thigh. NA #6 was trying to hold Resident #3's hands trying to prevent but she had let go of the residents' hands. NA #6 and NA #7 finished care and left the room. - Nurse Aide (NA) #7 statement dated 03/02/25 read in part, on 03/02/25 NA #6 asked to assist to put Resident #3 in bed around 1:00 AM. NA #7 revealed taking off Resident #3's pants the resident began to hit, and NA #6 stated "She is going to try to hit you." Resident #3 tried to hit NA #6 and NA #6 told the resident not to hit her. Resident #3 began to call NA #7 a "ni**ger and monkey." NA #7 stated "I swear to god I never touched that lady." NA #7 indicated NA #6 never	F 607	of 12 and above on March 3 and 4 asking them if they had been treated inappropriately during ADL care. None stated they had not been injured. Systemic Changes An inservice was initiated an in-service on the facility policy and procedure titled North Carolina Resident Abuse Policy, specifically, reporting immediately any abuse/neglect to their supervisor(s)on March 3. Any staff that did not receive the in-service by 4/3 will be taken off the schedule until they receive the training. This policy will be a part of the orientation process for newly hired staff. Quality Assurance The Social Worker(s), will randomly select 3 staff members, 3 times a week for 4 weeks, then 2 staff members weekly for 4 weeks then monthly, from different departments, example, Activities, Dietary, Nursing, Maintenance, Housekeeping/Laundry and or Rehab, to ensure that they understand the facility abuse policy and reporting any abuse/neglect immediately should they become aware, utilizing the QA monitoring tool for immediately reporting abuse. The results of the interviews will be submitted to the Quality Assurance and Performance Improvement (QAPI) committee by the Social Worker. The Quality monitoring schedule modified based on findings. The QAPI committee to evaluate and modify monitoring as needed. Date of Compliance:4/3/2025	

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voiced any concerns during care. NA #7 revealed she had tried to leave during care, but NA #6 had begged her to stay and help finish the resident. After care was provided NA #6 and NA #7 went immediately to the nurses' station discussing how Resident #3 had been combative and had called NA #7 names. NA #7 revealed she finished her charting at the nurses' station and passed out ice and did not go back to Resident #3's room. Around 5:00 AM Nurse #7 told NA #7 she had to leave the facility, and she left.

- Nurse #7 written statement dated 03/02/25 read in part, Nurse #7 was not in the room of question. NA #6 reported, NA #7 hit a resident on her left upper thigh. Resident #3 was also combative.

Review of NA #7's timecard revealed she worked on 03/1/24 from 7:00 PM until 5:45 AM on 03/02/25.

A phone interview conducted with NA #7 on 03/05/25 at 12:30 PM revealed NA #6 had asked her to assist with Resident #3 to complete incontinence care. NA #7 indicated she had cared for Resident #3 before, and the resident could be combative and resistive to care at times. NA#7 further revealed NA #6 and NA #7 began care and Resident #3 became combative and hit NA #6. NA #7 revealed NA #6 stated, "You don't need to hit us were just trying to help you." NA #7 indicated she wanted to stop and walk away from assisting the resident, but NA#6 wanted to complete care due to Resident #3 having a bowel movement. NA #7 stated Resident #3 continued to call her a "ni**ger and a monkey," and she replied to the resident "She was proud to be a nig**er." NA #7 revealed Resident #3 was combative while she cleaned her. NA #7

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explained NA #6 held Resident #3's hands for an estimated time of 5 minutes so that she could not hit the NAs during care. NA #7 revealed Resident #3 attempted to hit her but never made contact. NA #7 denied being aggressive or slapping Resident #3.

Review of NA #6's timecard revealed she worked on 03/1/24 from 7:00 PM until 7:45 AM on 03/02/25.

A phone interview conducted with NA #6 on 03/04/25 at 6:40 PM revealed on 03/02/25 she and NA #7 went into Resident #3's room to give incontinence care around 1:00 AM. NA #6 revealed she had cared for Resident #3 before, and the resident was sometimes combative and resistive to care. NA #6 indicated Resident #3 was not cognitively intact and was hard to understand. NA #6 revealed she and NA #7 had used a mechanical lift to put the resident into bed and then got Resident #3 undressed with no issues. It was further revealed when Resident #3 was rolled on her right side she became combative and hit NA #6 in the arm. NA #6 stated she told Resident #3, "We don't hit, and everything was okay." NA #6 revealed she and NA #7 continued care and rolled Resident #3 back to her back that Resident #3 was attempting to punch and grab at both NA's. #6 stated resident #3 hit her in the arm again. NA #6 indicated Resident #3 started to grab at her own thighs and she took Resident #3's hands and held them for 2-3 minutes while Resident #3 continued to be combative. NA #6 and NA #7 rolled Resident #3 onto her left hip as NA #6 continued to hold Resident #3's hands. NA #6 indicated Resident #3 freed herself loose from NA #6's grip and struck at NA #7 hitting her in the

