STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. BUILDING _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLETCHER REHABILITATION AND HEALTHCARE CENTER	86 OLD AIRPORT ROAD FLETCHER, NC 28732

(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, revisit and complaint investigation survey was conducted onsite 05/11/25 through 05/16/25. Additional information was obtained offsite on 06/02/25; therfore, the exit date was changed to 06/02/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E3S11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 05/11/25 to conduct a recertification, revisit and complaint investigation survey and exited on 05/16/25. Additional information was obtained offsite on 06/02/25. Therefore, the exit date was changed to 06/02/25. Event ID# 1E3S11. The following intakes were investigated: NC00230554, NC00229935, NC00229970, NC00230007, NC00229943, NC00229722, NC00229253, NC00228104, NC00225461, NC00224701, NC00223695, NC00222827, NC00220662, NC00218066, NC00213477, NC00215506, and NC00231132. 20 of the 55 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		6/20/25

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

Electronically Signed | 06/16/2025

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F 558	Continued From page 1 Based on observation, record review, and interviews with residents and staff, the facility failed to ensure resident's accessibility to the light switch located behind the bed and failed to provide a bed with adequate length to prevent a resident's feet from hanging off at the end of the mattress for 2 of the 2 residents reviewed for accommodation of needs (Residents #58 and #43). The findings included: 1. Resident #58 was admitted to the facility on 02/08/22. The quarterly MDS assessment dated 04/15/25 coded Resident #58 with intact cognition and impairment on one side of his upper and lower extremities. The MDS indicated walking between locations inside the room for more than 10 feet was not attempted during the assessment period due to medical condition or safety concerns. During an observation conducted on 05/12/25 at 11:43 AM, the switch for the light fixture behind Resident #58's bed was attached with a broken cord 2.5 inches in length. The switch cord was 5 feet from the floor and 6 feet from the bed. Resident #58 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #58 on 05/12/25 at 11:45 AM. He stated he was bedbound and unable to stand up and walk. He recalled the switch cord was broken since he moved into his room a few months ago. He did not have any control of the light fixture behind his bed as he could not stand up to reach the broken switch cord on the wall. He enjoyed reading	F 558	558 Reasonable Accommodations Needs/Preferences: 1. Resident #58 switch for the overbed light fixture did not have a pull cord that the resident could reach. The pull string was immediately replaced with an appropriate pull cord that the resident could reach and use to switch the overbed light on/off as needed. Resident #43 was in a bed that was not long enough for the resident. An appropriate length mattress was immediately ordered for the resident and applied to the residents bed on 5/20/2025. As an immediate temporary solution, until the appropriate length mattress arrived, the bed was extended to an appropriate length for the resident and a cushion was placed to fill the gap. 2. All residents have the potential to be affected. The Maintenance Director conducted an audit for all resident rooms to ensure overbed pull cords were present and at the appropriate length for residents to reach. This audit was completed on 5/12/2025. The Maintenance Director conducted an audit of all resident beds to ensure mattresses were proper fitting. Any issues were immediately corrected. This audit was completed on 5/15/2025 3. The maintenance director received education	

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F 558	Continued From page 2 before bedtime and had to rely on nursing staff to switch off the light fixture before sleeping. It was frustrating and inconvenient as he had to ask for assistance repeatedly. He wanted the maintenance staff to fix the switch cord to accommodate his needs immediately. Subsequent observation conducted on 05/13/25 at 11:49 AM revealed the switch cord for the light fixture behind Resident #58's bed remained inaccessible. During joint observation and subsequent interviews with Nurse Aide (NA) #2 and Nurse #2 on 05/13/25 at 12:15 PM, both nursing staff acknowledged that the broken switch cord needed to be fixed as soon as possible. NA #2 stated she provided care for Resident #58 frequently in the past few weeks and she had notified the Maintenance Manager about the broken switch cord. However, she did not follow up with the Maintenance Manager. Nurse #2 stated she had provided care for Resident # 58 frequently, but she did not notice the switch cord was broken and inaccessible for Resident #58. An interview was conducted with the Maintenance Director on 05/13/25 at 12:33 PM. He stated he walked through the facility at least once daily to identify repair needs. He also depended on nursing staff to report repair needs either verbally or with work order via facility website electronically. He could not recall receiving any work orders for Resident # 58's broken switch cord so far. He acknowledged that all the broken switch cords needed to be fixed immediately to accommodate residents' needs. During an interview conducted on 05/14/25 at	F 558	on 6/9/2025 on checking overbed light switch pull cords as part of the facility preventative maintenance schedule. In addition, all staff, including agency staff, received education on reporting any broken/missing overbed pull cords to maintenance immediately for repair. This education included reporting immediately to Maintenace any concerns for improper fitting mattresses/beds, including agency staff. This education was completed on 6/16/2025 and will be added to the facility orientation program for all newly hired employes, including new agency employees. 4. The maintenance director/designee will audit 5 rooms per week for 12 weeks to ensure compliance with overbed pull cords and proper fitting mattresses and beds for residents. The Maintenance Director/Desginee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of Compliance 6/17/2025	

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F 558	Continued From page 3	F 558		

8:45 AM, the Director of Nursing expected the staff to be more attentive to residents' living environment and reported repair needs in a timely manner. It was important to accommodate residents' needs and ensure full accessibility to their light fixture.

A phone interview was conducted with the Administrator on 05/16/25 at 10:46 AM. She stated it was her expectation for all the residents to have full accessibility to their light fixture to accommodate their needs all the time.

2. Resident #43 was admitted to the facility on 11/27/24 with diagnoses that included incomplete quadriplegia C1-C4 (spinal cord injury between the vertebrae in the upper neck resulting in loss of some motor functions but not all).

The quarterly Minimum Data Set (MDS) assessment dated 03/27/25 revealed Resident #43 had intact cognition. He had impairment of both sides of the upper extremities and was dependent on staff assistance with self-care tasks, bed mobility and transfers. It was noted Resident #43 had a height of 75 inches.

During an observation and interview on 05/11/25 at 11:30 AM, Resident #43 was observed sitting up in bed watching TV. The head of the bed was slightly elevated, Resident #43's head was aligned with the top edge of the mattress and the footboard had been removed from the bed frame. Resident #43's legs were in a straight position with his ankles resting on the bottom edge of the mattress and his feet extending past edge of the mattress. Resident #43 stated when he was first admitted to the facility, he was placed in a bed that was very narrow and shortly afterwards, he

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F 558	Continued From page 4	F 558		

could not recall when, the facility brought him another bed that was much wider. Resident #43 stated he was 76 inches tall and the Maintenance Director told him that the bed he was currently in was 80 inches in length but anytime he was positioned up in bed, his feet hung off the end of the bed. Resident #43 stated it was an uncomfortable position for him to have his feet extending past the bottom edge of the mattress.

Additional observations on 05/12/25 at 12:22 PM and 05/13/25 at 9:20 AM revealed Resident #43 lying supine (face upward) in bed with the head of the bed elevated and his feet extending past the bottom edge of the mattress.

During an observation and interview on 05/13/25 at 9:40 AM, the Maintenance Director revealed he had removed the footboard of the bed so that Resident #43's feet wouldn't press up against it. He stated he had been in and out of Resident #43's room several times since then but had not noticed his feet extending past the edge of the mattress. The Maintenance Director stated Resident #43's current bed was 80 inches in length and wasn't sure if he could order one any longer but he would research to see what he could find.

During an observation and interview on 05/14/25 at 8:45 AM, the Director of Nursing (DON) confirmed Resident #43 was positioned correctly up in bed and his feet still extended past the bottom edge of the mattress. The DON expressed the back of Resident #43's ankles rested at the bottom edge of the mattress which was concerning because that was a vulnerable area and he was already at risk for skin breakdown. The DON stated she would have

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F 558	Continued From page 5 expected for someone to have noticed and gotten him a longer bed so that his feet didn't extend past the bottom edge of the mattress. During an interview on 05/16/25 8:39 AM, the Administrator revealed that most of the times when she had been in Resident #43's room, he was either up in his wheelchair or he was lying in bed with his feet covered and she hadn't noticed his feet extending past the edge of the mattress. The Administrator stated she would have hoped that someone would have noticed Resident #43's bed was not long enough but no one had voiced any concerns to her. She explained there were bed extensions that could have been placed on Resident #43's bed or his bed switched out with one that would extend in length which would have prevented his feet from extending past the edge of the mattress.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		6/17/25

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F 578	Continued From page 6 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director (MD) interview, and staff interviews, the facility failed to obtain and document an advanced directive that included code status information upon admission for 1 of 4 residents reviewed for advance directive (Resident #283). Findings included: Resident #283 was admitted to the facility on 4/25/25 with diagnosis that included acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood, leading to low oxygen levels in the blood and	F 578	F578 Advanced Directive Step One: Facility failed to obtain and document an advanced directive that included code status information upon admission for Resident #283. An audit of advanced directives for all new admissions in the past 30 days was conducted on 5/19/2025 and any missing advanced directives were obtained and placed in residents' chart and code status book. Step Two: All residents have the potential	

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F 578	Continued From page 7 tissues). Review of the admission progress note dated 4/25/25 at 11:00 PM and written by Nurse #6 revealed there was no mention of Resident #283's advanced directive or code status. A phone interview on 05/14/25 at 4:09 PM with Nurse #6 revealed she admitted Resident #283 on 4/25/25. She stated that she had not been shown the full process of completing a new admission and learned by word of mouth when asking another nurse or after being told she had done something wrong. She stated that she had asked other nurses on many different occasions to show her the admission process, but it never happened. Nurse #6 further revealed that she had not asked about Resident #283's code status during the admission process on 04/25/25. An interview on 5/16/25 at 12:33 PM with the former DON revealed that when a resident was admitted to the facility the admitting nurse should review the residents advanced directive wishes with them and begin filling out the advanced directive form. She stated that she was not sure why Resident #283's advanced directive was never filled out as it should have been completed upon admission. She further revealed that the admitting nurse should also have put the order for the code status in the medical record. She stated that if the Social Worker was available to begin the advanced directive form with the resident, the Social Worker would hand the advanced directive form to the admitting nurse and the admitting nurse would place the initial order. The admitting nurse would then communicate to the Nurse Practitioner (NP) or the MD about the new advanced directive form and code status orders.	F 578	to be affected by this deficient practice. On 6/13/2025, the Social Services Director/designee completed a 100% audit of all residents Advanced Directives to ensure that each resident's current advanced directives were correct and present in the code status book and their chart. Advanced Directives and Most forms are reviewed and updated by the Social Services Director at each resident's quarterly care plan meeting, upon admission to the facility, readmission to the facility, and as appropriate per significant change or at the request of the resident/POA. Step Three: To prevent this from recurring, the Social Services Director/designee will educate all licensed nursing staff on the Advanced Directive policy, Advanced Directives care plans and on the Advanced Directive forms (MOST/Golden Rod). Education on the Advanced Directive binders containing the Advanced Directive forms, which are located at each nurse's station, was also provided to all licensed nursing staff, including agency and will be added to the new hire/agency orientation. All education will be completed by 6/16/2025. For any new resident or returning resident entering the facility, the licensed nurse will enter the Advanced Directives order in the electronic medical record and then place any Advanced Directive forms (MOST/Golden Rod) in the Social Service Director's mail box, the Social Services Director/designee will review the order, care plan and forms for accuracy and then	

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F 578	Continued From page 8 An interview on 5/15/25 at 3:38 AM with the MD revealed that normally on admission a staff member obtained the resident's code status and put in an order. Then the staff member notified him, and he confirmed that with the resident. He further revealed that the code status was usually gotten from the hospital paperwork. An interview on 5/16/25 at 5:21 PM with the Administrator revealed that she was familiar with Resident #283. The Administrator indicated that the admitting nurse should have asked for Resident #283's code status. She stated that Resident #283's admission paperwork wasn't done either and she was not sure why. She further stated that part of the admission paperwork involved advanced directives. She stated that her expectation was that residents had an advanced directive completed and code status ordered upon admission.	F 578	file in the appropriate location within the Advanced Directive binder. Step Four: To monitor and maintain compliance, the Social Services Director/designee will audit 5 resident's Advance Directive order, care plan and Advanced Directive forms (MOST/Golden Rod) for accuracy weekly for 12 weeks. The Social Services Director/Designee will review Advanced Directive Binders for accuracy weekly for 12 weeks. The Social Services Director will audit Advanced Directives and MOST forms at each resident care plan, admission and readmission or as requested by the resident/POA to ensure that residents most current wishes are updated in the Advanced Directives care plan, MOST form, order, and binder, this will be done weekly for 12 weeks. Results will be taken to QAPI for review and revision as needed for the next 3 months. The Social Services Director/designee is responsible for this plan of correction. Date of Compliance: 6/17/2025	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		6/17/25

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consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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F 580	Continued From page 10 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director and staff, the facility failed to notify the physician when pressure ulcers were identified on admission for 1 of 5 residents reviewed for pressure ulcers (Resident #86). Findings included: Resident #86 was admitted to the facility on 04/24/25 with diagnoses including muscle wasting and atrophy (decreased muscle mass and strength) at multiple sites and moderate protein-calorie malnutrition. The admission data collection assessment dated 04/24/25 identified Resident #86 had existing pressure ulcers on the right, and left buttock and sacrum. A review of Resident #86's physician orders revealed no wound care treatments were put in place until 04/30/25. During an interview on 05/14/25 at 4:09 PM, Nurse #6 confirmed she was the admitting nurse when Resident #86 arrived at the facility, and she completed the admission data collection assessment dated 04/24/25. She revealed when Resident #86's was admitted she identified pressure ulcers on the left, and right buttock and sacrum she described as red in color with no	F 580	F580 – Notification of Changes Step One: Provider was not notified of pressure ulcer on Resident #86 at the time of admission or obtain treatment order for wound at admission. Step Two: All residents have the potential to be affected. The Director of Nursing or designee will complete a head-to-toe skin assessment on all residents. The Director of Nursing or designee will ensure all wounds have a treatment order in place, care plan updated, Skin Assessment complete and provider/RP have been notified. Admission skin assessments were reviewed on all new admissions for the past 30 days to ensure the provider was aware of any alteration of skin integrity and treatment order for wound active if indicated. Audit completed on 6/13/25. Step Three: To prevent this from reoccurring, the Director of Nursing or designee will educate all licensed nursing staff and all licensed agency nursing staff on notification to provider with any new admission with wound present or new wound identified as it occurs. The Director of Nursing or designee will educate all newly hired licensed nursing staff and all new licensed agency nursing staff prior to the start of their first shift. Education	

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F 580	Continued From page 11 open skin or drainage and were on the surface of the skin. Nurse #6 revealed she did not notify the physician to obtain wound care orders on 04/24/25 but did report the pressure ulcers to the oncoming nurse. She revealed she wrote a note in the communication book for the Nurse Practitioner (NP) to see Resident #86 on the next scheduled visit to the facility and the NP came to the facility to see residents on Monday through Thursday. An interview with the former DON was conducted on 05/14/25 at 4:37 PM. The former DON revealed if pressure ulcer wounds were identified on the admission data collection assessment dated 04/24/25 the admitting nurse should notify the physician and obtain wound care orders. A review of the Medical Director progress note revealed Resident #86 was seen on 04/25/25 for a new patient assessment. The Medical Director's physical exam of the skin noted Resident #86 had no rashes. The Medical Director's plan of treatment indicated nursing was instructed to notify the provider or the on-call provider of any new or worsening changes in condition. The progress note did not mention pressure ulcers and no wound care orders were provided. An interview was conducted on 05/15/25 at 9:10 AM with the Medical Director. The Medical Director revealed he wanted to be notified when a resident was identified as having pressure ulcers. He further revealed wound care treatments should have been implemented when Resident #86 was admitted with existing pressure ulcers on 04/24/25. During an interview on 05/16/25 at 8:57 AM, the	F 580	completed by 6/16/25. Step Four: To monitor and maintain ongoing compliance, the Director of Nursing or designee will review new admission documentation during Clinical Morning Meeting to ensure skin assessment is complete, treatment orders active and provider aware of altered skin integrity 5 times per week for 12 weeks. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of Compliance: 6/17/25	

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F 580	Continued From page 12 Administrator revealed the admitting nurse (Nurse #6) was responsible for notifying the physician when Resident #86's pressure ulcers were identified on 04/24/25 to obtain treatment orders.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the resident and staff, the facility failed to protect a resident's right to be free from neglect when Nurse Aide (NA) #1 disregarded a resident's request for incontinence care and did not check the resident for incontinence prior to going on break (Resident #35). Resident #35 was left sitting in a chair in her room that had a strong odor resembling bowel incontinence for approximately one hour. When Resident #35's incontinence care was provided her brief was heavily soiled with a bowel movement that had leaked onto her inner thighs and clothing.	F 600	1.A head-to-toe skin assessment was completed for Resident #35 on 5/14/25 and on 5/20/25 with no adverse effects from delayed incontinence care. 2. All residents that require assistance with incontinence care have the potential to be affected. The Director of Nursing/designee will audit all residents continence status and ensure care plans reflect appropriate level of care.	6/20/25

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F 600	Continued From page 13 Resident #35 voiced she could smell herself and it was not the first time that had happened to her. The deficient practice occurred for 1 of 2 residents reviewed for abuse/neglect. Findings included: Resident #35 was admitted to the facility on 5/20/19 with diagnoses which included Alzheimer's disease, vascular dementia, cerebrovascular accident, hemiparesis (weakness) and hemiplegia (partial or total paralysis) affecting the left non-dominate side. The quarterly Minimum Data Set (MDS) assessment dated 4/12/25 revealed Resident #35's cognition was intact with no rejection of care behaviors during the lookback period. Resident #35's range of motion was impaired on both sides of the upper and lower extremities, she was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene. The care plan revised on 4/03/25 identified Resident #35 had a self-care deficit in performing activities of daily living related to a stroke with hemiplegia and hemiparesis, incontinence, and vascular dementia. The care plan interventions included Resident #35 was dependent on two staff for toilet use. A continuous observation was conducted on 05/13/25 from 11:52 AM through 12:35 PM in conjunction with an interview with Resident #35. Resident #35 stated she needed incontinence care and Nurse Aide (NA) #1 was aware she needed to be changed. When asked how long she had waited Resident #35 stated, "It's been a	F 600	Audit completed on 6/13/25 and all care plans updated to reflect assistance level required for care. 3. The Director of Nursing/Designee re-educated all clinical staff on incontinence care expectations, including providing timely incontinent care for residents that request care or need care even during meal times. This re-education was completed on 6/16/2025. Employees recieved this re-education prior to the beginning of their next shift. This education will be added to the facility orientation program for all newly hired clinical staff, including new agency staff. 4. The Director of Nursing/Designee will observe 5 residents per week for 12 weeks to ensure timely incontinence care is performed. The Director of Nursing/Designee will interview 5 residents per week for 12 weeks to ensure timely completion of incontinence care. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	

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F 600	Continued From page 14	F 600		

while" but gave no specific time. In the room there was a strong odor resembling bowel movement. Resident #35 stated she could "smell herself and this was not the first time this had happened." NA #1 was observed to enter and exit the room at 12:18 PM and again at 12:23 PM. Resident #35 was sitting in a reclined position in a chair and continued to need incontinence care. The strong odor resembling incontinence remained in the room and had lingered onto the hallway. At 12:35 PM, NA #1 and NA #2 provided a two person transfer and moved Resident #35 from the chair to the bed using a mechanical lift. When Resident #35's brief was removed it was heavily soiled with bowel movement. The bowel movement had leaked from the brief onto Resident #35's left and right inner thighs and clothing. The bowel movement was moist and had not dried on to Resident #35's skin and when removed there were two areas of intact pink colored skin resembling previously healed scar tissue.