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F 607	Continued From page 22	F 607		

arm. NA #6 stated at this time NA #7 laid the resident's leg back down from cleaning her and slapped her on her right upper thigh with an open hand. NA #6 revealed she was in shock and did not intervene. NA #6 indicated Resident #3's behavior remained combative throughout care and the resident seemed agitated. NA #6 stated she had been educated to walk away if residents were combative but did not with Resident #3 due to wanting to ensure, she was clean from her bowel movement. NA #6 revealed she and NA #7 completed care on Resident #3, and she did not report NA #7 had slapped Resident #3 on the thigh until around 5:00 AM to Nurse #7 due to being busy on the floor with residents. NA #6 indicated NA #7 worked the rest of the shift with residents and answering call lights.

A phone interview conducted with Nurse #7 on 05/05/25 at 11:15 AM revealed on 03/02/25 around 5:00 AM NA #6 reported to her that Resident #3 was combative during care and had called NA #7 a "ni**er," and NA #7 hit the resident on the resident's thigh. Nurse #7 further revealed NA #6 had stated the incident occurred between 1:00 AM and 1:30 AM. Nurse #7 indicated she educated NA #6 that she should have reported the incident immediately and not later in the shift. Nurse #7 revealed she immediately removed NA #7 from the floor around 5:00 AM once when NA #6 reported the incident.

An interview conducted with the Director of Nursing (DON) and the Administrator on 03/05/25 at 12:00 PM revealed on 03/02/25 at 5:30 AM they were notified NA #6 had observed NA #7 hitting Resident #7 on the upper left thigh. The DON further revealed she advised Nurse #7 to take NA #7 off the floor immediately and send her

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F 607	Continued From page 23 home. The DON indicated NA #6 and NA #7 had been educated on reporting abuse and walking away from residents who were combative during care. The DON revealed NA #6 and NA #7 should have walked away from Resident #3 when she was combative, NA #7 should have intervened and reported immediately when NA #6 restrained Resident #3's hands during care and NA #6 should have intervened and reported immediately when NA #7 slapped Resident #3.	F 607		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff	F 693	F693 Tube Feeding Management	3/27/25

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F 693	Continued From page 24 interviews, the facility failed to store an enteral feeding syringe with the plunger separated from the syringe for 2 of 4 residents (Resident #44 and Resident #65) reviewed for enteral feeding management. This practice had the potential for bacterial growth and contamination. Findings included: a. Resident #44 was admitted to the facility on 8/29/20217 with diagnoses of diabetes and difficulty swallowing. A significant change Minimum Data Set assessment dated 1/30/2025 indicated Resident #44 received 51% of more of her total calories from enteral feedings and 501 milliliter of fluids per day by enteral feedings. On 3/3/2025 an observation was made of Resident #44's a plastic enteral feeding flush syringe, stored in a plastic bag and hanging from the feeding tube pump pole, with the plunger in the syringe with thick white liquid in the tip of the syringe. During an observation on 3/4/2025 at 2:00 pm Resident #44's enteral feeding flush syringe was stored in a plastic bag with the plunger in the syringe, hanging from the feeding tube pump pole. An interview was conducted with Nurse #1 on 3/4/2025 at 2:13 pm and she stated Resident #44 was administered medication and flushes through her enteral feeding tube at 7:30 am. Nurse #1 stated she did not know that the plastic syringe should be stored separately from the plunger to allow the syringe to dry to prevent bacterial	F 693	1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #44 remains in the center and was provided with a new feeding syringe with plunger on 3/24/25. Resident #44□s feeding syringe is currently being stored with plunger and syringe separated. Resident #65 remains in the center and was provided with a new feeding syringe with plunger on 3/24/25. Resident #65□s feeding syringe is currently being stored with plunger and syringe separated. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. Current residents who receive tube feedings will have feeding syringe audited to ensure syringe and plunger are cleaned and stored separately following use by Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS) and/or designee by 4/3/25. Any concerns identified during the audit will be addressed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS) and/or designee. 3. Measures to be put in place or systemic changes are made to ensure the	

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F 693	Continued From page 25 growth. b. Resident #65 was admitted to the facility on 9/2/2021 with diagnoses of dementia and difficulty swallowing. A quarterly Minimum Data Set Assessment dated 12/8/2024 indicated Resident #65 received 51 % or more of her total calories from enteral feedings and 501 milliliters of fluids daily by enteral feedings. Resident #65's enteral feeding flush plastic syringe was observed on 3/3/2025 at 12:04 pm, with the syringe stored in a plastic bag on hanging from the tube feeding pump pole, and plunger was stored inside the syringe with a white liquid in the end of the syringe. Nurse #2 had taken the plastic syringe from the plastic bag and was going to administer Resident #65's flush and was stopped and she stated she was not aware the plunger should not be stored in the syringe. Nurse #2 replaced the plastic syringe and administered the flush. An interview was conducted with the Director of Nursing on 3/6/2025 at 2:56 pm and she stated the enteral feeding plastic syringe should be washed and the plunger left out of the syringe to allow it to air dry to prevent any bacterial growth in the syringe. During an interview with the Administrator on 3/6/2025 at 3:17 pm she stated Nurse #1 and Nurse #2 should have washed the plastic syringe and plunger separately to allow them to dry completely to prevent any bacterial growth.	F 693	practice will not re-occur: " Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS) and/or designee will provide education to current contract agency and facility licensed nurses noting feeding syringe and plunger should be inspected from cleanliness prior to use and feeding syringe and plunger should be cleaned and stored separately after each use to prevent bacterial growth and contamination. Education will be completed by 4/3/25. After 4/3/25, all contracted agency/facility staff that has not worked and received the education will complete upon their next scheduled shift. " Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will include education noting the same in general orientation for contract agency and facility licensed nurses. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will audit the cleanliness and storage of feeding tube syringes 3 times a week x 12 weeks. The Administrator is responsible for the plan of correction and monitoring audits. The QAPI committee will meet monthly for 3 months and review the audits to	

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F 693	Continued From page 26	F 693	determine trends and/or further problem resolution if needed. Date of compliance: 4/3/25.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide clean air intake filters on oxygen concentrators for 2 of 4 residents (Resident #34 and Resident #44) reviewed for respiratory care. Findings included: a. Resident #34 was admitted to the facility on 7/19/2024 with respiratory disease. Review of Resident #34's medical record revealed a Physician's Order written on 11/8/2024 which indicated Resident #34 required oxygen at 2 to 4 liters per minute by nasal canula to keep her oxygen saturation above 90%. A quarterly Minimum Data Set assessment dated 2/13/2025 indicated Resident #34 was cognitively intact and received oxygen therapy.	F 695	F695 Respiratory Care 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #34 remains in the center and has an air intake filter on the oxygen concentrator which was cleaned and is without film and or black dust on 3/7/25. Resident #44 remains in the center and has an air intake filter on the oxygen concentrator which was cleaned and is without film and or black dust on 3/7/25. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:	3/27/25

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F 695	Continued From page 27 During an observation of Resident #34 on 3/5/2025 at 6:39 am she was noted in bed with her nasal canula on and her oxygen concentrator machine was set at 2.5 liters per minute. The oxygen concentrator had a film of black dust approximately 1/8 inch thick covering the air intake filter. On 3/6/2025 at 8:45 am Resident #34 was observed up in her wheelchair in her room. Her oxygen concentrator machine was set at 2.5 liters per minute and 1/8 inch of black dust continued to cover the air intake filter. During an interview and observation of Resident #34's oxygen concentrator with Nurse #1 on 3/6/2025 at 2:46 pm she stated she did not know who was responsible for cleaning the air intake filter on the oxygen concentrators. She stated she thought that either a nurse or nurse aide should be responsible, or housekeeping could also clean the concentrator. b. Resident #44 was admitted to the facility on 8/29/2017 with diagnoses of dementia and respiratory disease. A Physician's Order dated 12/18/2024 indicated Resident #44 required oxygen at 2 liters per minute by nasal canula. A significant change Minimum Data Set assessment dated 1/30/2025 indicated Resident #44's was moderately cognitively impaired and received oxygen therapy. On 3/3/2025 at 10:34 am an observation of Resident #44 revealed she was in bed with her	F 695	Current residents who require oxygen have the potential to be affected. Current residents with oxygen concentrators will have air intake filters visualized to ensure they are clean and without film and/or black dust by the Maintenance Director, Maintenance Assistants, Housekeeping/Laundry Supervisor and/or designee by 4/3/2025. Any concerns identified during the audit will be addressed by the Maintenance Director, Maintenance Assistants, Housekeeping/Laundry Supervisor and/or designee. 3. Measures to be put in place or systemic changes are made to ensure the practice will not re-occur: " The Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or designee will provide education to the Maintenance Director and Maintenance Assistants noting air intake filters in the oxygen concentrators are to be cleaned weekly and replaced as needed to ensure they are clean and without film and/or black dust. Education will be completed by 4/3/25. " Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will include education noting the same in general orientation for any newly hired Maintenance Director and Maintenance Assistants. 4. How facility will monitor corrective	