An interview was conducted with NA #1 on 05/13/25 at 12:35 PM. NA #1 confirmed Resident #35 stated she was incontinent prior to her (NA #1) going on break at 11:30 AM. NA #1 revealed she did not physically check Resident #35 for incontinence at that time and stated there was no odor resembling incontinence. NA #1 described Resident #35 as having attention seeking behaviors that included saying she was incontinent but was not. NA #1 revealed she did not provide Resident #35 incontinence care when she returned from break at 12:00 PM due to it being almost time for her to begin delivering meal trays and she was told not to provide incontinence care for residents during meal tray service.

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F 600	Continued From page 15 An interview was conducted on 05/16/25 at 10:43 AM with the Director of Nursing (DON). It was explained Resident #35 requested incontinence care prior to NA #1 going on break at 11:30 AM but it was not provided until 12:35 PM. The DON stated it was poor quality of care to not provide incontinence care, and she would expect incontinence care to be provided when a resident asked to be changed. The DON stated she would expect incontinence care was completed regardless if it was during meal tray service or meal time. During an interview on 05/16/25 at 6:04 PM the Administrator stated she never told nurse or NA staff incontinence care was not provided during meal tray service. The Administrator stated she expected if Resident #35 asked to be changed, NA #1 would have done the care before going on break and was poor customer service it was not done. The Administrator stated it was not neglect as she did not think NA #1 intentionally neglected Resident #35 request for incontinence care.	F 600		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636		6/20/25

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F 636	Continued From page 16	F 636		

resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

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F 636	Continued From page 17 (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessment (CAA) comprehensively to address the underlying causes and contributing factors of the triggered areas for 1 of 1 sampled resident reviewed for comprehensive assessment (Residents #48). The findings included: Resident #48 was admitted to the facility on 06/05/23 with diagnoses including traumatic brain injury, aphasia, dementia, and cognitive communication deficit. The annual Minimum Data Set (MDS) assessment dated 03/26/25 coded Resident #48 with severely impaired cognition. A review of Section V (Care area assessment summary) of the annual MDS assessment dated 03/26/25 revealed a total of 9 care areas were triggered for Resident #48. The MDS Coordinator did not provide any information in analysis of findings for 8 of the 9 triggered areas to describe the nature of Resident #48's problems, possible causes, contributing factors, risk factors related to the care area, and reasons to proceed with care planning for the following triggered care areas:	F 636	1.Staff failed to provide background information regarding the resident that fully explained why a care area assessment was triggered in the minimum date set and why or why not that trigger should generate a care plan with goals and interventions. 2. All residents have the potential to be affected. The Regional Clinical Reimbursement Director/Designee completed an audit for all current residents that assessments that have Care Area Assessments (CAA) triggers for the last 30 days. Any issues were immediately corrected. This audit was completed on 6/19/2025. 3. The Regional Clinical Reimbursement Director re-educated the remote Minimum Data Set (MDS) Coordinator on completing any Care Area Assessments (CAAs) with details of resident's condition, including diagnosis, what the nature of the risk is and if there is a need for a care plan. This	

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F 636	Continued From page 18 1. Visual functions 2. Communication 3. Functional abilities 4. Urinary incontinence and indwelling catheter 5. Falls 6. Nutritional status 7. Pressure ulcer/injury 8. Psychotropic drug use During an interview conducted on 05/13/25 at 12:53 PM, the MDS Coordinator confirmed 8 of the 9 triggered care areas for Resident #48's annual MDS dated 03/26/25 were submitted without providing pertinent information in the analysis of findings in Section V to address the underlying causes and contributing factors of the triggered areas. She indicated Resident #48's annual MDS dated 03/26/25 was completed by the MDS Coordinator who worked remotely. The MDS Coordinator indicated she had only worked part-time (3 days per week) during the past 3 months. An interview was conducted with the Director of Nursing on 05/14/25 at 8:45 AM. She stated all the CAAs must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in Section V comprehensively before submission. An attempt to conduct a phone interview on 05/14/25 at 4:36 PM with the MDS Coordinator who completed Resident #48's annual MDS dated 03/26/25 was unsuccessful. During a phone interview conducted with the Administrator on 05/16/25 at 10:46 AM, she	F 636	re-education was completed on 6/10/2025. This education will be added to the facility orientation program to including any newly hired Minimum Data Set (MDS) employees. 4. The Minimum Data Set (MDS) Coordniator/Designee will audit all assessments that have Care Area Assessment triggers weekly for 12 weeks. The Minimum Data Set (MDS) Coordniator/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	

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F 636	Continued From page 19 expected the MDS Coordinator to follow MDS guidelines to ensure all the CAAs include at least the nature of problems, causative factors, and reasons to proceed to care plan before submission.	F 636		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 641		6/19/25

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F 641	Continued From page 20 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #3, Resident #6, Resident #36), pressure ulcer (Resident #86, Resident #74), and Preadmission Screening and Resident Review (PASRR), (Resident #23) for 6 of 8 residents reviewed for resident assessments. Findings included: 1. Resident #3 was admitted to the facility on 02/28/25 with diagnoses that included heart disease. The significant change MDS assessment dated 04/10/25 revealed Resident #3 was coded as receiving anticoagulant medication. Review of the April 2025 medication administration record (MAR) for Resident #3 revealed there was no physician order for anticoagulant medication and none was administered. During an interview on 05/16/25 at 10:48 AM, the MDS Coordinator reviewed the April 2025 MAR for Resident #3 and confirmed she did not receive anticoagulant medication during the MDS assessment period. The MDS Coordinator stated the significant change MDS assessment dated 04/10/25 was coded incorrectly. During an interview on 05/16/25 at 5:11 PM, the Administrator stated she expected MDS assessments to be completed accurately. 2. Resident #6 was admitted to the facility on 04/05/23 with diagnoses that included heart	F 641	1. The Minimum Data Set (MDS) assessment dated 4/10/2025 was modified on 5/16/2025 for Reisdnet #3 to reflect the anticoagulant medication was not administered. The Minimum Data Set (MDS) assessment dated 3/31/2025 was modified on 5/19/2025 to reflect that resident #6 did not receive insulin. The Minimum Data Set (MDS) assessment date 3/26/2025 was modified on 5/15/2025 to reflect the correct Level II PASSRR for resident #23. The Minimum Data Set (MDS) assessment date 2/27/2025 was modified on 5/16/2025 to reflect that resident #36 did not receive insulin. The Minimum Data Set (MDS) assessment date 4/29/2025 was modified on 5/19/2025 to reflect correct pressure ulcer status for resident #86. The Minimum Data Set (MDS) assessment date 4/25/2025 was modified on 5/16/2025 to reflect corrector pressure ulcer status for resident #74. 2. All residents have the potential to be affected. The Minimum Data Set (MDS) Coordinator/Designee completed an audit for the last 30 days of Minimum Data Set (MDS) to ensure accurate coding. This	

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F 641	Continued From page 21 failure and end-stage renal disease. The significant change MDS assessment dated 03/31/25 revealed Resident #6 was coded as receiving insulin and hypoglycemic (used to lower blood sugar levels) medication. Review of the March 2025 medication administration record (MAR) for Resident #6 revealed there were no physician orders for insulin or hypoglycemic medication and none was administered. During an interview on 05/16/25 at 10:48 AM, the MDS Coordinator reviewed the March 2025 MAR for Resident #6 and confirmed she did not receive insulin or hypoglycemic medication during the MDS assessment period. The MDS Coordinator stated the significant change MDS assessment dated 03/31/25 was coded incorrectly. During an interview on 05/16/25 at 5:11 PM, the Administrator stated she expected MDS assessments to be completed accurately. 3. Resident #23 was admitted to the facility on 03/16/24 with diagnoses that included bipolar disorder and Post-Traumatic Stress Disorder (PTSD). The annual MDS assessment dated 03/26/25 revealed Resident #23 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Review of a PASRR Level II determination notification letter provided by the Social Worker	F 641	audit was completed on 6/16/2025. 3. The Regional Clinical Reimbursement Director re-educated all Minimum Data Set (MDS) nurses on correct coding of Level of PADRRs, coding the accurate type of injections, including accurate number of injections received, coding the accurate skin related issues, including type and staging of ulcers. This education was completed on 6/10/2025 and will be added to the facility orientation program for any newly hired Minimum Data Set (MDS) employees. 4. The Minimum Data Set (MDS) Coordinator will audit all assessments that are completed by all MDS nurses weekly for 12 weeks to ensure accurate coding of medications, including injections, PASRRs and skin related issues, including pressure ulcers. The Minimum Data Set (MDS) Coordinator/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/19/2025	

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F 641	Continued From page 22	F 641		

(SW) on 05/15/25 revealed Resident #23 had a Level II PASRR effective 05/28/24 with no end date.

During an interview on 05/16/25 at 10:48 AM, the MDS Coordinator explained when conducting an audit of Level II PASRR, they realized Resident #23's annual MDS assessment dated 03/26/25 was not coded correctly to reflect that she had a Level II PASRR. She stated it was an oversight.

During an interview on 05/26/25 at 12:55 PM, the SW revealed the MDS Coordinator was the person responsible for coding Level II PASRR on the MDS assessments. The SW explained she tried to audit Level II PASRR weekly, or at the very least, every other week and then emailed the MDS Coordinator an updated list of residents who had a Level II PASRR to use when completing MDS assessments.

During an interview on 05/16/25 at 5:11 PM, the Administrator stated she expected MDS assessments to be completed accurately.

4. Resident #36 was admitted to the facility on 05/13/19 with diagnoses that included diabetes.

The quarterly MDS assessment dated 02/27/25 revealed Resident #36 was coded as receiving insulin injections daily during the MDS assessment period.

Review of the February 2025 medication administration record (MAR) for Resident #36 revealed there was no physician order for insulin and no insulin was administered.

During an interview on 05/16/25 at 10:48 AM, the

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MDS Coordinator reviewed the February 2025 MAR for Resident #36. She confirmed there was no physician order for insulin and he did not receive insulin during the MDS assessment period. The MDS Coordinator stated the quarterly MDS assessment dated 03/31/25 incorrectly indicated Resident #36 received insulin and it was an oversight.

During an interview on 05/16/25 at 5:11 PM, the Administrator stated she expected MDS assessments to be completed accurately.

5. Resident #86 was admitted to the facility on 04/24/25 with diagnoses that included muscle wasting and atrophy (gradual decrease in size of an organ or muscle tissue) multiple sites and moderate protein-calorie malnutrition.

A nurse admission data collection dated 04/24/25 revealed Resident #86's skin was not intact and he had pressure ulcers and non-pressure areas/other skin conditions. It was noted Resident #86 had a blister to the mid-back and pressure ulcers to the right buttock, left buttock and sacrum with no measurements specified.

An admission nurse progress note dated 04/25/25 revealed in part that Resident #86 had pressure sores in the middle of his right buttock, left buttock and sacrum with no drainage noted and all were less than the size of a quarter. There was no stage (system used to categorize the severity of pressure injuries) or measurements for the pressure ulcers noted.

The admission MDS assessment dated 04/29/25 revealed Resident #86 had no unhealed pressure ulcers or other skin conditions present upon

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admission.

During an interview on 05/16/25 at 10:48 AM, the MDS Coordinator stated she was not sure why the admission MDS assessment dated 04/29/25 did not reflect Resident #86 had a pressure ulcer based on the nurse admission note dated 04/25/25. The MDS Coordinator explained she did not complete the MDS assessment but if she had, she would have asked the wound nurse, doctor or someone else who would be knowledgeable to clarify what the nurse note didn't include, such as stage of the pressure ulcer.

During an interview on 05/16/25 at 5:11 PM, the Administrator stated she expected MDS assessments to be completed accurately.

6. Resident #74 was admitted to the facility 02/06/25 with a diagnosis including acute (new onset) pancreatitis (inflammation of the pancreas).

The Wound Care Physician #1's note dated 02/19/25 revealed Resident #74 was receiving wound care for an unstageable pressure wound with 100% necrotic (dead) tissue to the posterior (back) of his head that was present on admission.

Review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated 04/25/25 indicated he had a stage three pressure ulcer (full-thickness skin loss that extends into subcutaneous tissue but doesn't involve muscle or bone) that was not present on admission.

An interview with the MDS Coordinator on 05/16/25 at 11:17 AM revealed Resident #74's

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F 641	Continued From page 25 quarterly MDS assessment should have been coded to reflect he had a pressure ulcer that was present on admission and it was an oversight. An interview with the Director of Nursing (DON) on 05/16/25 at 4:52 PM revealed she expected MDS assessments to be coded correctly. An interview with the Administrator on 05/16/25 at 5:11 PM revealed she expected MDS assessments to be coded correctly.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Nurse Practitioner (NP), Medical Director (MD), resident and staff interviews, the facility failed to prevent a medication error when Nurse #1 administered an antidepressant, diuretic, hypoglycemic and blood pressure medications to Resident #283 that were prescribed for Resident #86. This deficient practice occurred for 1 of 2 residents reviewed for medication errors (Resident #283). The findings included: 1. Resident 283 was admitted to the facility on 4/25/25 with diagnosis that included parkinsonism, type 2 diabetes mellitus, chronic kidney disease stage 3, myocardial infarction type	F 658	1. Resident #238 no longer resides at the facility. Nurse #1 was immediately re-educated on the 7 rights of medication administration. This was completed on 4/28/2025. 2. All residents have the potential to be affected. The Director of Nursing/Designee completed a 100% audit to ensure patient identifies/photograph in the electronic medical record are present. This audit was completed on 6/13/2025. 3. The Director of Nursing/Designee re-educated all Licensed Nurses and	6/19/25

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F 658	Continued From page 26 2 (a heart attack that occurs due to an imbalance between the hearts oxygen supply and demand), hypertension (high blood pressure), and edema (swelling). Review of the 5-day Prospective Payment System (PPS) assessment dated 4/30/25 revealed that Resident #283 was cognitively intact. He received antidepressant, anticoagulant, antibiotic, diuretic, antiplatelet, and hypoglycemic medications. Review of the change in condition communication form written by Nurse #1 and dated 4/28/25 at 8:50 AM revealed Resident #283 was administered the wrong medications as follows: Lexapro (antidepressant) 10 milligrams (MG), Lasix (diuretic) 40 MG, Jardiance (a medication used to treat type 2 diabetes) 10 MG, Lisinopril (a medication used to treat high blood pressure) 40 MG, Metoprolol extended release (ER, a medication used to treat high blood pressure) 12.5 MG, and Prednisone (steroid medication used to treat many diseases and conditions that are associated with inflammation) 40MG. Resident #283 was informed of the medication that was given in error and the plan to notify the provider "now". Things that made the condition or symptom worse were unknown. Things that made the condition or symptoms better were noted as keeping Resident #283 and the family informed and monitoring Resident #283's vital signs every 15 minutes for 2 hours, then every 30 minutes for one hour, then every 4 hours. Other relevant information noted Resident #283 was provided with a list of medications given in error. Each medication was explained, including the indications for use and possible side effects. Resident #283's vital signs remained normal. Mental status changes included Resident #283	F 658	Medication Aides, including agency Licensed Nurses/Medication Aides on the 7 rights of medication administration, which included right medication, right resident, right dosage, right route, right time, right reason and right documentation. And to ensure residents are identified properly prior to medication administration. All staff received this education prior to the start of their next shift. This education was completed by 6/16/2025. This education will be added to the facility orientation program for new hired Licensed Nurses, Medication Aides, including any new agency Licensed Nurses and Medication Aides. 4. The Director of Nursing/Designee will Complete 2 medication pass observations weekly for 12 weeks to ensure residents are properly identified and receiving the correct medication. The Director of Nursing/designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/19/2025	

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became anxious when informed of the medication errors, all questions were answered, and he was seen by the Nurse Practitioner (NP) within 30 minutes. The NP assured Resident #283 he would be ok, and he seemed less anxious after the NP visit. Resident #283 had no functional status, respiratory, abdomen, or urine changes noted. The NP determined that Resident #283 did not need to be sent to the hospital, but staff would continue to monitor him at the facility.