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F 695	Continued From page 28 oxygen on at 2 liters per minute by nasal cannula. Her oxygen concentrator machine was at her bedside and had a 1/8-inch film of black dust covering the air intake filter. An interview and observation of Resident #44's oxygen concentrator machine was conducted with Nurse #1 on 3/6/2025 at 2:27 pm and Nurse #1 stated the oxygen concentrator's air intake filter was covered with dust and she did not know who should clean them. During an interview with the Housekeeping Supervisor on 3/6/2025 at 2:49 pm she stated nursing staff was responsible for cleaning the oxygen concentrator air intake filters. An interview was conducted with the Director of Nursing on 3/6/2026 at 2:54 pm and she stated the assigned nurse should clean the oxygen concentrators every Sunday night. On 3/6/2025 at 3:15 pm the Administrator was interviewed and stated the nursing staff should clean the oxygen concentrator machines and the air intake filter at least weekly.	F 695	action(s) to ensure deficient practice will not re-occur: Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will visualize 10 residents air intake filters in the oxygen concentrators weekly x 12 weeks. The Administrator is responsible for the plan of correction and monitoring audits. The QAPI committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 4/3/25.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, and family member, Physician, and staff interviews, the facility failed to ensure a resident was transported to a	F 745	F 745 Provision Medically Related Social Services	3/27/25

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F 745	Continued From page 29 scheduled neurologist appointment on 2/28/25 for 1 of 1 resident reviewed for medical related social services (Resident #72). The findings included: Resident #72 was admitted to the facility 6/29/22 with diagnoses including Parkinson's disease. Review of Resident #72's medical record revealed a neurologist progress note dated 11/25/24. The note made recommendations for physical therapy, speech therapy, and occupational therapy. The progress note did not mention a follow-up appointment. The quarterly Minimum Data Set assessment dated 12/2/24 assessed Resident #72 to be severely cognitively impaired. A care plan dated 7/8/24 and a revision date of 2/27/25 addressed Resident #72' Parkinson's disease and that family member "prefers Resident to be seen by specialist and facility will provide transport as able." Interventions included monitoring for cognitive changes. Review of Resident #72's medical record did not reveal any documentation related to a neurologist appointment on 2/28/25. Resident #72's family member was interviewed by phone on 3/3/25 at 3:07 PM. The family member reported he takes Resident #72 to a neurologist about every 2 months for medication adjustments and recommendations for therapies to treat her disease progression. The family member explained he made an appointment for Resident #72 for 2/28/25 to see the neurologist	F 745	Corrective Action for the Resident Affected Resident #73 has an appointment with the neurologist on May. If the facility transportation van is unable to transport the resident, the Administrator will schedule the transport with the outside transportation company. Corrective Action for the Residents Potentially Affected All residents have the potential to be affected. On March 26,2025, the Administrator reviewed all outside appointments scheduled going back for 30 days, Feb 24-March 26 to ensure the residents were transported to their scheduled appointments. Of the 46 appointments scheduled, all were transported by the facility transport van and 8 were transported by the outside transportation company. The only missed appointment was the one cited. Systemic Changes On March 26, 2025, the Administrator in-serviced the facility transporter on the importance of scheduling the residents going to their scheduled outside appointments, including reviewing the transportation schedule weekly with the Director of Nursing to ensure that all outside appointments are set up with the facility van and or scheduled with the outside contracted transportation company. Quality Assurance The Administrator will monitor the outside appointment schedule 3 times a week for 4 weeks then weekly for 8 weeks, then monthly utilizing the QA Monitoring Tool	

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F 745	Continued From page 30 and he notified the facility of the appointment in November 2024. The family member explained he received a phone call 2 days before the appointment on 2/26/25 when he was told the facility could not provide transportation to the appointment. The family member reported he met Resident #72 at the appointments, but he was unable to transport her to the appointments and relied on the facility to get her to the neurologist. The family member reported he rescheduled the neurologist appointment, but the only available time was in May 2025 and Resident #72 would have to go almost 6 months without seeing the neurologist and this was very upsetting to him. The facility Transporter was interviewed on 3/5/25 at 2:43 PM. The Transporter reported she was the only driver for the facility van, although the facility did have a contracted transportation company for some transportation. The Transporter explained that about one week before Resident #72's appointment with the neurologist, she realized that she would be unable to take Resident #72 to the appointment because it was approximately 48 miles from the facility to the neurologist and the Transporter had to be close to the facility for another appointment. The Transporter explained she called the contracted transportation company, but they did not have any openings for 2/28/25 to take Resident #72 to her neurologist appointment. The Transporter reported she called Resident #72's family member on 2/26/25 to notify him that the facility would not be able to transport Resident #72 to the neurologist. The Transporter reported the family member was very upset. The Physician was interviewed on 3/6/25 at 11:24	F 745	for scheduled appointments/transportation ensure that the resident is transported by the facility transporter or that the transportation was set up with the outside contracted transportation company. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance & Performance Improvement (QAPI) Committee by the Administrator for review by the IDT members monthly. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance:4/3/2025	

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F 745	Continued From page 31 AM. The Physician reported the family member felt that Resident #72 needed to continue the neurologist appointments, but the neurologist had not changed the medications to treat her Parkinson's disease for a long time, and the missed appointment was unlikely to impact her care. The Director of Nursing (DON) was interviewed on 3/6/25 at 1:47 PM. The DON explained that when the Transporter realized she would be unable to take Resident #72 to her neurology appointment, the Transporter attempted to find alternative transportation. The DON reported the contracted transportation company was booked up on 2/28/25 and had been unable to take Resident #72 to the appointment. The DON reported the Transporter communicated this to the family member and the appointment was rescheduled for May 2025. The DON explained that since then, the Transporter has been bringing the transportation schedule for weekly review to identify any conflicts in the schedule, and the DON reported she expected those conflicts to be addressed by arranging transportation with the contracted company. The Administrator was interviewed on 3/6/25 at 2:01 PM. The Administrator reported she discussed the missed appointment with the facility Physician, and he said that the missed appointment had not impacted Resident #72's care. The Administrator reported a transportation conflict prevented the facility from transporting Resident #72 to the appointment and she expected alternative transportation to be arranged if possible for future appointments.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		3/27/25

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F 755	Continued From page 32 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Physician's Assistant interviews, the facility failed to ensure 1 of 4 residents (Resident #72) reviewed for medication administration was provided	F 755	F755 Pharmacy Services 1. What corrective action will be accomplished for each resident found to	

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F 755	Continued From page 33 medication from the pharmacy as ordered by the physician. Findings included: Resident #72 was admitted to the facility on 6/29/2022 with Parkinson's disease a neurocognitive disorder with dementia. A Physician's Order dated 9/11/2024 indicated Resident #72 was prescribed Carbidopa-Levodopa (medication used to manage the symptoms of Parkinson's disease) 25-100 milligrams 2.5 tablets should be given four times a day. A Nurse's Progress Note dated 11/10/2024 at 7:28 pm indicated Nurse #7 discovered there was no Carbidopa-Levodopa 25-100 milligrams for Resident #72, and the correct dose was not available from the facility's electronic emergency medication system. The Progress Note further stated Nurse #7 notified the Director of Nursing and the pharmacy the medication needed to be sent to the facility. Nurse #7's Progress Note further stated she was told by the pharmacy that Resident #72's medication would not be sent to the facility until 11/17/2024 and she called the Physician's Assistant and was told the Carbidopa-Levodopa was an essential medication and to call the pharmacy back. Nurse #7 called the pharmacy again and was told they spoke with the Director of Nursing and a "Refill Too Soon" form was faxed to the facility and once the form was received by the pharmacy the medication would be sent. During the survey attempts were made to reach Nurse #7 who cared for Resident #72 on	F 755	have been affected by the deficient practice: Resident #72 remains in the center and is being provided medications from the pharmacy as ordered by the physician. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), or designee will complete a 100% audit of medication carts to ensure current residents have medications available on the cart from pharmacy for administration as ordered by the physician by 4/3/25. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), and/or designee will address any concerns noted during the audit. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), or designee will provide education to current agency and facility licensed nurses noting residents are to have medications provided from the pharmacy available for administration on the medication cart. The education will	

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F 755	Continued From page 34 11/10/2024 without success. The Medication Administration Record (MAR) for 11/10/2024 indicated Resident #72's Carbidopa-Levodopa was not available to be administered because it was not available. Nurse #7 had documented on the MAR that the 11/10/2024 the 12:00 pm and 4:00 pm doses were not administered, and the Physician's Assistant was notified but no hold order was given for the medication, and the facility was working to resolve the issue. On 11/11/2024 at 10:49 pm a Nurse's Progress Note written by Nurse #6 indicated Resident #72's Carbidopa-Levodopa was held because Nurse #6 was waiting on it to be delivered by the pharmacy and the provider gave an order for the medication to be held. The Progress Note also stated the Physician and Responsible Party were aware. Nurse #6 documented on the MAR on 11/11/2024 the 8:00 am and 12:00 pm doses of Resident #72's Carbidopa-Levodopa were not available and was on hold. No Physician's Order was found for Resident #72's Carbidopa-Levodopa to be held on 11/11/2024. On 11/20/2024 at 5:39 pm Nurse #6's Progress Note stated Resident #72 did not have a scheduled dose of Carbidopa-Levodopa and the Physician gave an order to hold the medication until it was delivered at midnight from the pharmacy. During a review of the MAR for 11/20/2024 the following doses were documented as not	F 755	include steps to take in the event medication is not available to include: notifying provider and pharmacy, checking Omnicell, etc. Education will be completed by 4/3/25. After 4/3/25, all contract agency and/or facility nursing staff that has not worked and received the education will complete upon their next scheduled shift. • Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Licensed Nurse Supervisor (LS), or designee will include education noting the same in general orientation for contract agency and facility licensed nurses. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will audit 2 of 4 medication carts 3x per week x 12 weeks to ensure residents have medications provided from the pharmacy available for administration on the medication cart. The Administrator is responsible for the plan of correction and monitoring audits. The QAPI committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 4/3/25.	