An interview on 5/15/25 at12:03 PM with Nurse #1 revealed that she was Resident #283's assigned nurse on 4/28/25 during the hours of 7:00 AM to 3:00 PM. Nurse #1 stated that she entered Resident #283's room and called him by Resident #86's name but she did not think he had heard her because he had his continuous positive airway pressure (CPAP, a machine that is used to treat sleep apnea and other breathing disorders) machine on. She stated that his nasal canula needed to be put on and there was no oxygen tubing in the room, so she left the room to go get Resident #283 oxygen tubing. Nurse #1 stated it was at this point she felt very overwhelmed and when she returned to the medication cart, she pulled out Resident #86's medications to administer to Resident #283. Nurse #1 stated she then reentered Resident #283's room and administered the medications. After Resident #283 took the medications, she called him by Resident #86's name and Resident #283 replied that was not his name. Nurse #1 stated she realized she had administered the wrong medications to Resident #283 and immediately took his vital signs, called the physician, and notified the Director of Nursing (DON). Nurse #1 further stated she also printed off a list of the medications that she had given Resident #283 in

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error and notified him that she would be monitoring him every 15 minutes. Nurse #1 recalled Resident #283 stating that he was scared but he refused the offer to go to the hospital. Nurse #1 further revealed that Resident #283 never displayed any side effects from having received the wrong medications.

Review of the April 2025 MAR for Resident #86 revealed the following medications prescribed for Resident #86 that were administered to Resident #283 in error on 04/28/25:
- Jardiance (medication used to lower blood glucose levels) 10 mg - one tablet by mouth one time a day for congestive heart failure.
- Lasix (diuretic) 40 mg - one tablet by mouth one time a day for edema (swelling).
- Lexapro (antidepressant) 10 mg - one tablet by mouth one time a day for depression.
- Lisinopril (antihypertensive) 40 mg - one tablet by mouth one time a day for hypertension.
- Metoprolol Succinate (antihypertensive) ER 25 mg - give 0.5 tablet by mouth one time a day for hypertension.

Review of the April 2025 medication administration record (MAR) for Resident #283 revealed physician orders for the following routine medications to be administered at 8:00 AM daily:
- Aspirin (antiplatelet) 81 MG - one tablet by mouth one time a day for supplement
- Bumetanide (diuretic) 1 MG - one tablet by mouth one time a day for chronic kidney disease.
- Citalopram (antidepressant) 20 MG - one tablet by mouth one time a day for depression.
- Glucotrol extended release (oral hypoglycemic) 5 MG - one tablet by mouth one time a day for diabetes.
- Valsartan (antihypertensive) 320 MG - give 0.5

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tablet by mouth one time a day for hypertension.
- Famotidine (treats gastroesophageal reflux) 20 MG - one tablet by mouth one time a day for gastroesophageal reflux disease (GERD, chronic condition where stomach acid flows back into the esophagus causing heartburn).
- Enoxaparin injection (anticoagulant) 40 MG/0.4 milliliter (ml) - inject 0.4 ml (40 mg) under the skin in the morning and at bedtime.
- Sodium Bicarbonate (treats heartburn) 650 MG - one tablet by mouth two times a day for supplement.
- Multivitamin with minerals - one capsule by mouth two times a day for supplement.
- Carbidopa-Levodopa (medication used to treat Parkinson's disease) oral tablet 25-250 mg - one tablet by mouth four times a day for Parkinson's.

Further review of Resident #283's April 2025 MAR revealed all 8:00 AM medications were held on 04/28/25 except for the Carbidopa-Levodopa 25-250 mg.

Review of the vitals monitoring form for Resident #283 initiated on 04/28/25 at 9:00 AM revealed his vitals (temperature, pulse, respiratory rate, blood pressure, and oxygen saturation) were checked every 15 minutes for the first 2 hours, then every 30 minutes for one hour, then every 4 hours for 24 hours, and then every shift for 48 hours with no issues noted.

Review of a nurse progress note written by the former DON dated 4/28/25 revealed that Resident #283 was seen by the NP after a reported medication error. There were no adverse effects noted for Resident #283. Resident #283 and his family chose not to be transferred to the hospital. Monitoring was put in place immediately and vital

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signs were stable.

Review of a NP progress note dated 4/28/25 revealed in part, that Resident #283 was found sitting up in his bed, tearful. Nursing staff told the NP that Resident #283 had received medications that were not prescribed to him. The NP assessed Resident #283 and found his vital signs were within normal limits and instructed nursing staff to continue ongoing assessment of Resident #283's vital signs. Resident #283's heart, lung and bowel sounds were all normal and there was slight trace edema on the lower extremities (legs). Resident #283 had oxygen via nasal cannula present on admission and was alert and oriented. Resident #283's medications were reviewed.

An interview on 5/16/25 at 12:33 PM with the former DON revealed that she recalled Resident #283. The former DON stated that when Nurse #1 made a medications error on 4/28/25, Nurse #1 informed Resident #283, the NP and the DON. She stated that she and Nurse #1 assessed Resident #283 after the medication error and put in place continued monitoring every 15 minutes. The former DON further revealed that Resident #283's vital signs remained stable after the incident. The former DON indicated that she reviewed the 5 rights of medication administration education with all nurses and medication aides (MA). She stated that there were no adverse effects noted for Resident #283. The former DON stated that Nurse #1 should have identified Resident #283 prior to pulling the medications and then again before administering the medications by asking Resident #283 to state his name, since Resident #283 was alert and oriented and a new resident. She stated that the

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facility offered to take Resident #283 to the hospital, but he declined.

An interview on 5/15/25 at 11:20 AM with the NP revealed that Nurse #1, who administered the wrong medications, called her when she was on her way to the facility. The NP stated that she told Nurse #1 to lock her cart, tell the DON, and assess Resident #283. The NP stated that when she arrived at the facility, she assessed Resident #283 and reviewed the medications that were given in error. The NP stated that she offered to send Resident #283 to the hospital, but he refused. She further revealed that she informed Nurse #1 to hold his regular medications for the remainder of the day. The NP stated that the medications Resident #283 received in error were similar to the medications that he was prescribed. She further stated that he suffered no ill effects to his health or well-being because of the medication error. The NP stated that after she was done assessing Resident #283, she went to speak with the DON about the medication error. She revealed that she checked on Resident #283 the following day and he remained stable and continued to refuse transfer to the hospital.

An interview on 5/16/25 at 3:36 PM with the Medical Director revealed that he was familiar with Resident #283 and was aware of the medication error. The Medical Director stated that the doses of the medication Resident #283 received in error were low and the medications were similar to what Resident #283 was prescribed. He stated that they had no negative effect on Resident #283 and they did not harm him.

An interview on 5/16/25 at 5:21 PM with the

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F 658	Continued From page 32 Administrator revealed that Nurse #1 gave the wrong medication to Resident #283 and she was very up front about it and notified Resident #283, the NP, and the family. She stated that she was not sure why the medication error occurred. The Administrator stated that there were 2 new admissions that day and maybe Nurse #1 got confused. She stated that Nurse #1 should have asked Resident #283's name before she pulled the medications and then asked him again before she gave the medications to him. The Administrator stated that Resident #283 was monitored for 48 hours after the medication error occurred and he had no adverse effects because of the error. She stated that her expectation was that the 7 rights of medication administration were completed which included verifying the right resident got the right medications before medication was administered.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide assistance with oral hygiene and nail care (Resident #86), and showers (Resident #43, #74, and #86) for 3 of 8 dependent residents reviewed for activities of daily living. Findings included: 1 a. Resident #86 was admitted to the facility on	F 677	F677 – ADLs for Dependent Residents Step One: Facility did not follow standards of practice and facility-based policy to provide oral hygiene, nail care and bathing/showers for Residents #43, #74 and #86. Residents #43, #74 and #86 all received shower and hygienic care without adverse outcomes from deficient practice. Step Two: All residents have the potential	6/17/25

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F 677	Continued From page 33 4/24/25 with diagnoses including obstructive pulmonary disease, pneumonia, and acute respiratory failure. The admission MDS assessment dated 4/29/25 revealed Resident #86's cognition was moderately impaired with no rejection of care behaviors during the lookback period. Resident #86 had no natural teeth and required setup/cleanup assistance with oral hygiene and partial/moderate assistance with personal hygiene. The care plan revised on 5/11/25 identified Resident #86 had a self-care deficit in performing activities of daily living. The care plan interventions included Resident #86 required assistance from staff with oral care and personal hygiene. During observations and interviews with Resident #86 on 05/12/25 at 9:30 AM, 05/13/25 at 8:39 AM and 05/14/25 at 11:43 AM, the upper denture had a white colored buildup of debris. Resident #86 revealed he had an upper denture but not a lower one and had no difficulty with eating. Resident #86 stated he was not assisted with denture care or oral hygiene and did not know if he had a denture cup or denture brush and was unable to locate those items. The resident went on to say he was able and willing to take care of his own denture care, but due to not being able to locate, or having the supplies to complete the denture care, he was unable to take care of the denture himself. An observation and interview were conducted with the DON on 05/14/25 at 12:11 PM. Resident #86 removed his upper denture upon request to	F 677	to be affected. The Director of Nursing or designee will audit bathing/shower schedule to ensure all residents have assigned bath/shower scheduled. The Director of Nursing or designee will audit all residents' oral cavity and prepare a list for provider review if needed or refer to dentist if needed, as well as complete oral care if indicated during assessment. Audit completed on 6/13/25. Step Three: To prevent this from reoccurring, the Director of Nursing or designee will educate all clinical staff and all clinical agency staff on expectations of performing hygienic best practices including oral hygiene, nail care and bathing/showers. The Director of Nursing or designee will complete competency for oral hygiene and nail care on all facility and agency Certified Nursing Assistants. The Director of Nursing or designee will educate and complete competencies on all newly hired clinical staff and new clinical agency staff prior to the start of their first shift. This education was completed by 6/16/25. Step Four: To monitor and maintain ongoing compliance, the Director of Nursing or designee will observe and/or interview at least 5 residents' oral cavity per week for 12 weeks. The Director of Nursing or designee will observe and/or interview at least 5 residents' nails per week for 12 weeks. The Director of Nursing or designee will audit and/or interview completion of bath/shower for at least 5 residents per week for 12 weeks. The Director of Nursing or designee will be responsible for reporting the results of	

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F 677	Continued From page 34 show there was no change and the denture continued to have white colored buildup of debris. The DON stated denture care should have been done daily, Resident #86 should have a denture cup for soaking overnight, a denture brush for cleaning, and she expected assistance with oral hygiene to be provided. An interview was conducted with NA #3 on 05/14/25 at 12:44 PM and 12:54 PM. NA #3 confirmed she worked the 7:00 AM to 3:00 PM shift on 05/14/25 and assigned to assist Resident #86 with activities of daily living including oral hygiene. NA #3 stated she had not assisted Resident #86 with oral hygiene due to the resident taking a long time to eat breakfast. NA #3 stated she was not given report during shift change, typically did not work on that hall, was not familiar with Resident #86, and unsure if he had dentures. During an interview on 05/16/25 at 8:57 AM, the Administrator stated the expectation was for residents to receive assistance with oral hygiene and denture care twice a day, and dentures to be soaked overnight. b. A review of the shower schedule binder located at the nurse station revealed Resident #86's showers were scheduled on Tuesday and Friday to be completed during the 3:00 PM to 11:00 PM second shift. Included in the binder were paper body audits for the Nurse Aide (NA) staff to document skin issues and care provided. There were completed body audit sheets in the binder, but none of them were for Resident #86. A review of NA documentation for the previous 30 days indicated on 04/25/25 Resident #86 refused	F 677	these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of Compliance: 6/17/2025	

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a shower. On 04/26/25 received a shower and on 05/13/25 refused the shower. There was no further documentation of shower activity or refused showers for Resident #86.

An observation and interview were conducted with Resident #86 on 05/12/25 at 9:30 AM. Resident #86 stated he was supposed to get shower today (Monday) and his showers were scheduled twice a week. Resident #86 thought he had a shower on Wednesday (05/07/25) but was not sure. Resident #86's hair was uncombed but not greasy.

An observation and interview were conducted with Resident #86 on 05/13/25 at 08:39 AM. Resident #86 stated he did not get a shower yesterday (Monday) and was told he would, but no one came to get him. He thought maybe he was asleep when the person came and stated he did not refuse his shower. Resident #86 stated it does not bother him he missed a shower but does want a shower twice week. Resident #86's hair was observed to be uncombed but not greasy.

During an interview on 05/14/25 at 12:44 PM, NA #9 revealed she was the assigned shower person and stated Resident #86 refused his scheduled shower due to be completed on 05/13/25 (Tuesday) when she offered. NA #9 revealed she did not report, or document Resident #86 had refused his shower.

During an interview on 05/14/25 at 1:39 PM, the DON stated she would expect if Resident #86 consistently refused showers that documentation would be included in the resident's medical record, progress notes, and care planned.

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During an interview on 05/16/25 at 9:45 AM, the Administrator stated she expected residents to receive their showers as scheduled and if they did not receive a shower then she or the DON should be notified.

c. During observations and interviews with Resident #86 on 05/12/25 at 9:30 AM, 05/13/25 at 8:39 AM and 05/14/25 at 11:43 AM the fingernails on the right and left hand were approximately one forth inch long from the tip of the finger with a black-colored buildup of debris underneath the nails. Resident #86 revealed he did not recall being offered nail care and denied he refused nail care.

An interview was conducted with NA #3 on 05/14/25 at 12:44 PM and 12:54 PM. NA #3 confirmed she worked the 7:00 AM to 3:00 PM shift on 05/14/25 and assigned to assist Resident #86 with activities of daily living including personal hygiene and nail care. NA #3 stated she noticed Resident #86's had a black colored buildup under his nails but he had refused nail care from her when offered.

An observation and interview were conducted with the DON on 05/14/25 at 12:11 PM. The DON observed Resident #86's fingernails continued to have a buildup of black colored debris and stated nail care was provided during showers/bathing or as needed. Resident #86 agreed to have his fingernails clipped, cleaned, and nail care was provided.

During an interview on 05/16/25 at 8:57 AM the Administrator stated nail care was provided during showers or as needed. The Administrator

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explained she was made aware Resident #86's nail care was not being done, and the resident had refused showers.

2. Resident #43 was admitted to the facility on 11/27/24 with diagnoses that included incomplete quadriplegia C1-C4 (spinal cord injury between the vertebrae in the upper neck resulting in loss of some motor functions but not all).

The quarterly Minimum Data Set (MDS) assessment dated 03/27/25 revealed Resident #43 had intact cognition. He had impairment of both sides of the upper extremities and was dependent on staff assistance with self-care tasks, bed mobility and transfers. He displayed no behaviors and did not reject care during the MDS assessment period.

A review of Resident 43's comprehensive care plans, last reviewed/revised on 05/07/25, revealed he had an activities of daily living self-care performance deficit related to quadriplegia. Interventions included dependence on staff with showering twice weekly on Wednesday and Saturday and 2-person staff assistance with transfers using a mechanical lift.

Review of the master shower schedule revealed Resident #43 was scheduled to receive a shower on Wednesday and Saturday during the hours of 3:00 PM to 11:00 PM.

Review of the Nurse Aide (NA) point of care documentation report for 05/01/25 through 05/14/25 revealed no documentation that Resident #43 received his showers on Wednesdays or Saturdays as scheduled.

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During an observation and interview on 05/11/25 at 11:30 AM and follow-up interview on 05/12/25 at 12:22 PM, Resident #43 was lying in bed with the head of bed slightly elevated and his hair was unkempt. Resident #43 stated he was supposed to receive two showers per week on Wednesday and Saturday, but he did not always receive a shower on Saturdays due to there not being enough help on the weekends. He stated when he did not get a shower, staff did not offer him a bed bath and the last shower he received was this past Wednesday (05/07/25). Resident #43 stated he was supposed to get a shower yesterday (05/10/25) but was told by Nurse Aide (NA) #7 that he wouldn't be getting a shower because they didn't have enough staff. He stated that although he would have liked to have gotten his shower, he knew it wasn't the staff's fault. Resident #43 stated not getting a shower made him feel "nasty" and embarrassed to be seen this way.

During an interview on 05/11/25 at 1:00 PM, NA #8 revealed she worked on 05/10/25 during the hours of 7:00 AM to 3:00 PM and provided care to Resident #43. NA #8 stated there were only 3 NAs for the entire shift and they were not able to get a lot of the residents up out of bed or provide residents with any showers or bed baths. She expressed when working short-staffed, it was very difficult to get resident care provided and they basically had to focus on keeping the residents dry and fed.

During an interview on 05/14/25 at 2:45 PM, NA #7 revealed she worked on 05/10/25 during the hours of 7:00 AM to 3:00 PM and provided care to Resident #43. NA #7 stated there were only 3 NAs for the entire shift and they basically had to

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focus on completing rounds and making sure the residents were kept dry and fed. NA #7 stated she explained to the residents, including Resident #43, that they were short-staffed and they wouldn't be able to get them up out of bed or give them a shower.

During a phone interview on 05/15/25 at 2:27 PM, NA #6 confirmed she was assigned to provide Resident #43's care on 05/03/25 and 05/10/25 during the hours of 3:00 PM to 11:00 PM but she did not give him a shower or bed bath during her shifts. NA #6 explained resident showers were almost always provided on first shift (7:00 AM to 3:00 PM) and she usually didn't have to give any showers during her shift unless first shift wasn't able to get them all done.

During an interview on 05/16/25 at 4:52 PM, the DON revealed she expected Resident #43 to receive his showers as scheduled.

During an interview on 05/16/25 at 9:45 AM, the Administrator stated she expected residents to receive their showers as scheduled and if they did not receive a shower then she or the Director of Nursing (DON) should be notified.

3. Resident #74 was admitted to the facility 02/06/25 with a diagnosis including diabetes.

The quarterly Minimum Data Set (MDS) assessment dated 04/25/25 indicated Resident #74 was cognitively intact and had no rejection of care during the lookback period. Resident #74 had impaired range of motion affecting one side of the upper extremity and required partial/moderate assistance with showers.