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F 755	Continued From page 35	F 755		

administered by Nurse #6: 11/20/2024 at 12:00 pm, and 11/20/2024 at 4:00 pm. The MAR for 11/20/2024 indicated Resident #72's Carbidopa-Levodopa was on hold.

No Physician's Order was found for Resident #72's Carbidopa-Levodopa to be held on 11/20/2024.

Nurse #6 was interviewed by phone on 3/6/2025 at 11:52 am and she stated she cared for Resident #72 frequently during November 2024 and remembered there was an issue with getting her Carbidopa-Levodopa from the pharmacy. Nurse #6 stated Resident #72's Carbidopa-Levodopa dose was not available from the electronic emergency medication system, and she reported to the Nurse Practitioner that the medication was not available and got an order to hold the medication. Nurse #6 stated she could not remember the date the medication was not available, but she would have written a nurse note and documented the order to hold Resident #72's medication.

During an interview with the Physician's Assistant on 3/6/2025 at 11:18 am she stated Resident #72 had diagnoses of Parkinson's disease with Lewy body dementia and required the physician's ordered Carbidopa-Levodopa. The Physician's Assistant stated she does not remember the staff notifying her Resident #72's Carbidopa-Levodopa was not available or giving an order to hold the medication.

During an interview with the Director of Nursing on 3/6/2025 at 2:59 pm she stated she did not recall anyone reporting Resident #72 did not have Carbidopa-Levodopa available for administration.

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F 755	Continued From page 36 The Director of Nursing stated Nurse #6 and Nurse #7 should have checked the electronic emergency medications and called the pharmacy to ensure Resident #72's medication was sent as soon as possible, and they should have notified the provider. The Administrator was interviewed on 3/6/2025 at 3:15 pm and stated she expected the nursing staff to ensure Resident #72 received her medication from the pharmacy and administered according to the physician's orders.	F 755		
F 760 SS=D	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's Assistant and Physician interviews, the facility failed to ensure 1 of 4 residents (Resident #72) reviewed for medication administration was free of significant medication errors. Resident #72 was not administered six doses of Carbidopa-Levodopa (a drug that treats Parkinson's disease, a central nervous system disease) 25-100 milligrams 2 ½ tablets which was ordered four times a day. Findings included: Resident #72 was admitted to the facility on 6/29/2022 with Parkinson's disease a neurocognitive disorder with dementia. A Physician's Order dated 9/11/2024 indicated	F 760	F760 Significant Med Error 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #72 remains in the center and is free of significant medication errors as evidenced by audit of medication administrations for the past 30 days which revealed no significant medication errors and resident is receiving medication as order by the physician. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same	3/27/25

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F 760	Continued From page 37 Resident #72 Carbidopa-Levodopa 25-100 milligrams 2.5 tablets should be given four times a day. A quarterly Minimum Data Set assessment dated 12/2/2024 indicated Resident #72 was severely cognitively impaired. A Nurse's Progress Note dated 11/10/2024 at 7:28 pm indicated Nurse #7 discovered there was no Carbidopa-Levodopa 25-100 milligrams for Resident #72, and the correct dose was not available from the facility's electronic emergency medication system. The Progress Note further stated Nurse #7 notified the Director of Nursing and the pharmacy the medication needed to be sent to the facility. Nurse #7's Progress Note indicated she was told by the pharmacy that Resident #72's medication would not be sent to the facility until 11/17/2024 and she called the Physician's Assistant and was told the Carbidopa-Levodopa was an essential medication and to call the pharmacy back. Nurse #7 called the pharmacy again and was told they spoke with the Director of Nursing and a Refill Too Soon form was faxed to the facility and once the form was received by the pharmacy the medication would be sent. Nurse #7 documented on the Medication Administration Record (MAR) on 11/10/2024 at 12:00 pm and 11/10/2024 at 4:00 pm that Resident #72's Carbidopa-Levodopa was not available. The MAR also indicated the dose was not available on 11/10/2024 at 12:00 pm and The Physician's Assistant was notified, and no hold order was given, and the facility was working to resolve the issue. Nurse #7 also documented on the MAR the dose due at 11/10/2024 at 4:00 pm	F 760	deficient practice: Current residents have the potential to be affected. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), or designee will complete a 100% audit of medication administration records of current residents for the last 30 days to ensure current residents are receiving medications as ordered by the provider by 4/3/25. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), and/or designee will address any concerns noted during the audit. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • Director of Nursing (DON), Assistant Director of Nursing (ADON), Licensed Nurse Supervisor (LNS), or designee will provide education to current agency and facility licensed nurses and medication administration aides noting residents are to receive medications as ordered by the physician to be free from significant medication errors. Education will be completed by 4/3/25. After 4/3/25, all contract agency and/or facility nursing staff that has not worked and received the education will complete upon their next scheduled shift. • Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Licensed Nurse Supervisor (LS), or designee will include education noting the	

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F 760	Continued From page 38 was not administered because it was not available, and the Physician's Assistant and Director of Nursing were notified and the facility continued to work on the issue. During the survey attempts were made to reach Nurse #7 who cared for Resident #72 on 11/10/2024 without success. On 11/11/2024 at 10:49 pm a Nurse's Progress Note written by Nurse #6 indicated Resident #72's Carbidopa-Levodopa was held because Nurse #6 was waiting on it to be delivered by the pharmacy and the provider gave an order for the medication to be held. The Progress Note also stated the Physician and Responsible Party were aware. A review of Resident #72's MAR for 11/11/2024 revealed the following doses of Carbidopa-Levodopa were documented as not administered because the drug was unavailable and was on hold by Nurse #6: 11/11/2024 at 8:00 am, 11/11/2024 at 12:00 pm. An order to hold the Carbidopa-Levodopa on 11/11/2024 at 8:00 am and 12:00 pm was not indicated on Resident #72's Physician's Orders. The Responsible Party provided a copy of an email sent to Social Worker #2 on 11/11/2024 at 2:49 pm which stated he was concerned when he got a call from the facility stating Resident #72 did not have her medication (Carbidopa-Levodopa) and was told she had not had her medication for a couple of days. The Responsible Party's email stated he asked for full details regarding Resident #72 not receiving her medication. During the survey attempts were made to contact	F 760	same in general orientation for contract agency and facility nursing staff. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or LPN Supervisor (LS), or designee will audit medication administration in electronic health record for current residents' 3 x week for 12 weeks. The Administrator is responsible for the plan of correction and monitoring audits. The QAPI committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 4/3/25.	

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F 760	Continued From page 39	F 760		

Social Worker #2, who no longer worked at the facility, without success.

On 11/20/2024 at 5:39 pm Nurse #6's Progress Note stated Resident #72 did not have a scheduled dose of Carbidopa-Levodopa and the Physician gave an order to hold the medication until it was delivered at midnight from the pharmacy. The Progress Note further stated the Responsible Party was made aware the medication would be held.

Review of the Medication Administration Record for 11/20/2024 the following doses of Resident #72's Carbidopa-Levodopa were documented as not administered and on hold by Nurse #6: 11/20/2024 at 12:00 pm and 11/20/2024 at 4:00 pm.

A Physician's Order was not found to hold Resident #72's Carbidopa-Levodopa.

Nurse #6 was interviewed by phone on 3/6/2024 at 11:52 am and stated she cared for Resident #72 frequently during November 2024 and remembered there was an issue with getting her Carbidopa-Levodopa but was not sure about the exact dates of when the medication was not available or when she notified the Physician's Assistant the medication was not available and received a hold order for the medication. Nurse #6 stated she would have documented in a nurse's note on both 11/11/2024 and 11/20/2024 if she documented the medication was not available.

During an interview with the Physician's Assistant on 3/6/2025 at 11:18 am she stated Resident #72 had diagnoses of Parkinson's disease with Lewy

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F 760	Continued From page 40 body dementia and required the physician ordered Carbidopa-Levodopa. The Physician's Assistant stated she did not remember being notified of Resident #72's Carbidopa-Levodopa not being available. The Physician's Assistant stated the missed doses of Carbidopa-Levodopa could have caused problems with Resident #72's mobility, breathing, and swallowing and the dosing and administration of the medication for her Parkinson's disease would have been critical. The Physician's Assistant stated Resident #72 did not have any issues related to the missed doses in November 2024. An interview was conducted with the Physician on 3/6/2025 at 12:30 pm and he stated that although Resident #72's doses of Carbidopa-Levodopa were missed during November 2024 it did not cause her any harm but could have potentially affected her mobility, swallowing and breathing. During an interview with the Director of Nursing on 3/6/2025 at 2:59 pm she stated she did not recall anyone reporting Resident #72 did not have Carbidopa-Levodopa available for administration. The Director of Nursing stated Nurse #6 and Nurse #7 should have checked the electronic emergency medications and called the pharmacy to ensure Resident #72's medication was sent as soon as possible, and they should have notified the provider. The Administrator was interviewed on 3/6/2025 at 3:15 pm and stated she expected the nursing staff to ensure Resident #72 received her medication as ordered by the physician.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/27/25