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The activities of daily living (ADL) care plan last revised 02/19/25 revealed Resident #74 had an ADL self-care performance deficit related in part due to a diagnosis of diabetes and interventions included assisting him with showering on Wednesday and Saturday.

Review of the master shower schedule revealed Resident #74 was scheduled to receive a shower every Wednesday and Saturday on the 3:00 PM to 11:00 PM shift. Review of shower documentation revealed he did not receive a shower on 05/10/25. There was no documentation in Resident #74's medical record that he received a bed bath if he did not receive a shower.

An interview with Resident #74 on 05/12/25 at 9:21 AM revealed he was scheduled to receive his showers on Saturday and Wednesday, but he frequently missed his showers on Saturdays and if he missed his shower on Saturday, he had to wait until Wednesday to receive his shower. He stated he would like to receive his showers as scheduled. Resident #74 stated if he missed a shower he did not want or receive a bed bath instead.

In an interview with Nurse Aide (NA) #4 on 05/14/25 at 4:47 PM she confirmed she was assigned to care for Resident #74 on 05/10/25 on the 3:00 PM to 11:00 PM shift. She stated her assigned residents included all residents on 400 hall and all residents on 300 hall until 5:00 PM or 5:30 PM, when another NA came in to help. NA #4 stated from 5:00 PM or 5:30 PM she was assigned to care for all of 400 hall and the bottom half of 300 hall, and she did not have time to give Resident #74 his shower. NA #4 stated she did

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F 677	Continued From page 41 not specifically notify the nurse on 400 hall that Resident #74 did not receive his shower on 05/10/25 because the nurse was aware she was assigned to the 300 hall and 400 hall. An interview with the Administrator on 05/16/25 at 9:45 AM revealed she expected residents to receive their showers as scheduled and if they did not receive a shower then she or the Director of Nursing (DON) should be notified. An interview with the DON on 05/16/25 at 4:52 PM revealed she expected Resident #74 to receive his showers as scheduled.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the Wound Care Medical Doctor (MD), the Medical Director and staff, the facility failed to obtain treatment orders for pressure ulcers identified on 04/24/25 resulting in a seven day	F 686	1. Head to toe skin assessment was completed for Resident #86 with new wound measured and provider notification and treatment	6/17/25

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F 686	Continued From page 42 delay of treatment. Additionally, the facility failed to complete accurate head-to-toe skin checks used to identify new or existing pressure ulcers that include the site (location), type of wound, the length, width, depth, and stage. The skin/wound assessment completed on 05/13/25 indicated the resident's skin was intact with no new pressure ulcer. On 05/14/25 a tissue injury (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) on the left heel was identified and measured 4 centimeters (cm) in length and 4.1 cm with width. The deficient practice occurred for 1 of 5 residents reviewed for pressure ulcers (Resident #86). Findings included: Resident #86 was admitted to the facility on 04/24/25 with diagnoses including muscle wasting and atrophy (decreased muscle mass and strength) at multiple sites and moderate protein-calorie malnutrition. The admission data collection tool dated 04/24/25 was documented by Nurse #6 and included Resident #86's skin conditions. The tool noted Resident #86's skin was not intact and identified pressure ulcers were present. The site/location of the pressure ulcers were on the right and left buttock, and sacrum. The information related to the length, width, depth, and stage of the pressure ulcers was left blank. Nurse #6 documented left foot/heel pain was noted and Resident #86's skin integrity was at moderate risk for pressure ulcers. Included was a skin integrity care plan with the goal Resident #86's skin would remain intact without signs of breakdown by next review. Interventions were to provide wound care	F 686	ordered on 5/14/2025. 2. All residents have the potential to be affected. The Director of Nursing/Designee performed head to toe skin assessments on all residents to ensure all wounds are documented, care planned, and a treatment order is in place. This audit was completed on 6/13/2025. The Director of Nursing/Designee audited the admission skin assessments all new admissions for the past 30 days to ensure the provider was aware of any alteration of skin integrity and treatment order for wound active if indicated. Audit completed on 6/13/25. 3.The Director of Nursing/Designee provided re-education for all nursing staff, including nursing agency staff on preventing pressure ulcers, notification to the physician or Nurse Practitioner, completion of skin assessments, and proper documentation on weekly skin assessment. This education was completed on 6/16/25, prior to the start of the next scheduled shift and will be added to the facility orientation program for all newly hired nursing staff, including agency nursing staff. 4. The Director of Nursing/Designee	

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F 686	Continued From page 43 and preventive skin care per physician's order, weekly skin checks per facility protocol and document findings, turn and reposition frequently to decrease pressure. Resident #86's Treatment Administration Record (TAR) revealed no treatments were administered for pressure ulcers from 04/24/25 through 04/30/25. The baseline care plan dated 04/25/25 completed by the former/interim Director of Nursing (DON) identified Resident #86 had pressure ulcers and/or potential for developing pressure ulcers with the goal the ulcer would show signs of healing and remain free from infection by the review date. Interventions were to administer treatments as ordered and observe effectiveness, reposition and/or turn at frequent intervals, observe dressing to ensure it was intact and adhering, and report loose dressing to the treatment nurse. An interview with the former/interim DON was conducted on 05/14/25 at 4:37 PM. The interim/former DON revealed for a newly admitted resident the baseline care plan, admission data collection, nurse note, and skin assessment needed to be completed and should be done by the admitting nurse. She revealed newly admitted residents were discussed during their next morning Interdisciplinary Team meeting to ensure if pressure wounds were identified treatments orders were care planned and initiated by admitting nurse. The interim/former DON revealed at the time of Resident #86's admission nurse staffing had little to no support and on 04/24/25 there were three other new admissions to complete. The interim/former DON revealed if	F 686	will audit the skin assessments 5 skin assessment weekly for 12 weeks to ensure accuracy and notification to physician or Nurse Practitioner. The Director of Nursing/Designee will review new admission skin assessments in Clinical Morning Meeting 5 times a week for 12 weeks to ensure correct wound information, orders are obtained and measurements are accurate as indicated. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/17/2025	

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pressure ulcer wounds were identified on the baseline care plan there should be physician orders in place for treatment and stated she did the best she could with three admissions and sometimes the Interdisciplinary Team meetings were short and might not have the entire team present.

The nurse progress note dated 4/25/25 was documented by Nurse #6 and identified Resident #86 as having pressure sores on the middle right and left buttock and sacrum. Nurse #6 noted there was no drainage from the ulcers, the ulcers were red, and all were less than the size of a quarter.

A review of Resident #86's head-to-toe skin checks used to identify skin integrity concerns of new or existing pressure ulcers and documentation of the site (location), type of wound, the length, width, depth, and stage completed on 05/01/25 indicated the skin was intact but did note changes to the skin integrity as "redness under a dressing but no open areas." On 05/03/25, 05/05/25, and 05/09/25 the checks indicated Resident #86's skin was intact with no changes to skin integrity.

The admission Minimum Data Set (MDS) assessment dated 04/29/25 revealed Resident #86's cognition was moderately impaired with no rejection of care behaviors during the lookback period. Resident #86 needed setup assistance with rolling left to right in bed and partial to moderate assistance with transfers. The MDS skin conditions indicated there were no unhealed pressure ulcers at stage one (intact skin with non-blanchable redness over a localized area) or higher.

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A review of the Wound Care MD note dated 04/30/25 revealed Resident #86's visit was rescheduled. There were no other Wound Care MD notes in Resident #86's medical records to indicate the pressure ulcers were evaluated by the provider.

An interview was conducted on 05/15/25 at 1:38 PM with the Wound Care MD. The MD revealed she was the wound care provider for the facility and visited every Wednesday. She relied on the facility to inform her which residents she needed to evaluate and was provided a list of who to see. She was not aware of any pressure ulcer wounds for Resident #86 and confirmed on 04/30/25 the visit was rescheduled. She was unsure why Resident #86 fell off her list of residents to evaluate after 04/30/25 and revealed it could have been an oversight.

A review of Resident #86's current physician orders revealed on 04/30/25 an order was obtained to cleanse an area on the sacrum with normal saline or wound wash, pat dry and apply a hydrocolloid dressing (a moist insulated bandage used to promote healing) and cover with a clean and dry dressing every day shift for wound care.

A review of Resident #86's TAR revealed the physician order was transcribed to cleanse the area to sacrum with normal saline or wound wash, pat dry and apply hydrocolloid dressing, and cover with clean and dry dressing every day shift for wound care. On 05/01/25 wound care treatments were started and continued daily except on 05/02/25, it was noted as Resident #86 refused and on 05/03/25 and 05/06/25 the TAR was blank with no nurse initials to indicate it was

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F 686	Continued From page 46	F 686		

done.

The nursing daily skilled charting dated 05/13/25 was documented by Nurse #6 and noted Resident #86's skin was intact and there were no changes in the resident's skin integrity.

During an interview on 05/14/25 at 4:09 PM, Nurse #6 confirmed she completed Resident #86's admission data collection dated 04/24/25. She described the areas on Resident #86's left, and right buttock and sacrum were not open or draining and were on the surface of the skin. Nurse #6 revealed she did not check if the pressure ulcers were blanchable and she did not measure the wounds. She further revealed she was not aware measuring the pressure ulcers was an expectation until approximately one month later and stated she had not been shown the full process of completing a new admission and learned by word of mouth or after being told she did something wrong. Nurse #6 stated she was not provided education on how to complete the nursing daily skilled charting when hired and had asked for that on many different occasion. Nurse #6 confirmed she completed the nursing daily skilled charting on 05/13/25 and her documentation incorrectly noted Resident #86's skin was intact. Nurse #6 stated it was an error on her part, and she knew Resident #86 continued to have pressure ulcer wounds on his buttock and sacrum and stated she "must have hit the wrong button." Nurse #6 revealed she did not visually check Resident #86's skin integrity when she completed her nursing daily skilled charting on 05/13/25 but knew Resident #86's skin was not intact based on the admission assessment she completed on 04/24/25.

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An observation of Resident #86's head-to-toe skin check was made on 05/14/25 at 12:12 PM with the Unit Manager who completed the check. There was no hydrocolloid dressing in place as ordered on the sacrum. A stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) sacrum pressure ulcer with no visible drainage or odor was identified. Several small, different shaped scattered red and purple areas were observed on the left and right buttock that were blanchable. A non-blanchable deep tissue injury was observed on the left heel that was circular in shape and colored dark purple with surrounding redness. When touched Resident #86 did not verbalize pain.

An interview was conducted with Nurse Aide (NA) #3 on 05/14/25 at 12:44 PM and 12:54 PM. NA #3 revealed she was assigned to assist Resident #86 with activities of daily living on 05/14/25 from 7:00 AM through 3:00 PM. NA #3 revealed the care she had provided included emptying the catheter bag and catheter care. NA #3 stated she did not recall if she saw a dressing on the sacrum but did observe the skin on Resident #86's buttock was red, but she did not report that to the nurse. NA #6 revealed Resident #86 was already wearing socks, and she did not observed the resident's left foot and normally she was not assigned to the hall and not very familiar with Resident #86 and did not receive report at the beginning of her shift.

An interview was conducted on 05/15/25 at 2:38 PM with Nurse #3. Nurse #3 confirmed she was assigned to complete wound care for residents on 05/14/25. Nurse #3 revealed the Wound Care MD did not see Resident #86 and confirmed the

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F 686	Continued From page 48	F 686		

resident was not on the list. Nurse #3 revealed Resident #86's hydrocolloid dressing was in place on the sacrum when she went to provide wound care on 05/14/25. She revealed the hydrocolloid dressing was soiled and she placed a new dressing on the sacrum.

A review of Resident #86's head-to-toe skin check dated 05/14/25 documented by the Unit Manager revealed a new pressure ulcer was identified. The new ulcer was located on the left heel and measured 4 cm in length, 4.1 cm in width, had no depth and staged as a deep tissue injury. The existing pressure ulcer on the sacrum measured 3.8 cm in length, 4.9 cm in width, and 0.2 cm in depth and was a stage 2.

A review of Resident #86's current physician orders included a Wound MD consult and to treat as needed dated 05/14/25. For a left heel deep tissue injury cleanse the area with mild soap and water, apply a protective foam dressing to heel and secure with stretch gauze every Monday, Wednesday, Friday, and as needed dated 05/14/25. For the resident to wear multi-podus boot (a device used to offload pressure) to left foot while in bed for offloading/skin integrity dated 05/14/25.

During an interview on 05/15/25 at 10:43 AM and on 05/16/25 at 4:41 PM, the DON revealed she expected inventions were implemented on 04/24/25 when Resident #86 was admitted with pressure ulcers and measurements of those ulcers were completed and used as a reference for monitoring. She revealed skin assessments were not consecutively completed, and she expected those were done weekly as the facility's standard of practice. The DON revealed the

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F 686	Continued From page 49 expectation for completing the skin/wound assessments was for the nurse to visually check the resident's skin and identify existing and new skin breakdown. An interview was conducted on 05/15/25 at 9:10 AM with the Medical Director. The Medical Director revealed the Wound Care Nurse completed treatments and notified the Wound Care MD who followed pressure ulcer wounds. The Medical Director revealed he expected pressure ulcer treatments were obtained for Resident #86 when first admitted on 04/24/25 and the dressing was in place as ordered. He was unsure if Resident #86's pressure ulcers were avoidable and described Resident #86 as being emaciated (thin and frail) weighing 126 pounds on admission with a diagnoses of muscle wasting and atrophy placing the resident at high risk for worsening or developing a pressure ulcer.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		6/20/25

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F 690	Continued From page 50 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the Medical Director, resident and staff, the facility failed to monitor the resident's urinary catheter for complications of skin breakdown and ensure the catheter tubing was kept clean. A buildup of a white colored substance was observed on the urinary meatus (the opening at the tip of the penis where urine exits the body) where the catheter tubing was inserted, on the scrotum and between the skin folds of the groin. There was redness and irritation present on the genitals and skin folds between the groin and a strong odor resembling yeast. The deficient practice occurred for 1 of 3 residents reviewed for urinary catheters (Resident #86). Findings included:	F 690	1. Resident #86 received catheter care and hygienic care on 5/14/25 The Medical Provider notified of redness, presumed fungal rash, and gave order for Nystatin Powder twice daily for 14 days for Resident #86. 2. Residents requiring a catheter have the potential to be affected. The Director of Nursing/Designee audited all catheters for cleanliness, orders, appropriate diagnosis and care plans. The Director ofNursing/Designee audited the residents individual Kardexs to ensure it reflects residents utilizing catheters. This audit was completed on 6/13/25.	

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F 690	Continued From page 51 Resident #86 was admitted to the facility on 04/24/25 with diagnoses including muscle wasting and atrophy (decreased muscle mass and strength) at multiple sites and acute and chronic congestive heart failure. A review of Resident #86's active physician orders included tamsulosin (a medication used to promote urine flow) give 0.4 milligrams at bedtime for urine retention started 04/24/25; empagliflozin (sodium-glucose cotransporter-2 inhibitors) give a 10 mg tablet one time a day for congestive heart failure started 4/26/25; provide catheter cleansing and perineal hygiene daily and as need if soiled; monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter started 04/28/25. There were no orders for antifungal medications or treatments for skin redness and irritation. The baseline care plan dated 04/25/25 identified the placement of an indwelling urinary catheter with the goal Resident #86 would not show signs or symptoms of a urinary tract infection. Interventions included position catheter bag and tubing below the bladder and hand washing before and after delivery of care. The admission Minimum Data Set (MDS) assessment dated 04/29/25 revealed Resident #86's cognition was moderately impaired, partial to moderate assistance was needed with toileting hygiene, an indwelling urinary catheter was in place and always incontinent of bowel. No genitourinary diagnoses were checked. The MDS	F 690	Any issues were immediately corrected 3.The Director of Nursing/Designee provied re-educate for all clinical facility nursing staff, including agency nursing staff on proper catheter care, visual inspection of skin and catheter use policy. Certified Nursing Assistants, including agency Certified Nursing Assistants were re-educated to notify the Licensed Nurse of any redness/irriation, Licensed Nurses, including agency Licensed Nurses were re-educated to notify the Physician or Nurse Practitioner of any skin related issues. This education was completed on 6/16/2025 and will be added to the facilities orientation program for all newly hired nursing staff, including new agency nursing staff. 4. The Director of Nursing/Designee will monitor all new admissions to ensure appropriate drainage bag, order, diagnosis and care plan/Kardex are in place in Clinical Morning Meeting 5 times a week for 12 weeks. The Director of Nursing/Designee will observe 3 catheter care observations weekly for 12 weeks to ensure cleaniness, without any skin related issues. The Director of Nursing/Designee will be responsible for reporting the results	

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F 690	Continued From page 52 indicated Resident #86 had no rejection of care behaviors during the lookback period. A review of Resident #86's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 05/01/25 through 05/14/25 revealed the physician's order to provide catheter cleansing and perineal hygiene daily and as need if soiled; monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter were not included. There was no treatment order for skin related redness or irritation, or for the use of an antifungal powder or cream. A review of the Nursing Daily Skilled Charting dated 05/13/25 included a skin/wound assessment and indicated Resident #86's skin was intact and there were no skin integrity changes. Nurse #6 documented the assessment. An observation was made on 05/14/25 at 12:12 PM of Resident #86's catheter care provided by the Unit Manager (UM). When the brief was removed, the skin on Resident #86's genitals including the urinary meatus where the catheter tubing was inserted and skin folds between the groin was red and irritated. There was a buildup of a white colored substance on the genitals and between the groin skin folds and a strong odor resembling yeast was present. The UM revealed it appeared Resident #86's catheter care had not been done and noted the presence of a strong odor resembling yeast. The UM cleaned the catheter tubing, genitals and between the skin folds and removed the white substance from	F 690	of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	

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Resident #86's skin and revealed it appeared an antifungal powder had been applied. There was a small area of skin on the scrotum that was peeling and red. There was no drainage or leakage noted from the catheter insert site. Resident #86 tolerated catheter care and did not voice pain when asked by the UM.

During an interview on 05/14/25 at 12:12 PM, Resident #86 revealed he did not refuse catheter care. Resident #86 revealed he was unsure why the urinary catheter was placed and did not recall the last time catheter care was provided. Resident #86 did not share he was itching or had pain related to his urinary catheter.

An interview was conducted on 05/14/25 at 4:09 PM with Nurse #6. Nurse #6 confirmed she completed the Nursing Daily Skilled Charting on 05/13/25. Nurse #6 revealed she did not visually check Resident #86's skin integrity when she completed the skin/wound assessment.

An interview was conducted on 05/14/25 at 12:44 PM with Nurse Aide (NA) #3, Resident #86's assigned NA. NA #3 confirmed she worked the day shift on 05/14/25 starting at 7:00 AM and was assigned to provide catheter care for Resident #86. NA #3 stated she had emptied Resident #86's catheter bag and checked for a bowel movement and there was no incontinence. NA #3 revealed she had done catheter care earlier today (05/14/25) and cleaned the catheter tubing at the insert site. When asked if she cleaned the perineal area and between the skin folds to remove a white substance NA #3 stated, "yes." NA #3 revealed she noted Resident #86's skin was red, but did not report it to the nurse.

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During an interview on 05/14/25 at 1:39 PM and 05/15/25 10:43 AM, the Director of Nursing (DON) stated it was obvious NA #3 had not provided Resident #86's catheter care based on the observation made by the UM and surveyor. The DON revealed catheter care was provided as needed and she expected it was done. The DON revealed the expectation for completing the skin/wound assessments was for the nurse to visually check the resident's skin and identify existing and new skin breakdown.

During an interview on 05/16/25 at 8:57 AM, the Administrator stated it appeared NA staff were just emptying Resident #86's catheter bag. The Administrator revealed Resident #86 should be check every two hours for bowel incontinence and at some point someone should have noticed his catheter needed cleaned and his perineal hygiene care needed to be done.

During an interview on 05/16/25 at 3:43 PM, the Medical Director stated catheter care should be done as ordered and if not provided could put Resident #86 at risk of an infection. When asked about the strong body odor resembling yeast and the skin redness, the Medical Director stated Resident #86 received empagliflozin a medication that could cause yeast. He revealed on 04/22/25 Resident #86 could not urinate and the catheter was placed at the hospital then Resident #86 was admitted to facility with no instructions for a trial to remove it. The Medical Director revealed based on his initial visit progress note dated 04/26/25 Resident #86 was put on tamsulosin (a medication used to increase urine flow) for urinary retention and in a male that was obstructive uropathy and why the urinary catheter was in place.

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F 690	Continued From page 55 During an interview on 05/16/25 at 4:03 PM in the presence of the Medical Director, Resident #86 was unsure why he needed an indwelling urinary catheter. The Medical Director explained to Resident #86 a voiding trial period would be started, and the urinary catheter would be removed and if Resident #86 could urinate the catheter was not needed.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		6/19/25

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F 725	Continued From page 56 paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with residents and staff, the facility failed to provide sufficient nursing staff to ensure residents received bathing, incontinence care and personal hygiene assistance as needed and requested for 4 of 8 sampled residents (Residents #35, #43, #74, and #86) reviewed for activities of daily living. This tag is cross-referenced to: F 677: Based on observations, record review, resident and staff interviews, the facility failed to provide assistance with incontinence care upon request (Resident #35), oral hygiene and nail care (Resident #86), and showers (Resident #43, #74, and #86) for 4 of 8 dependent residents reviewed for activities of daily living. During an interview on 05/11/25 at 10:05 AM and follow-up interview on 05/14/25 at 12:55 PM, Confidential Staff Member #1 revealed for the past few months staffing had been ok during the week but had been short on the weekends. Confidential Staff Member #1 stated this past weekend on (05/10/25) there were only 3 Nurse Aides (NA) for the entire shift (7:00 AM to 3:00 PM) and they weren't able to get many residents up out of bed or provide residents with bathing assistance. Confidential Staff Member #1 stated when working short staffed, they were only able to complete rounds and primarily focused on keeping the residents clean, dry and fed.	F 725	1. The schedules for the week were immediately reviewed, and agency was contacted to fill any open shifts. 2. All residents have the potential to be affected. A review of the next 30 days schedules was completed on 5/19/2025. Facility staff and agencies were notified of open position. 3. The Director of Nursing/Designee re-educated all nursing staff on the facility attendance policy including when calling out, to give the facility at least 2 hours notice before scheduled shift. This education was completed on 6/16/2025 and will be added to the facility orientation program for any newly hired nursing staff. The scheduler was re-educated on the importance of filling open shifts as soon as possible. This education was completed on 5/16/2025 and will be added to the facility orientation program for any newly hired schedulers. 4. The Director of Nursing/Designee will audit nursing schedules weekly for 12 weeks to ensure that all	

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F 725	Continued From page 57 During an interview on 05/11/25 at 10:09 AM and follow-up interview on 05/15/25 at 8:48 AM, Medication Aide (MA) #1 revealed weekend staffing had been short since she had been working at the facility. MA #1 revealed on 05/10/25 she was assigned to a medication cart and there were only 3 Nurse Aides (NAs) during the shift to provide resident care. MA #1 explained while working on the medication cart, she helped the NAs as she could and she did assist with providing incontinence care to 2 residents but did not provide any residents with bathing assistance. MA #1 stated there were only 2 other nurses working with her today (05/11/25) and they were all behind with getting the residents morning medications passed. She explained when short-staffed and covering more than one hall, it was difficult for them to get the medications passed on time and she just did the bed she could. During an interview on 05/11/25 at 10:15 AM, Nurse #1 revealed she worked every weekend and they usually had to work short-staffed. Nurse #1 explained staffing was really good when she first started her employment in February 2025 but since then, staff either called-out or just not showed up to work and administration wasn't always able to get the shifts covered at the last minute. Nurse #1 stated yesterday (05/10/25) there were 3-4 staff members that called out which left her covering the rehab hall with 17 residents who all required max assistance and she just did her best to focus on her priorities which were getting medications passed, fluids passed and feeding assistance provided. She stated today (05/11/25) there were only 2 nurses (including herself) and a MA and they were all behind on getting residents morning medications	F 725	open shifts are covered, and open shifts have been offered to facility staff and agencies have been notified. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/19/2025	

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passed on time. Nurse #1 stated when working short-staffed, she felt rushed and it was very difficult to get everything done in a timely manner.

During an interview on 05/11/25 at 10:28 AM, Nurse #2 revealed staffing was hit or miss with some days/shift being better than others. Nurse #2 stated today had been rough as they only had 2 Nurses (including herself) and a MA. Nurse #2 stated she was covering 2 resident halls and still had not finished the morning medication pass. Nurse #2 expressed when working short-staffed, it was difficult to get things done timely and residents were getting their medications late.

During an interview on 05/11/25 at 3:33 PM, NA #10 revealed she only worked weekends and some days staffing was good and other days they might only have 1-2 NAs for the entire shift. NA #10 expressed when working short-staffed, it was rough getting dinner served, making rounds every 2 hours and answering call-lights quickly. She explained she might not get to take a break but she did her best to make sure everything was done for the residents, it just took her longer.

During an interview on 05/11/25 at 11:30 AM, the former Interim Director of Nursing (DON) confirmed staffing had been a challenge. She explained they had been utilizing a lot of agency staffing to supplement the schedule but still had a lot of call-outs. The former Interim DON stated this past Friday (05/09/25) she worked all day on the weekend schedule (5/10/25 and 5/11/25), had the shifts covered and then staff either called-out or didn't show up for their scheduled shift(s). The former Interim DON stated the previous DON had switched back to 8-hour shifts, which made it even more difficult to get shifts covered,

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especially the 3:00 PM to 11:00 PM shift, and they had recently made the decision to go back to 12-hour shifts which she hoped would get them back on the right track with ensuring there was adequate staff coverage each shift.

During a Resident Council group interview on 05/13/25 at 10:26 AM, Resident #70, Resident #63, Resident #41, Resident #14, Resident #11, Resident #18, Resident #23, Resident #69, and Resident #42 all voiced there was an issue with the facility being short-staffed on the weekends and as a result, showers were not given as scheduled and call-lights took longer to be answered by staff.

During an interview on 05/16/25 at 5:38 PM, the Staffing Scheduler revealed daily staffing coverage was based on the resident census and/or acuity (level of care an individual required) needs of the residents. She stated facility staff were currently scheduled for 8-hour shifts with the following preferred minimums: on the day shift (7:00 AM to 3:00 PM) she tried to have 4 nurses and 7-8 NAs; on the evening shift (3:00 PM to 11:00 PM) she tried to have 4 nurses and 5-6 NAs; and on the night shift (11:00 PM to 7:00 AM) she tried to have 2 nurses and 4 NAs. The Staffing Scheduler confirmed staffing had been a challenge, especially on the weekends. The Staffing Scheduler explained she made the schedule out a month in advance and for shifts needing coverage, she started with in-house staff to request volunteers and then reached out to staffing agencies to fill in the gaps. She stated she would get the shifts covered but then at the last minute, staff would call-out or not show up as scheduled. When that happened, they tried to find someone to cover the shift but if unable, she

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F 725	Continued From page 60 or other administrative nursing staff would help out. The Staffing Scheduler revealed the current open positions at the facility were 2 Nurses and 2-3 NAs for the day shift, 3 Nurses and 2 NAs for the evening shift, and 1 full-time nurse, 1 part-time nurse and 1-2 NAs for the night shift. During an interview on 05/16/25 at 8:39 AM, the Administrator confirmed staffing was a challenge and she realized it was an area that needed more attention. She stated that they were actively trying to hire more staff and in the interim, they were using several different staffing agencies to supplement the schedule. The Administrator stated with the current resident census, only having 2-3 NAs on first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM) was not adequate and explained they were supposed to be able to get agency staffing coverage last minute but it didn't always happen. The Administrator stated she felt that part of the reason for the current staffing issues was due to the previous administration had changed back to 8-hour shifts because facility-hired staff had threatened to quit; however, agency staff did not want to work 8-hour shifts, they wanted to work longer hours. She stated agency staff would sign up for shifts and then call-out or not show up for the shift because they were able to find more hours elsewhere. She stated they had recently made the decision to return back to 12-hour shifts, which she felt would help with having adequate staffing coverage.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services	F 726		6/20/25

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F 726	Continued From page 61 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide effective orientation to a new nurse on the facility's admission process when Nurse #6 failed to obtain and document code status information, obtain treatment orders for pressure ulcers, and complete accurate head-to-toe skin checks used to identify skin	F 726	1. The Director of Nursing/Designee immediately re-educated all nurses and medication aides on the admissions process, the seven rights of medication administration, requesting a hard script from provider for narcotics to process	

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F 726	Continued From page 62 breakdown and new or existing pressure ulcers. In addition, the facility also failed to ensure nursing staff were able to demonstrate the competency and skills necessary for providing care to meet the individual care needs of residents when Nurse Aide (NA) #3 failed to inform the nurse she had noticed a resident's skin was red and irritated during catheter care, Nurse #1 failed to identify a resident prior to administering medication prescribed for another resident, Nurse #7 failed to request a prescription from the physician when refilling a controlled medication, and Nurse #8 failed to utilize the medication resources stored in the Pyxis (an automated dispensing machine that provided secure medication storage on patient care units, along with electronic tracking of the use of narcotics and other controlled medications). This occurred for 5 of 8 staff reviewed for competency (Nurse #6, NA #3, Nurse #1, Nurse #7 and Nurse #8). Findings included: This tag is crossed referenced to: F 578: Based on record review, Medical Director (MD) interview, and staff interviews, the facility failed to obtain and document an advanced directive that included code status information upon admission for 1 of 4 residents reviewed for advance directive (Resident #283). F 686: Based on observations, record review, interviews with the Wound Care Medical Doctor (MD), the Medical Director and staff, the facility failed to obtain treatment orders for pressure ulcers identified on 04/24/25 resulting in a seven-day delay of treatment. Additionally, the	F 726	refills, and how to utilize the back up medication dispensing machine (Pyxis). Certified Nursing Assistants (CNAs) were re-educated to report any skin issues or redness identified during incontinence or catheter care to the nurse immediately. This education was completed on 5/22/2025. 2. All current residents have the potential to be affected. The Director of Nursing/Designee reviewed all new admissions for the past 30 days for accuracy of code status, treatment orders were obtained for pressure ulcers, complete/accurate head to toe skin assessments were completed, resident identifiers/photographs in the electronic medical records were present, door name tags were accurate, residents received narcotic medications/prescription timely and Licensed Nurses were enrolled in and were able to utilize the facility backup medication dispensing machine (Pyxis). This audit was completed on 6/13/2025 Any areas of concern were immediately corrected. . The Director of Nursing/Designee re-educated all Licensed Nurses, Medication Aides, including any current agency on the admissions process, the seven rights of medication administration, requesting hard script from the provider	

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F 726	Continued From page 63 facility failed to complete accurate head-to-toe skin checks used to identify new or existing pressure ulcers that include the site (location), type of wound, the length, width, depth, and stage. The skin/wound assessment completed on 05/13/25 indicated the resident's skin was intact with no new pressure ulcer. On 05/14/25 a tissue injury (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) on the left heel was identified and measured 4 centimeters (cm) in length and 4.1 cm with width. The deficient practice occurred for 1 of 5 residents reviewed for pressure ulcers (Resident #86). F 690: Based on record review, observations, and interviews with the Medical Director, resident and staff, the facility failed to monitor the resident's urinary catheter for complications of skin breakdown and ensure the catheter tubing was kept clean. A buildup of a white colored substance was observed on the urinary meatus (the opening at the tip of the penis where urine exits the body) where the catheter tubing was inserted, on the scrotum and between the skin folds of the groin. There was redness and irritation present on the genitals and skin folds between the groin and a strong odor resembling yeast. The deficient practice occurred for 1 of 3 residents reviewed for catheters (Resident #86). F 760: Based on observations, record review, and Nurse Practitioner (NP), Medical Director (MD), resident and staff interviews, the facility failed to prevent a significant medication error when Nurse #1 administered antidepressant, diuretic, blood pressure, hypoglycemic (oral medication used to treat diabetes) and steroid medications to	F 726	to refill narcotics, and using the Pyxis machine. All Certified Nursing Assistants were re-educated on identifying and reporting any skin breakdown or red areas found during incontinence care or catheter care. This re-education was completed on 6/16/2025 and will be added to the facility orientation program for all newly hired nursing staff, including any newagency nursing staff. 4. The Director of Nursing/Designee will interview 3 Licensed Nurses and/or medication aides weekly for 12 weeks on the admissions process, seven rights of medication administration, requesting narcotics refills, and using the Pyxis for back up medications. The Director of Nursing/Designee will interview 3 Certified Nursing Assistance weekly for 12 weeks on reporting skin breakdown to nursing. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 726	Continued From page 64 Resident #283 that were prescribed for Resident #86. In addition, the facility failed to request a prescription from the physician to avoid a gap in medication administration when refilling a controlled medication and failed to utilize medication resources stored in the Pyxis (an automated dispensing machine that provided secure medication storage on patient care units, along with electronic tracking of the use of narcotics and other controlled medications) which resulted in the Resident #11 missing 3 doses of nerve pain medication, 3 doses of diabetic medication, and 1 dose of insulin. This deficient practice occurred for 2 of 2 residents reviewed for significant medication error (Resident #283 and Resident #11). During an interview on 05/11/25 at 10:40 AM the Administrator revealed there had been a recent change in administration, the Director of Nursing (DON) just started her position the week prior and the Assistant DON was starting her position this week. During follow-up interviews on 05/16/25 at 8:30 AM and 6:36 PM, The Administrator revealed she realized there were issues with staff orientation and training dating back to the previous DON and management team. She stated they had put performance improvement plans in place to work on the various issues and going forward, the current DON and Assistant DON would be responsible for ensuring skills competencies for nursing staff were completed annually. The Administrator expressed she felt they now had a strong management team in place, and she had no doubt that processes would be fixed and improvement achieved but it would take time for them to get things turned around.	F 726	Compliance Date: 6/20/2025	

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F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		6/9/25

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F 732	Continued From page 66 by: Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff who worked for 16 of 16 days reviewed (11/09/24, 11/10/24, 11/23/24, 12/07/24, 12/08/24, 12/28/24, 12/29/24, 04/13/25, 04/19/25, 04/20/25, 04/26/25, 04/27/25, 05/03/25, 05/04/25, 05/10/25, and 05/11/25). Findings included: Review of the facility's daily nurse staffing sheet revealed underneath the facility's name was a space to specify the date along with columns to specify the resident census, number of staff and hours worked for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) for each 8-hour shift, 7:00 AM to 3:00 PM (first shift), 3:00 PM to 11:00 PM (second shift) and 11:00 PM to 7:00 AM (third shift). a. The daily nurse staffing sheet dated 11/09/24 revealed on third shift there were 2 LPNs, 4 NAs and no RNs. The nursing staff time clock report for 11/09/24 revealed on third shift there were 2 LPNs, 2 NAs and no RNs. b. The daily nurse staffing sheet dated 11/10/24 revealed on first shift there 2 RNs, 2 LPNs and 7 NAs. On second shift there were 2.5 RNs, 1.5 LPNs and 5 NAs. The nursing staff time clock report for 11/10/24 revealed on first shift there were 2 RNs, 2 LPNs and 5.5 NAs. On second shift there were 1.5 RNs, 1.5 LPNs and 4 NAs. c. The daily nurse staffing sheet dated 11/23/24 revealed on first shift there were 4 RNs, 1 LPN and 7 NAs. On second shift there were 1.5 RNs,	F 732	F732- Posted Nurse Staffing Information Step one: Facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff. The daily staffing postings were immediately reviewed by the administrator for November 2024-May 2025 and corrections were made as necessary. Step two: On 6/9/2025 the administrator reviewed staff postings for the past 30 days for accuracy and changes were made as needed to reflect accurate staffing hours. Step three: The scheduler was educated by the administrator on 6/9/2025 on ensuring the daily staff postings are accurate, posted daily, and maintained for 18 months. Any potential new hires in this position will be educated on daily posting and maintaining postings for 18 months. Step four: The administrator/designee will audit the daily staff postings 5 times per week for 12 weeks to ensure accuracy. The audits will be reviewed monthly in Quality Assurance Performance Improvement. The team may change the Plan of Correction or extend the audit to ensure ongoing compliance. The administrator is responsible for this plan of correction. Date of compliance 6/9/2025	