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F 812	Continued From page 41 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to label and date leftover food items, remove food items with signs of spoilage and not store staff food in 1 of 2 nourishment room refrigerators (the 600 Hall nourishment room); and failed to remove expired food stored for use in 1 of 1 walk-in coolers. These practices had the potential to affect food served to residents. Findings included: 1. An observation and interview on the 600 hall nourishment room refrigerator conducted with Nurse Aide (NA) #4 and NA #5 on 03/03/25 at 10:45 AM revealed a bag of croutons not labeled or dated, a quart size sealed plastic bag with strawberries and blueberries that were observed	F 812	pF □ 812 □ Food Procurement, Store/Prepare/Serve-Sanitary Corrective Action for the Resident Affected On 3/3/25, the housekeeping supervisor removed the items from the 600 hall nourishment room refrigerator that were not properly labeled, and or dated. On3/3/2/25, the dietary manager removed any items that were not properly labeled and or dated from the walk-in cooler. Corrective Action for the Residents Potentially Affected All nourishment room refrigerators have the potential to be affected. On 3/7/25, the housekeeping supervisor observed the	

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F 812	Continued From page 42 to have discoloration and with fuzzy white substance, a microwavable dinner tray not labeled or dated of meat and broccoli observed to have discoloration and fuzzy substance on the food, a unlabeled and undated plastic container with white substance that resembled mold, and NA #4's lunch bag. NA #4 revealed she put her lunch in the fridge but was aware that it should not be in there. NA #4 and NA #5 nursing staff and dietary were responsible for checking the nourishment rooms daily and ensuring items are labeled, dated and discarded. 2. An observation and interview in the kitchen on 03/03/25 at 11:35 AM revealed a container of leftover cream of mushroom soup that had a discard date of 02/28/25 in the walk-in cooler. The Dietary Manager further revealed the soup should have already been discarded and must have been missed when items were checked. A follow up interview conducted with the Dietary Manager on 03/06/24 at 8:15 AM revealed Dietary Aide #1 oversaw checking nourishment rooms over the weekend. The Dietary Manager further revealed she did not know why the nourishment room on the 600 hall was not checked but expected nourishment rooms and kitchen items to be checked daily for labeling and dating leftover food items. Dietary aide #1 was unable to be interviewed during the survey. An interview conducted with the Administrator on 03/06/25 at 11:20 AM revealed he expected nourishment rooms to be checked daily and foods be stored and labeled correctly.	F 812	400 and 600 hall nourishment room refrigerators. No employee food was found. On 3/7, the administrator observed the walk-in cooler, No opened food was found. Systemic Changes On 3/24/25 , the Administrator in-serviced the Dietary Manager on monitoring the nourishment refrigerators and walk-in cooler, specifically checking them for proper labeling, dating and removing food items out of date. The in-service also included monitoring and discarding items that belonged to staff. On 3/27 , the Dietary Manger in-serviced the dietary staff on monitoring the nourishment refrigerators and walk-in cooler, specifically checking them for proper labeling, dating and removing food items out of date. The in-service also included monitoring and discarding items that belonged to staff. On 3/27, the Administrator in-serviced all staff on the policy for the nourishment refrigerators. Specifically, the resident□s nourishment refrigerators are not to be utilized for staff. Any staff member that was not available for the in-service, will be taken off the schedule until they receive the in-service. All newly hired staff will receive the in-service during the orientation process. Quality Assurance The Dietary Manager and or dietary aide will audit the nourishment refrigerator□s on the 400 and 600 hallways daily for 7 days, then 3 times weekly times 4 weeks,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 43	F 812	then monthly utilizing the QA Monitoring Tool for Food Procurement, Store/Prepare/Serve-Sanitary for the nourishment refrigerators, to ensure that the items in the refrigerators are properly dated, stored and items removed if spoiled . The monitoring will also ensure that staff are not storing their personal items in the nourishment refrigerators. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance & Performance Improvement (QAPI) Committee by the Dietary Manager for review by the IDT members monthly. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. The Administrator and or Director of Nursing, will monitor the walk-in cooler 3 times a week for 4 weeks, then monthly x 2 months, to ensure that items in the refrigerators are properly dated, stored. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance & Performance Improvement (QAPI) Committee by the Administrator and or Director of Nursing for review by the IDT members monthly. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: 4/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 03/06/2025

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