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1.5 LPNs and 6.5 NAs. The nursing staff time clock report for 11/23/24 revealed on first shift there were 3.5 RNs, 1 LPN and 6 NAs. On second shift there were 1.5 RNs, 1.5 LPNs and 6 NAs.

d. The daily nurse staffing sheet dated 12/07/24 revealed on second shift there were 2 RNs, 2 LPNs and 4 NAs. On third shift there were 2 LPNs, 4 NAs and no RNs. The nursing staff time clock report for 12/07/24 revealed on second shift there were 2.5 RNs, 1.5 LPNs and 4 NAs. On third shift there were 2 LPNs, 2 NAs and no RNs.

e. The daily nurse staffing sheet dated 12/08/24 revealed on first shift there were 2 RNs, 2 LPNs and 8 NAs. On third shift there were 1 RN, 1 LPN and 3 NAs. The nursing staff time clock report for 12/08/24 revealed on first shift there were 1.5 RNs, 3 LPNs and 7 NAs. On third shift there were 2 LPNs, 5 NAs and no RNs.

f. The daily nurse staffing sheet dated 12/28/24 revealed on third shift there were 2 LPNs, 3 NAs and no RNs. The nursing staff time clock report for 12/28/24 revealed on third shift there were 2 LPNs, 2 NAs and no RNs.

g. The daily nurse staffing sheet dated 12/29/24 revealed on first shift there were 4 LPNs, 8 NAs and no RNs. On third shift there were 1 RN, 1 LPN and 3 NAs. The nursing staff time clock report for 12/29/24 revealed on first shift there were 3 LPNs, 6 NAs and no RNs. On third shift there were 3 LPNs, 4 NAs and no RNs.

h. The daily nurse staffing sheet dated 04/13/25 revealed on first shift there were 2 RNs, 2 LPNs and 8 NAs. On second shift there were 1 RN, 1

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LPN and 7 NAs. The nursing staff time clock report for 04/13/25 revealed on first shift there were 1 RN, 2 LPNs and 8 NAs. On second shift there were 1 RN, 1 LPN and 6 NAs.

i. The daily nurse staffing sheet dated 04/19/25 revealed on first shift there were 2 RNs, 2 LPNs and 7 NAs. On second shift there were 2 RNs, 2 LPNs and 5 NAs. The nurse staffing time clock report for 04/19/25 revealed on first shift there were 1 RN, 1.5 LPNs and 7 NAs. On second shift there were 2 RNs, 2 LPNs and 3 NAs.

j. The daily nurse staffing sheet dated 04/20/25 revealed on first shift there were 2 RNs, 2 LPNs and 7 NAs. On second shift there were 1.5 RNs, 2.5 RNs and 5 NAs. There was no resident census listed on the sheet. The nursing staff time clock report for 04/20/25 revealed on first shift there were 1.5 RNs, 1 LPN and 8 NAs. On second shift there were 1.5 RNs, 2.5 LPNs and 3 NAs.

k. The daily nurse staffing sheet dated 04/26/25 revealed on first shift there were 2 RNs, 2 LPNs and 8 NAs. The nursing staff time clock report revealed on first shift there were 3 RNs, 1 LPN and 7 NAs.

l. The daily nurse staffing sheet dated 04/27/25 revealed on second shift there were 1 RN, 2 LPNs and 5 NAs. On third shift there were 1 RN, 1 LPN and 3 NAs. The nursing staff time clock report for 04/27/25 revealed on second shift there were 1 RN, 4 LPNs and 4 NAs. On third shift there were 1 LPN, 3 NAs and no RNs.

m. The daily nurse staffing sheet dated 05/03/25 revealed on first shift there were 2 RNs, 2 LPNs

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and 9 NAs. On second shift there were 3 RNs, 1 LPN and 7 NAs. On third shift there were 1 RN, 1 LPN and 4 NAs. The nursing staff time clock report for 05/03/25 revealed on first shift there were 1 RN, 3 LPNs, 1 Certified Medication Aide (CMA), and 7 NAs. On second shift there were 2 RNs, .5 LPN and 4.5 NAs. On third shift there were 1 RN, 1 LPN and 3 NAs.

n. The daily nurse staffing sheet dated 05/04/25 revealed on second shift there were 1 RN, 1 LPN and 7 NAs. The nursing staff time clock report for 05/04/25 revealed on second shift there were 1 RN, no LPNs and 4.5 NAs.

o. The daily nurse staffing sheet dated 05/10/25 revealed on first shift there were 1 RN, 2 LPNs and 4 NAs. The staff assignment schedule and nursing staff time clock report for 05/10/25 revealed on first shift there were 2 RNs, 1 LPN, 1 CMA, and 3 NAs.

p. The daily nurse staffing sheet dated 05/11/25 revealed on first shift there were 1 RN, 2 LPNs and 8 NAs. On second shift there were 1 RN, 1.5 LPNs and 5 NAs. The staff assignment schedule and nursing staff time clock report for 05/11/25 revealed on first shift there were 1 RN, 1 LPN, 1 CMA, and 6 NAs. On second shift there were 1 RN, 1.5 LPNs, .5 CMA, and 3.5 NAs.

During an interview on 05/16/25 at 5:38 PM, the Scheduler revealed she was responsible for posting the daily staffing sheets and usually posted them first thing in the morning. The Scheduler stated she did not update the daily staffing sheets to reflect call-outs and/or staff schedule changes and was not aware she needed to do that.

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F 732	Continued From page 70 During an interview on 05/16/25 at 8:39 AM, the Administrator revealed the Scheduler was responsible for posting and updating the daily nurse staffing sheets. The Administrator stated she would expect for the daily nursing staffing sheets to be updated as needed to reflect the correct number and hours of nursing staff that worked each shift.	F 732		
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 observations, record review, and Nurse Practitioner (NP), Medical Director (MD), resident and staff interviews, the facility failed to prevent a significant medication error when Nurse #1 administered a steroid medication to Resident #283 that were prescribed for Resident #86. In addition, the facility failed to request a prescription from the physician to avoid a gap in medication administration when refilling a controlled medication and failed to utilize medication resources stored in the Pyxis (an automated dispensing machine that provided secure medication storage on patient care units, along with electronic tracking of the use of narcotics and other controlled medications) which resulted in the Resident #11 missing 3 doses of nerve pain medication, 3 doses of diabetic medication, and 1 dose of insulin. This deficient practice occurred for 2 of 2 residents reviewed for significant medication error (Resident #283 and Resident #11).	F 760	1. On 4/28/2025 resident #283 received incorrect medications, resident #283 was immediately assessed and vital signs obtained and did not have any adverse outcomes. Nurse Practitioner, resident #283 and responsible party were immediately notified. Resident #11 was assessed by the facility Medical Director on 5/16/2025 and did not have any adverse outcomes from missed doses of prescribed medications. 2. The Director of Nursing/Designee completed an audit of all residents Medication Administration that received medications from Nurse #1	6/19/25

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F 760	Continued From page 71 The findings included: 1. Resident #283 was admitted to the facility on 4/25/25 with diagnosis that included parkinsonism, type 2 diabetes mellitus, chronic kidney disease stage 3, myocardial infarction type 2 (a heart attack that occurs due to an imbalance between the hearts oxygen supply and demand), hypertension (high blood pressure), and edema (swelling). Review of the 5-day Prospective Payment System (PPS) assessment dated 4/30/25 revealed that Resident #283 was cognitively intact. He received antidepressant, anticoagulant, antibiotic, diuretic, antiplatelet, and hypoglycemic medications. Review of the change in condition communication form written by Nurse #1 and dated 4/28/25 at 8:50 AM revealed Resident #283 was administered the wrong medications as follows: Lexapro (antidepressant) 10 milligrams (MG), Lasix (diuretic) 40 MG, Jardiance (a medication used to treat type 2 diabetes) 10 MG, Lisinopril (a medication used to treat high blood pressure) 40 MG, Metoprolol extended release (ER, a medication used to treat high blood pressure) 12.5 MG, and Prednisone (steroid medication used to treat many diseases and conditions that are associated with inflammation) 40MG. Resident #283 was informed of the medication that was given in error and the plan to notify the provider "now". Things that made the condition or symptom worse were unknown. Things that made the condition or symptoms better were noted as keeping Resident #283 and the family informed and monitoring Resident #283's vital	F 760	to ensure medications received were given correctly. This audit was completed on 4/28/2025. No areas of concern were noted. The Director of Nursing/Designee completed an audit of all residents receiving controlled pain medications, including Lyrica, and diabetic medications, including insulin medications. This audit was completed on 5/16/2025 and no areas of concern were noted. 3. Nurse #1 was immediately re-educate by the Director of Nursing on the 7 rights of medications administration 1. right medication, 2. right patient, 3. right dosage, 4. right route, 5. right time, 6. right reason and 7. right documentation on 4/28/2025. The Director of Nursing/Designee re-educated all Licensed Nursing, Medication Aides, includign agency Licensed Nurses and Medication aides on the 7 rights of medication administration. The 7 rights of medication administration are: 1. right medication, 2. right patient, 3. right dosage, 4. right route, 5. right time, 6. right reason and 7. right documentation, including obtaining a prescription for refills from the physician or Nurse Practitioner for any controlled pain medications, including Lyrica, ordering stat if needed, checking the facility backup medication dispensing	

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F 760	Continued From page 72 signs every 15 minutes for 2 hours, then every 30 minutes for one hour, then every 4 hours. Other relevant information noted Resident #283 was provided with a list of medications given in error. Each medication was explained, including the indications for use and possible side effects. Resident #283's vital signs remained normal. Mental status changes included Resident #283 became anxious when informed of the medication errors, all questions were answered, and he was seen by the Nurse Practitioner (NP) within 30 minutes. The NP assured Resident #283 he would be ok, and he seemed less anxious after the NP visit. Resident #283 had no functional status, respiratory, abdomen, or urine changes noted. The NP determined that Resident #283 did not need to be sent to the hospital, but staff would continue to monitor him at the facility. An interview on 5/15/25 at12:03 PM with Nurse #1 revealed that she was Resident #283's assigned nurse on 4/28/25 during the hours of 7:00 AM to 3:00 PM. Nurse #1 stated that she entered Resident #283's room and called him by Resident #86's name but she did not think he had heard her because he had his continuous positive airway pressure (CPAP, a machine that is used to treat sleep apnea and other breathing disorders) machine on. She stated that his nasal canula needed to be put on and there was no oxygen tubing in the room, so she left the room to go get Resident #283 oxygen tubing. Nurse #1 stated it was at this point she felt very overwhelmed and when she returned to the medication cart, she pulled out Resident #86's medications to administer to Resident #283. Nurse #1 stated she then reentered Resident #283's room and administered the medications. After Resident #283 took the medications, she called him by	F 760	machine (Pyxis) for any medications not available and notification to physician if medications are not available. This re-education was completed on 6/13/2025 and will be added to the facility orientation program including agency for all newly hired Licensed Nurses, Medication Aides, including agency Licensed Nurses and Medication Aides. 4. The Director of Nursing/Designee will complete 2 medication pass observations weekly for 12 weeks. The Director of Nursing/Designee will randomly audit 5 residents medications weekly for 12 weeks to ensure controlled medications, diabetic medications, including insulin are availabe. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/19/2025	

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Resident #86's name and Resident #283 replied that was not his name. Nurse #1 stated she realized she had administered the wrong medications to Resident #283 and immediately took his vital signs, called the physician, and notified the Director of Nursing (DON). Nurse #1 further stated she also printed off a list of the medications that she had given Resident #283 in error and notified him that she would be monitoring him every 15 minutes. Nurse #1 recalled Resident #283 stating that he was scared but he refused the offer to go to the hospital. Nurse #1 further revealed that Resident #283 never displayed any side effects from having received the wrong medications.

Review of the April 2025 MAR for Resident #86 revealed the following significant medication prescribed for Resident #86 was administered to Resident #283 in error on 04/28/25:
- Prednisone (steroid) 20 mg - two tablets by mouth one time a day for pneumonia, chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe) for 5 days.

Review of the April 2025 medication administration record (MAR) for Resident #283 revealed physician orders for the following routine medications to be administered at 8:00 AM daily:
- Aspirin (antiplatelet) 81 MG - one tablet by mouth one time a day for supplement
- Bumetanide (diuretic) 1 MG - one tablet by mouth one time a day for chronic kidney disease.
- Citalopram (antidepressant) 20 MG - one tablet by mouth one time a day for depression.
- Glucotrol extended release (oral hypoglycemic) 5 MG - one tablet by mouth one time a day for diabetes.

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- Valsartan (antihypertensive) 320 MG - give 0.5 tablet by mouth one time a day for hypertension.
- Famotidine (treats gastroesophageal reflux) 20 MG - one tablet by mouth one time a day for gastroesophageal reflux disease (GERD, chronic condition where stomach acid flows back into the esophagus causing heartburn).
- Enoxaparin injection (anticoagulant) 40 MG/0.4 milliliter (ml) - inject 0.4 ml (40 mg) under the skin in the morning and at bedtime.
- Sodium Bicarbonate (treats heartburn) 650 MG - one tablet by mouth two times a day for supplement.
- Multivitamin with minerals - one capsule by mouth two times a day for supplement.
- Carbidopa-Levodopa (medication used to treat Parkinson's disease) oral tablet 25-250 mg - one tablet by mouth four times a day for Parkinson's.

Further review of Resident #283's April 2025 MAR revealed all 8:00 AM medications were held on 04/28/25 except for the Carbidopa-Levodopa 25-250 mg.

Review of the vitals monitoring form for Resident #283 initiated on 04/28/25 at 9:00 AM revealed his vitals (temperature, pulse, respiratory rate, blood pressure, and oxygen saturation) were checked every 15 minutes for the first 2 hours, then every 30 minutes for one hour, then every 4 hours for 24 hours, and then every shift for 48 hours with no issues noted.

Review of a nurse progress note written by the former DON dated 4/28/25 revealed that Resident #283 was seen by the NP after a reported medication error. There were no adverse effects noted for Resident #283. Resident #283 and his family chose not to be transferred to the hospital.

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Monitoring was put in place immediately and vital signs were stable.

Review of a NP progress note dated 4/28/25 revealed in part, that Resident #283 was found sitting up in his bed, tearful. Nursing staff told the NP that Resident #283 had received medications that were not prescribed to him. The NP assessed Resident #283 and found his vital signs were within normal limits and instructed nursing staff to continue ongoing assessment of Resident #283's vital signs. Resident #283's heart, lung and bowel sounds were all normal and there was slight trace edema on the lower extremities (legs). Resident #283 had oxygen via nasal cannula present on admission and was alert and oriented. Resident #283's medications were reviewed.

An interview on 5/16/25 at 12:33 PM with the former DON revealed that she recalled Resident #283. The former DON stated that when Nurse #1 made a medications error on 4/28/25, Nurse #1 informed Resident #283, the NP and the DON. She stated that she and Nurse #1 assessed Resident #283 after the medication error and put in place continued monitoring every 15 minutes. The former DON further revealed that Resident #283's vital signs remained stable after the incident. The former DON indicated that she reviewed the 5 rights of medication administration education with all nurses and medication aides (MA). She stated that there were no adverse effects noted for Resident #283. The former DON stated that Nurse #1 should have identified Resident #283 prior to pulling the medications and then again before administering the medications by asking Resident #283 to state his name, since Resident #283 was alert and

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oriented and a new resident. She stated that the facility offered to take Resident #283 to the hospital, but he declined.

An interview on 5/15/25 at 11:20 AM with the NP revealed that Nurse #1, who administered the wrong medications, called her when she was on her way to the facility. The NP stated that she told Nurse #1 to lock her cart, tell the DON, and assess Resident #283. The NP stated that when she arrived at the facility, she assessed Resident #283 and reviewed the medications that were given in error. The NP stated that she offered to send Resident #283 to the hospital, but he refused. She further revealed that she informed Nurse #1 to hold his regular medications for the remainder of the day. The NP stated that the medications Resident #283 received in error were similar to the medications that he was prescribed. She further stated that he suffered no ill effects to his health or well-being because of the medication error. The NP stated that after she was done assessing Resident #283, she went to speak with the DON about the medication error. She revealed that she checked on Resident #283 the following day and he remained stable and continued to refuse transfer to the hospital.

An interview on 5/16/25 at 3:36 PM with the Medical Director revealed that he was familiar with Resident #283 and was aware of the medication error. The Medical Director stated that the doses of the medication Resident #283 received in error were low and the medications were similar to what Resident #283 was prescribed. He stated that they had no negative effect on Resident #283 and they did not harm him.

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An interview on 5/16/25 at 5:21 PM with the Administrator revealed that Nurse #1 gave the wrong medication to Resident #283 and she was very up front about it and notified Resident #283, the NP, and the family. She stated that she was not sure why the medication error occurred. The Administrator stated that there were 2 new admissions that day and maybe Nurse #1 got confused. She stated that Nurse #1 should have asked Resident #283's name before she pulled the medications and then asked him again before she gave the medications to him. The Administrator stated that Resident #283 was monitored for 48 hours after the medication error occurred and he had no adverse effects because of the error. She stated that her expectation was that the 7 rights of medication administration were completed which included verifying the right resident got the right medications before medication was administered.

2. Resident #11 was admitted to the facility on 12/13/24 with diagnosis including type 2 diabetes mellitus with diabetic polyneuropathy.

The care area assessment dated 12/20/24 revealed Resident #11 was diagnosed with diabetic polyneuropathy and bilateral osteoarthritis of knee with chronic pain. She was cognitively intact and had reported experiencing almost constant pain within the 7-day review period.

The quarterly Minimum Data Set (MDS) assessment dated 03/21/25 coded Resident #11 with intact cognition. She had adequate vision and hearing with clear speech. The MDS indicated Resident #11 received both scheduled and "as needed" (PRN) pain medications, insulin,

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antianxiety, antidepressant, and hypoglycemic during the 7-day review period.

The care plan for pain initiated on 03/27/25 revealed Resident #11 had pain related to osteoarthritis. The goals were for her to verbalize adequate pain relief through the review date. Interventions included anticipating Resident #11's need for pain relief and responding immediately to any complaint of pain.

The physician's orders dated 03/17/25 revealed Resident #11 had obtained orders to receive insulin glargine (a long-acting insulin used to control high blood sugar) 8 units subcutaneously once daily for diabetes and 2 tablets of metformin (an oral antidiabetic medication used to treat diabetes) 500 milligrams (mg) by mouth twice daily for diabetes. On 03/19/25, the physician started Lyrica (a fibromyalgia agent used to treat nerve pain) 100 mg, 1 capsule by mouth 3 times daily for pain.

A review of nurse's progress notes dated 05/11/25 at 6:04 AM, 05/12/25 at 8:37 AM, and 05/12/25 at 6:12 PM revealed 3 different nurses working in 3 different shifts documented metformin was unavailable and it was not administered to Resident #11. A further review of nurse's progress notes dated 05/12/25 at 7:33 AM revealed Nurse #7 documented the pharmacy needed prescription of Lyrica for Resident #11. She notified the Nurse Practitioner (NP) regarding the need of a prescription for Lyrica immediately. Then, she checked on Resident #11 who stated she did not have any pain or discomfort at that time. On 05/12/25 at 8:23 PM, Nurse #8 documented insulin glargine was unavailable. He could not find the insulin in the medication cart or

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refrigerator.

A review of Pyxis records and inventory list revealed 251 different medications were kept in the Pyxis for emergency uses. Further review of the Pyxis Inventory Replenishment Report dated 05/11/25 revealed the facility had 8 tablets of Metformin 500 mg and one 3 milliliters (ml) pen of insulin glargine in the Pyxis.

The Medication Administration Records (MAR) revealed Resident #11 did not receive 3 doses of metformin scheduled on 05/11/25 at 8 AM, 05/12/25 at 8 AM and 6 PM; 3 doses of Lyrica scheduled on 05/11/25 at 8 PM, 05/12/25 at 6 AM and 2 PM; and 1 dose of insulin glargine scheduled on 05/12/25 at 9 PM.

A further review of Resident #11's medical records revealed the refill order for Lyrica was submitted to the pharmacy by Nurse #7 on 05/11/25 at 2:50 AM when there were 2 tablets remaining in the medication cart. The last tablet of Lyrica was administered on 05/11/25 at 2 PM. When Nurse #7 called on 05/12/25 at 7:30 AM to follow up with the Lyrica order, the pharmacy staff stated they needed the prescription as it was a controlled medication. Nurse #7 notified the NP to submit a prescription for Lyrica immediately. When Lyrica arrived at the facility on 05/12/25 at 11 PM, Resident #11 had already missed 3 doses of Lyrica. On the other hand, both metformin 500 mg and insulin glargine were available in Pyxis but not being administered by the nurse.

During an interview conducted on 05/12/25 at 3:31 PM, Resident #11 stated she had not received her Lyrica for 3 days and added she started to feel the pain since 05/10/25. She

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wanted to know why her Lyrica had not been refilled yet and indicated this was not the first time it had happened.

A further review of MAR indicated Resident #11 had missed 3 doses of Lyrica at the time of interview on 05/12/25 at 3:31 PM, but not 3 days. She received Lyrica 3 times per day until she missed the first dose on 05/11/25 at 8 PM, then 2 more doses on 05/12/25 at 6 AM and 2 PM. Further review of MAR revealed Resident #11 had a scheduled order of hydrocodone/acetaminophen (a semi-synthetic opioid used to treat pain) 5/325 mg that was discontinued on 05/06/25, and a new order of tramadol (an analgesic/opioid used to relieve pain) was initiated on 05/12/25.

During a phone interview conducted on 05/15/25 at 1:23 PM, Nurse #7 stated she was the nurse who submitted the refill order of Lyrica for Resident #11 on 05/11/25 morning when 2 tablets remained in the medication cart. She recalled she could not put in a "STAT" order as she did not even have a prescription when submitting the refill order through the computer system. When she returned to work on 05/12/25 in the morning and found that Lyrica had still not arrived at the facility, she called the pharmacy to follow up and was told that the pharmacy needed a prescription. She could not recall whether she had told the pharmacy staff to code this Lyrica order as a STAT order during the phone call. She notified the NP that the pharmacy needed a prescription for Resident #11's Lyrica and went to check Resident #11. She recalled Resident #11 did not appear to be in pain or distress. She explained to Resident #11 that the pharmacy needed a prescription, and she had notified the

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NP about it. She asked Resident #11 if she was suffering any nerve pain Resident #11 replied that she was okay.

During a subsequent observation and interview conducted on 05/12/25 at 4:12 PM, Resident #11 appeared to be calm, pleasant, and free of signs and symptoms of pain or distress. She stated her nerve pain was okay and manageable, but she was upset about not getting her Lyrica as ordered.

An interview was conducted with Nurse #8 on 05/13/25 at 4:44 PM. He stated Resident #11's Lyrica was delivered from the pharmacy on 05/12/25, arrived at the facility around 11:00 PM, and was administered right after receiving it. He stated he could not find metformin and insulin glargine in the medication cart or refrigerator on 05/12/25 in the evening and added he did not check for both medications in Pyxis. Nurse #8 acknowledged that he did not check with the pharmacy on 05/12/25 in the evening to ensure both medications had been re-ordered.

During an interview conducted on 05/13/25 at 4:53 PM, the Interim Director of Nursing stated the facility had Pyxis that provided emergency medications including several narcotics and controlled substances as needed. Not only did the facility have metformin and insulin glargine in the Pyxis, but the facility also had a back-up pharmacy approximately 0.25 miles from the facility. She did not receive any notification regarding availability of metformin and insulin glargine on 05/12/25. Otherwise, she could have gotten both medications from Pyxis. She stated Pyxis had 8 tablets of metformin 500 mg and one insulin glargine pen on regular basis and this

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resources should be fully utilized. She stated the pharmacy would not dispense any controlled medication such as Lyrica without a prescription issued by the physician. It was her expectation for nurses to start refilling procedures at least 5 days before the last pill was used to avoid a gap, especially controlled medication that required a prescription.

A phone interview was conducted with the Pharmacy Manager on 05/15/25 at 12:20 PM. He stated the pharmacy computer system received the refill order of Lyrica for Resident #11 on 05/11/25 at 2:50 AM. As the order was not coded as a "STAT" (signified the order needed to be done immediately, with the highest priority) order and the pharmacy did not receive a refill prescription from the physician, the pharmacy could not process and fill the medication until the next day after the prescription for Lyrica was received on 05/12/25 at 9:07 AM. Lyrica was filled and then placed in the pharmacy totes at 3:17 PM and delivered to the facility as a regular order. He stated the delivery typically arrived at the facility before mid-night. The Pharmacy Manager stated if the facility staff specified it was a STAT order, they would try to deliver it to the facility within the specified time frame. Otherwise, the pharmacy had designated a back-up pharmacy locally near the facility. He confirmed the facility had Pyxis for medication needed after hours or emergency, and it consisted of insulin glargine and metformin 500 mg, but not Lyrica 100 mg. He indicated tramadol could alleviate nerve pain, but not to a great extent. He stated if the refilled order for Lyrica was submitted with a prescription and specified as a STAT order, the pharmacy could have filled and delivered the ordered Lyrica to the facility on 05/11/25 before midnight. He stated

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nurses should retrieve both metformin 500 mg and insulin glargine in Pyxis instead of charting it as missed doses.

A phone interview was conducted on 05/16/25 at 9:57 AM with the MD. He stated Resident #11 had a personality disorder and drug seeking behavior. Almost each time he visited her, she would ask for more pain medications, including Lyrica. He stated Resident #11 had been taking Lyrica since 03/19/25 and it typically took approximately 35 hours to be fully eliminated from the body. As Resident #11 was out of Lyrica for approximately 24 hours, clinically, she should still have certain level of Lyrica in her system to prevent her from triggering nerve pain. In addition, Resident #11 received Depakote 500 mg daily for bipolar disorder which had also been used as off-label to treat neuropathic pain. Resident #11 used to have an order of Norco 5/325 mg for 14 days and it was just discontinued on 05/06/25, about a week before Lyrica was run out. Besides, Resident #11 was taking other medications such as trazodone, clonazepam, and methocarbamol which could alleviate her pain level. He stated there were many factors that could affect her pain level and Resident #11 could have confused about muscular pain versus nerve pain. He would not rule out the possibility of Resident #11 experiencing nerve pain 24 hours without Lyrica, but the chances were very low. It was his expectation for the nursing staff to start the refilling process at least a few days before the supply ran out, especially for those controlled substances that required a prescription. He also expected nursing staff to pay attention to the content of Pyxis and fully utilize it as needed as indicated.

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F 760	Continued From page 84 During a phone interview conducted on 05/16/25 at 10:46 AM, the Administrator expected nursing staff to submit refill order at least 3-5 days before the medication ran out and ensure refill order for controlled medication was submitted with the prescription. It was her expectation for all nursing staff to be proficient in the content of Pyxis and fully utilized it as needed as indicated.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		6/17/25

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F 761	Continued From page 85 Based on observation, record review, and staff interviews, the facility failed to secure an opened tube of antifungal cream for 1 of 2 residents reviewed for medication storage (Resident #40). The findings included: Resident #40 was admitted to the facility on 04/04/22. The annual Minimum Data Set (MDS) assessment dated 02/20/25 coded Resident #40 with severely impaired cognition. A review of Resident #40's medical records revealed she had never been assessed for self-administration of medication. During an observation conducted on 05/12/25 at 9:40 AM, one opened tube of Miconazole nitrate cream (an over-the-counter antifungal medication used to treat fungal infections of the skin, such as athlete's foot, jock itch, and ringworm) with the concentration of 2% was left unattended on top of the bedside table in Resident #40's room and was ready to be used. An attempt to interview Resident #40 was unsuccessful. She was unable to answer questions. During a joint observation and subsequent interview conducted with Nurse #3 on 05/12/25 at 9:44 AM, she stated the antifungal cream should be kept in the medication cart instead of leaving unattended in Resident #40's room. She did not notice the tube of antifungal was in Resident #40's room when she did medication pass on 05/12/25 in the morning. She confirmed Resident	F 761	F761 – Label/Store Drugs and Biologicals Step One: Facility did not follow policy to maintain bedside free of medications, open tube of antifungal cream was observed on bedside table in Resident #40's room. Tube of antifungal cream was immediately removed from bedside table and thrown away on 5/12/25. Step Two: All residents receiving medicated topical creams have the potential to be affected. The Director of Nursing or designee will audit residents utilizing creams and check rooms to ensure no medicated creams are left at bedside. This audit was completed on 6/13/25. Step Three: To prevent this from reoccurring, the Director of Nursing or designee will educate all staff on expectations of medications and medicated creams at bedside. The Director of Nursing or designee will educate all newly hired facility staff and agency staff on expectations of medications/creams at bedside prior to the start of their first shift. This education was completed by 6/16/25. Step Four: To monitor and maintain ongoing compliance, the Director of Nursing or designee will perform bedside checks for any medications and/or medicated creams at bedside in 10 rooms per week for 12 weeks. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the	

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F 761	Continued From page 86 #40 had not been assessed for self-administration of medication. An interview was conducted with Nurse Aide #2 (NA) on 05/25/25 at 10:38 AM. She stated she had provided care for Resident #40 in the past few weeks. She did not notice the tube of antifungal cream was left unattended on Resident #40's bedside table when she rounded her on 05/12/25 in the morning During an interview conducted with the Director of Nursing (DON) on 05/14/25 at 8:45 AM, she expected all the nursing staff to be more attentive to residents' room when providing care to ensure none of the medications were left unattended in the facility. An interview was conducted with the Administrator on 05/16/25 at 10:46 AM. She expected nursing staff to pay attention to residents' living environment when providing care. It was her expectation for the facility to remain free of unattended medications at all time.	F 761	findings of the audits. Date of Compliance: 6/17/25	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		6/20/25

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F 806	Continued From page 87 by: Based on observation, record review, resident and staff interviews, the facility failed to ensure a food preference listed on the meal card was received for 1 of 3 residents reviewed for preferences (Resident #67). Findings included: Resident #67 was admitted to the facility on 02/16/24. The quarterly Minimum Data Set (MDS) dated 03/07/25 revealed Resident #67 was cognitively intact and required setup or clean-up assistance with meals. A review of the active physician's order dated 7/15/24 revealed Resident #67 received a regular textured diet. A review of Resident #67's meal card revealed a bacon, lettuce, and tomato sandwich was included on the list of food items to be served for lunch. The meal card did not include the food items Resident #67 disliked. An observation of the lunch meal on 05/12/25 at 12:44 PM revealed Resident #67 was served a ham and cheese sandwich instead of the bacon, lettuce, and tomato sandwich. During an interview on 05/12/25 at 12:44 PM, Resident #67 revealed he received an extra sandwich with the lunch meal and was supposed to get a bacon, lettuce, and tomato sandwich. Resident #67 revealed he did not like the ham and cheese sandwich and was not going to eat it. Resident #67 stated he wanted the bacon,	F 806	1.The food preference and food dislikes for resident #67 was updated by the Dietary Manager on 6/1/2025. 2. All residents have the potential to be affected. An audit was completed by the Dietary Manager/Designee to ensure food preferences and food dislikes for all residents was accurate and up to date in the tray card system. This audit was completed on 6/16/2025. 3. The Dietary Manager/Designee re-educated all dietary staff on honoring food preferences and following the tray card. This education was completed on 6/17/2025 and will be added to the dietary orientation program for newly hired dietary employees. 4.The Dietary Manager/Designee will audit 10 trays weekly for 12 weeks to ensure food preferences are correctly served on residents trays and food dislikes are not included on the food trays. The Dietary Manager/designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations	

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F 806	Continued From page 88 lettuce, and tomato sandwich. Resident #67 revealed most of the time he did not receive a bacon, lettuce, and tomato sandwich and had discussed his food preferences with someone but could not recall who. An interview was conducted 05/12/25 at 01:14 PM with the Dietary Manager. The Dietary Manager confirmed a ham and cheese sandwich was served with the lunch meal instead of the bacon, lettuce, and tomato sandwich that was listed on Resident #67's meal card. The DM was unsure why a ham and cheese sandwich was served with the lunch meal instead of the bacon, lettuce, and tomato sandwich and confirmed dislikes were not included on the meal card and she would need to discuss those with Resident #67. During an interview on 05/16/25 at 10:10 AM, the Administrator revealed Resident #67's choice of a bacon, lettuce, and tomato sandwich should have been served as listed on the meal card. She revealed food dislikes were reviewed with residents but have not been added to the meal cards. She revealed there had been a turnover of kitchen staff and updating the dislikes on resident meal cards was still a work in progress.	F 806	and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		6/20/25

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F 809	Continued From page 89 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with an individual resident, resident council and staff, the facility failed to serve the lunch meal at the scheduled times and in accordance with resident preferences on 05/11/25 and 05/12/25 in the main dining room for 2 of 3 meal observations. Findings included: Review of the facility's mealtimes revealed lunch was to be served at 12:00 PM in the main dining room. An observation of the lunch meal being served in the main dining room on 05/11/25 revealed meal trays arrived at 12:38 PM. An observation of the lunch meal being served in the main dining room on 05/12/25 revealed meal trays arrived at 12:48 PM. An interview with Resident #49 on 05/12/25 at 12:48 PM in the main dining room revealed she	F 809	No adverse effects occurred as a result of residents not receiving their meals per schedule. All residents have the potential to affected. The Administrator re-educated the Dietary Manager and Dietary staff on following mealtime schedules. This education was completed on 6/17/2025 and will be added to the dietary orientation program for newly hired dietary employees. The Administrator/Designee will audit 5 meals weekly for 12 weeks to ensure meals are delivered timely per schedule.	

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F 809	Continued From page 90 was frustrated at having to wait so long to receive her lunch meal. Resident #49 was admitted to the facility 01/09/25. The quarterly Minimum Data Set (MDS) assessment dated 04/18/25 revealed Resident #49 was cognitively intact and required set-up assistance with eating. A Resident Council group interview was conducted on 05/13/25 at 10:26 AM with Resident #70, Resident #63, Resident #41, Resident #14, Resident #11, Resident #18, Resident #23, Resident #69, and Resident #42 in attendance. The residents voiced that meal trays were often served late regardless if they ate in their rooms or in the main dining room. The Dietary Manager was unavailable for an interview. An interview with the Regional Director of Operations on 05/14/25 at 3:15 PM revealed he and the Administrator recently met and revised the meal schedule in an attempt to ensure meals were sent out in a timely manner. He stated he felt it was still a new process but he felt the change in scheduled meal times would ensure meals were sent to the main dining room and halls on time. An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected residents to receive meals at their scheduled serving time.	F 809	The Administrator/designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		6/20/25

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F 812	Continued From page 91 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard food with signs of spoilage in 1 of 1 walk-in cooler; date and use or discard open food items on or before the best-by date in 1 of 1 walk-in cooler; date open food items in 1 of 1 dry storage room; date and cover an open food item in 1 of 1 walk-in freezer; and failed to implement their infection control policies when Dietary Aide #1 handled ice in the ice machine used to serve residents with her bare hands and when Dietary Aide #2 failed to remove her gloves and perform hand hygiene after handling dirty dishes and before touching other items in the kitchen. These failures had the potential to affect food served to 71 residents. 1. An initial observation of the walk-in cooler with the Dietary Manager on 05/11/25 at 10:55 AM revealed the following:	F 812	1. Chicken Base dated for 2/4 & 4/5, Beef Base, and 2 apples with visible signs of spoilage were discarded on 5/11/2025. Egg Noodles, Croutons, Red Potatoes and Hamburger Patties were discarded on 5/13/2025. The Ice Machine was emptied and cleaned on 5/13/2025. Dishes/cups, counter, cooler coffee containers were cleaned and re-washed on 5/13/2025. 2. The District Manager completed an audit of all kitchen food storage areas, including	

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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 92 a) An opened 16-ounce container of chicken base with the date of "2/4" written on top of the lid and no use-by date. There was no pre-printed expiration date on the container. b) An opened 16-ounce container of chicken base with the date of "4/5" written on top of the lid and no use-by date. There was no pre-printed expiration date on the container. c) An opened 16-ounce container of beef base with an illegible date written on top of the lid. There was no pre-printed expiration date on the container. d) A carton of apples stored together and open to air were 2 apples with visible signs of spoilage. One apple had white spots around the surface and one apple had a large, round, brown soft spot at the base of the stem. During an interview on 05/11/25 at 10:55 AM, the Dietary Manager explained the dates of 2/4 and 4/5 that were written on the lids of the chicken base containers were the dates the containers were opened. She stated the containers should have also been labeled with a use-by date which she thought was 30-days after opening. She confirmed the date written on the container of beef base was illegible and was not sure when it was opened and placed in the walk-in refrigerator. The Dietary Manager stated all three containers should have been removed and discarded. The Dietary Manager confirmed the two apples both had visible signs of spoilage and should have been discarded. She stated all dietary staff were responsible for checking the cooler and discarding any food items with signs of spoilage or past the expiration date. During an interview on 05/16/25 at 9:47 AM, the	F 812	walk in coolers to ensure all open items were labeled with open date and discard date. The District Manager verified the ice machine had been emptied and cleaned. Any issues were immediately corrected. This audit was completed on 6/1/2025 3. The District Manager for Dietary completed re-education with the Dietary Manager and all Dietary staff on ensuring open items have open dates and discard dates, and discarding per policy. This education included removal of gloves between clean and dirty, proper hand hygiene and utilizing the ice scoop to obtain ice from the ice machine, not using bare hands. This education was completed on 6/17/2025. and will be added to the dietary orientation program for newly hired dietary employees. 4. The Dietary Manager/Designee will audit Kitchen storage rooms, including walk in coolers 5 times a week for 12 weeks to ensure open items are dated per policy. The Dietary Manager/Designee will audit 3 dietary employees weekly for 12 weeks to	

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F 812	Continued From page 93 Administrator revealed she expected for all food items to be labeled, dated and for dietary staff to check the coolers and discard any items that were expired or had visible signs of spoilage. 2. An observation of the dry storage room on 05/13/25 at 11:35 AM revealed 2 opened and undated bags of egg noodles and one opened and undated bag of croutons sitting on a shelf. An interview with the Regional Director of Operations on 05/13/25 at 11:40 AM revealed all opened food items should be dated when they were opened, and the Dietary Manager was responsible for ensuring all opened food items were labeled and dated. The Dietary Manager was unavailable for interview throughout the remainder of the survey. An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected all opened food items to be dated when opened by the staff member opening the item. 3. An observation of the walk-in cooler on 05/13/25 at 12:00 PM revealed an undated plastic bag of red potatoes sitting on a shelf. An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected all items in the cooler to be dated. 4. An observation of the walk-in freezer on 05/13/25 at 12:25 PM revealed a box of hamburger patties that were open to air and did not have an opened date. An interview with the Regional Director of Operations on 05/13/25 at 12:26 PM revealed the	F 812	ensure hand hygiene is performed per facility hand hygiene policy, including hand hygiene before each applying clean gloves, remove gloves and utilization of the ice scoop to obtain ice, not using bare hands The Dietary Manager/Designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	

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F 812	Continued From page 94	F 812		

hamburger patties should be covered and should have an opened date.

An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected all food to covered appropriately and should have an opened date.

5. (a). An observation of Dietary Aide #1 on 05/13/25 at 12:45 PM revealed she opened the ice machine in the kitchen used for resident beverages, removed a handful of ice with her ungloved right hand and touched ice that remained in the ice machine, placed the ice in her personal beverage, closed the lid to the ice machine, and immediately walked out of the kitchen.

In an interview with Dietary Aide #1 on 05/13/25 at 12:50 PM she confirmed she removed ice from the ice machine with her bare hand but stated she had just washed her hands. She declined to answer if she had received training on using the ice scoop to obtain ice instead of reaching directly in the ice machine.

An interview with the Regional Director of Operations on 05/14/25 at 3:15 PM revealed all dietary staff had received training on using the ice scoop to obtain ice rather than obtaining it with their bare hands. He stated all the ice in the ice machine was discarded on 05/13/25 after Dietary Aide #1 obtained ice without using the scoop.

An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected staff to use the ice scoop rather than using their bare hands to obtain ice.

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(b). A continuous observation of Dietary Aide #2 on 05/13/25 from 1:42 PM until 2:00 PM revealed with gloved hands, she removed the food from dirty dishes and dumped the liquids from used coffee cups and glasses in a plastic bin, loaded the used coffee cups and glasses onto a dishwasher rack, slid the dishwasher rack into the dishwasher and started the dishwasher, wiped the counter where the coffee pots were sitting with a cloth, rinsed out 3 coffee dispensers and placed them back on the shelf with the coffee pots, wiped down the reach-in cooler with a cloth, removed the dishwasher rack containing clean coffee cups and glasses from the dishwasher and sat the rack at the end of the table on the clean side of the dishwasher, loaded a dishwasher rack with used coffee cups and glasses, poured the liquid in the plastic bin from used coffee cups and glasses down the drain, placed the dishwasher rack with dirty coffee cups and glasses into the dishwasher and started the dishwasher, removed her gloves, and walked away from the dishwasher. Dietary Aide #2 did not remove her gloves and perform hand hygiene after handling dirty dishes and before touching other items in the kitchen.

An interview with Dietary Aide #2 on 05/13/25 at 2:00 PM revealed she thought she removed her gloves and performed hand hygiene after touching dirty plates, coffee cups, and glasses and it was an oversight.

An interview with the Regional Director of Operations on 05/14/25 at 3:15 PM revealed he expected dietary staff to remove their gloves and perform hand hygiene any time they moved from a dirty task to a clean task.

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F 812	Continued From page 96 An interview with the Administrator on 05/16/25 at 9:47 AM revealed she expected staff to wash their hands after handling dirty dishes.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		6/20/25

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F 880	Continued From page 97 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse Aide (NA) #3 and NA #5 did not don (put on) a gown while providing incontinence care to Resident #31 who required enhanced barrier precautions (EBP) due	F 880	1.Resident #31 did not have any adverse outcomes as a result of Certified Nursing Assistants (CNA) #3 and #5 not donning a gown while providing incontence care, when Certified Nursing Assistant (CNA) #3	

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F 880	Continued From page 98 to the presence of a pressure ulcer and failed to follow their Hand Hygiene policy when NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #31; when Nurse #4 and Nurse #5 did not don gowns while providing pressure ulcer care to Resident #45 who required EBP due to the presence of a pressure ulcer; and failed to follow their Hand Hygiene policy when NA #1 and NA #2 did not remove their soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #35. These deficient practices occurred for 6 of 11 staff members observed for infection control practices (NA #3, NA #5, Nurse #4, Nurse #5, NA #1, and NA #2). Findings included: Review of the facility's Hand Hygiene/Handwashing Policy last revised 06/01/24 read in part as follows: "Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. Perform hand hygiene before and after having direct contact with residents, after removing gloves, and after contact with body fluids or excretions and wound dressings." Review of the facility's Enhanced Barrier Precautions policy last revised March 2024 read in part as follows: "Enhanced barrier precaution (EBP) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to	F 880	did not remove soiled gloved and perform hand hygiene. Resident #45 did not have any advere outcomes as a result of Nurses #4 and #5 not donning gowns while providing pressure ulcer care, Resident #35 did not have any adverse outcomes as a result of Certified Nursing Assistants (CNA) #1 and #2 not removomg soiled gloves and perform hand hygiene before applying a clean brief or touch other items. 2.All residents have the potential to be affected. The Director of Nursing/designee will audit all residents to ensure EBP is in place, signage on door, order and care plan in place. The Director of Nursing or designee will audit facility for all available alcohol based hand rub (ABHR) dispensers and soap dispensers to ensure they are in proper working order and filled. These audits were completed on 6/13/25. 3.The Director of Nursing/designee re-educated all staff on expectations of infection control best practices, EBP and hand hygiene. The Director of Nursing/Designee will educate all staff on infection control best practices, EBP and hand hygiene	

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F 880	Continued From page 99 residents. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, providing hygiene, and changing briefs. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds (i.e. pressure ulcers). Indwelling medical devices include urinary catheters and feeding tubes. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at risk." 1. An observation of Resident #31's door on 05/15/25 at 10:43 AM revealed a sign taped on the door indicating she was on EBP and a shelf containing gowns was hanging on the door. A continuous observation of NA #3 and NA #5 on 05/15/25 from 11:04 AM until 11:13 AM revealed they both performed hand hygiene, donned gloves, entered Resident #31's room, pulled back the bed covers, unfastened her brief, and rolled Resident #31 on her left side. NA #3 performed incontinence care for stool by removing the stool with a resident care wipe, discarded the soiled wipe in a trash bag, placed a clean brief under Resident #31, and assisted the resident to roll on her right side. NA #5 assisted with positioning the clean brief under Resident #31. NA #3 fastened Resident #31's brief, removed her gloves, opened the resident's closet doors, removed a shirt and pants, closed the closet door, applied clean gloves and placed the shirt and pants on	F 880	for all newly hired facility staff and agency staff prior to the start of their first shift. This education was completed on 6/13/25. 4.The Director of Nursing/Designee will conduct 3 staff interviews weekly for 12 weeks on use of EBP. The Director of Nursing/Designee will observe competency checks with 3 clinical staff per week for 12 weeks on proper donning/doffing of personal protective equipment. The Director of Nursing/Designee will observe 3 staff per week for 12 weeks on proper incontient care. The Director of Nursing/Designee will observe 3 clinical staff per week for 12 weeks on proper hand hygiene. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Compliance Date: 6/20/2025	

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Resident #31, placed the mechanical lift sling under the resident, removed her gloves and performed hand hygiene. NA #3 and NA #5 did not don a gown before entering Resident #31's room and NA #3 did not remove her gloves and perform hand hygiene after cleaning stool and before touching other items in the resident's room.

A joint interview with NA #3 and NA #5 on 05/15/25 at 11:13 AM revealed they did not know that the sign on Resident #31's meant they were supposed to don a gown when providing care. They stated the EBP sign had been on Resident #31's door for quite a while but they had not received any education on when to use EBP precautions. NA #3 stated she should have removed her gloves after cleaning stool and performed hand hygiene before touching other items in Resident #31's room and it was an oversight.

An interview with the Director of Nursing (DON) on 05/15/25 at 12:40 PM revealed staff should follow the EBP signage on the door and don gowns before providing care. She stated gloves should be removed and hand hygiene should be performed after cleaning stool and before touching other items.

An interview with the Administrator on 05/16/25 at 6:33 PM revealed she expected staff to follow EBP signage and to remove gloves and perform hand hygiene after cleaning stool and before touching other items.

2. An observation on 05/15/25 at 2:55 PM of Nurse #4 and Nurse #5 entering Resident #45's room that had a sign on the door for Enhanced

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Barrier Precautions which instructed staff to don gloves and gown. Nurse #4 and Nurse #5 entered the room and informed Resident #45 they were going provide wound care, washed their hands, and applied clean gloves. Nurse #4 and Nurse #5 proceeded to position Resident #45 to provide wound care. This surveyor stopped Nurse #4 and Nurse #5 and asked about the sign for Enhanced Barrier Precautions. Nurse #4 and Nurse #5 stopped what they were doing, removed their gloves, sanitized their hands and put on gowns and new gloves.

A joint interview with Nurse #4 and Nurse #5 on 05/15/25 at 3:05 PM revealed that they should have put gowns and gloves on. Nurse #5 stated that they had been trained on Enhanced Barrier Precautions. Nurse #4 stated that they overlooked the Enhanced Barrier Precautions sign and PPE hanging on the door.

An interview with the DON/ Infection Preventionist on 05/15/25 at 3:39 PM revealed that her expectation was for staff to put on the appropriate PPE for all residents who are on Enhanced Barrier Precautions when providing direct resident care such as wound care.

An interview with the Administrator on 05/16/25 at 10:06 AM revealed that her expectation was for staff to put on the appropriate PPE for the residents who were on Enhanced Barrier Precautions when providing direct patient care such as wound care.

3.During a continuous observation on 05/13/25 from 12:23 PM through 12:35 PM, NA #1 and NA #2 entered the room of Resident #35 and closed the door. Upon entry to the room NA #1 and NA

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#2 had gloves on and stated they had performed hand hygiene prior to donning. NA #1 and NA #2 used a mechanical lift to transfer Resident #35 from the chair to bed to provide incontinence care. Resident #35's brief was heavily soiled with a bowel movement that had leaked onto her inner thighs and pants. Both NA #1 and NA #2 removed Resident #35 pants. NA #1 unfastened Resident #35's brief and used moistened wipes to clean bowel movement from the front perineal area and between the skin folds. NA #2 repositioned Resident #35 onto her side and NA #1 continued to wipe bowel movement from the buttock until clean and removed the absorbent pad and soiled brief. Wearing the same gloves NA #1 placed a clean absorbent pad and clean brief underneath Resident #35. NA #2 repositioned Resident #35 onto her back and used moistened wipes to clean bowel movement from the resident's inner thighs. Wearing the same gloves used to clean bowel movement both NA #1 and NA #2 fastened the clean brief and covered Resident #3 with the bed linens. Wearing the same gloves NA #1 repositioned the pillow underneath Resident #35's head and NA #2 moved the mechanical out of the way. Both NA #1 and NA #2 removed their gloves when exiting the room and performed hand hygiene. NA #1 washed her hands using soap and water at a sink located in the nutrition room and NA #2 sanitized her hands with an alcohol based rub located by the nurse station.

During an interview on 05/13/25 at 12:35 PM, NA #1 and NA #2 revealed they were trained to remove their gloves after contact with body fluids including urine and bowel movement and to perform hand hygiene after gloves were removed. NA #1 and NA #2 revealed it was an oversight on their part they did not remove their gloves and

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F 880	Continued From page 103 perform hand hygiene as trained. An interview was conducted on 05/15/25 at 12:40 PM with the DON. The DON revealed gloves were removed and hand hygiene performed after contact with bowel movement as needed. An interview was conducted with the Administrator on 05/16/25 at 6:33 PM. The Administrator revealed for incontinence care when stool/bowel movement was cleaned gloves were removed and hand hygiene performed.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345522	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/2/2025

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FLETCHER REHABILITATION AND HEALTHCARE CENT	**86 OLD AIRPORT ROAD FLETCHER, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 583	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, visitor and staff interviews, the facility failed to protect the private health information of a resident for 1 of 1 resident reviewed for privacy (Resident #283). The findings included: Resident #283 was admitted to the facility on 4/25/25. A phone interview on 5/13/25 at 12:18 PM with Visitor #1 revealed that on 4/30/25 Staff Member #1 was in the hall and told Visitor #1 that Resident #283 was given the wrong medication 2 days prior. She stated that she could not recall Staff Member #1's name nor could she describe what she looked like. Visitor #1 said she had not reported the conversation to any management staff in the facility. Visitor #1 stated that she was there to see another resident and had stepped into the hallway near Staff Member #1 who told her that Resident #283 had received the wrong medication. An interview on 5/16/25 at 12:33 PM with the former Director of Nursing revealed that she recalled Resident #283. She stated that a medications error had occurred on 4/28/25 for Resident #283. She stated that she was not aware that staff told a visitor about another resident's personal health information. She stated her expectation was that staff kept the personal health information of residents private. An interview on 5/16/25 at 5:38 PM with the Administrator revealed that there was a medication error for

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345522	A. BUILDING: _____ B. WING _____	6/2/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLETCHER REHABILITATION AND HEALTHCARE CENT	86 OLD AIRPORT ROAD FLETCHER, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 583	Continued From Page 1 Resident #283 on 4/28/25. She stated that Staff Member #1 should not have shared that information with Visitor #1. She further revealed that her expectation was that staff would not share protected health information with visitors and that staff had recently been educated on privacy.
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a discharge-return anticipated Minimum Data Set (MDS) assessment within the regulated timeframe for 1 of 8 residents reviewed for

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 2

resident assessments (Resident #71).

Findings included:

Resident #71 was admitted to the facility on 12/18/24.

Review of Resident #71's electronic medical record revealed a discharge-return anticipated MDS assessment dated 12/26/24 that was marked as completed on 01/07/25. There was no submission date.

During an interview on 05/16/25 at 10:48 AM, the MDS Coordinator verified the discharge-return anticipated MDS assessment dated 12/26/24 for Resident #71 was completed but had no submission date. She explained the box indicating "do not submit" was accidently checked which prevented the MDS assessment from being submitted within the regulated timeframe.

During an interview on 05/16/25 at 5:11 PM, the Administrator stated she would expect for MDS assessments to be completed accurately and submitted within the regulated timeframe.