STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 06/05/2025

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CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/02/25 through 06/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G22W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/02/25 through 06/05/25. Event ID# G22W11. The following intakes were investigated: NC00218754, NC00220277, NC00220469, NC00221384, NC00222550, NC00222609, NC00225734, NC00226136, NC00227166, NC00228268, NC00228299, NC00228452, NC00228521, NC00228973, NC00229484, and NC00229752. 7 of the 45 complaint allegations resulted in deficiency.	F 000		
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	F 600		6/27/25

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

Electronically Signed | 06/24/2025

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident, resident representative, and staff interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #28 hit Resident #98 on the left of his forehead with his fist when Resident #28 tried to exit his room in his wheelchair and was blocked by Resident #98's geriatric reclining chair (geri-chair, a reclining chair used to support individuals with limited mobility). Resident #98 had a raised red area on the left of his forehead after the incident. This deficient practice affected 1 of 4 residents reviewed for abuse (Resident #98). The findings included: Resident #28 was admitted to the facility on 10/13/21 with diagnoses that included traumatic brain injury, cerebral infarction (stroke), and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated 2/28/25 indicated Resident #28 was cognitively intact and had no behavioral concerns. He was coded as requiring partial to moderate assistance with transfers but was independent wheeling himself in his wheelchair. A review of Resident #28's care plan revised 2/21/25 read he had variable levels of cognitive and communications impairment related to a head injury and history of a CVA (stroke). The goal read Resident #28 would be able to communicate basic needs daily. Interventions	F 600	Residents #28 and #98 continue to reside in the facility and remain in stable condition. At the time of occurrence Resident #28 was placed on one-on-one (1:1) supervision and Resident #98's room was changed. There have been no further incidents between residents #28 and #98. On 3/22/2025 the Director of Nursing completed an audit of 1) current resident's progress notes for 14 days prior ensuring no documentation exists that could be construed as abuse and 2) grievances for 90 days ensuring no grievances rise to the level of abuse and/or grievances of residents that may have lead a resident with behaviors to strike out and/or become aggressive. No concerns were identified. Additionally on 3/22/2025 the DON, Social Service (SS), RN Supervisor initiated 1) interviews with residents scoring 12 and above on Brief Interview of Mental Status (BIMS) to ensure the residents did not witness and/or be victim of resident to resident abuse; 2) skin checks on residents scoring 11 and below on BIMS to ensure no new skin impairments were identified that may result from resident to resident abuse. Audits were completed on 3/24/2025. No concerns were identified. On 3/22/2025 the Staff Development Coordinator (SDC) initiated education with	

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F 600	Continued From page 2 included discussing the resident's concerns about confusion, disease process, and nursing home placement. Resident #98 was admitted to the facility on 12/13/24 with diagnoses that included unspecified dementia with psychotic disturbance, cerebral infarction (stroke), and unspecified intracranial injury (traumatic brain injury) with loss of consciousness. A quarterly MDS assessment dated 3/21/25 indicated Resident #98 was severely cognitively impaired and had no behavioral concerns. He was coded as being dependent on transfers and mobility. A review of Resident #98's care plan last revised on 3/21/25 read he had been verbally and physically aggressive towards staff such as hitting, kicking and biting related to dementia and mood disorder. The goal read Resident #98 would not harm self or others and staff would encourage seeking out of a staff member when agitated or in pain. An initial allegation report dated 3/22/25 read Resident #98 was hit on the head by Resident #28. Resident #28 alleged he could not get past Resident #98. Resident #28 stated he asked Resident #98 to move. Resident #98, who is nonverbal, attempted to speak but could not be understood. Resident #28 stated he removed his brace and struck Resident #98 on the head. Staff immediately separated the residents involved and evaluated both. Resident #98 had a small, raised bump on the forehead and Resident #28 had a scratch on his finger. Resident #98's room was changed, and his Representative was notified.	F 600	current facility staff regarding 1) abuse, what constitutes abuse, and reporting abuse, and interventions when an abusive event occurs including, but not limited to, separating residents, placing 1:1 with resident(s), room changes; and 2) triggers that may cause a resident with known behaviors to become aggressive including, but not limited to, blocked passage to/from, increased noise levels, bright lighting, unaddressed pain, personal care needs not met. Education will be completed on 6/25/2025. After 6/25/2025 any staff not educated will be educated by the SDC prior to beginning their next scheduled shift. After 6/25/2025 newly hired staff will be educated during orientation by the SDC. SS/Unit Managers/Wound Nurse(s) will conduct 1) five (5) resident interviews a week for twelve (12) weeks with residents scoring 12 and over on BIMS ensuring no resident has witnessed or been a victim of resident to resident abuse; 2) five (5) skin checks on residents who score 11 and under on BIMS to ensure no new skin impairments are identified that may result from resident to resident abuse; 3) five (5) roommate interactions ensuring no actions are taken that may lead to or be construed as resident with behaviors to strike out and/or become aggressive. The NHA and DON will present findings of audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for three (3) months. The QAPI committee will review audits to	

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F 600	Continued From page 3	F 600		

Resident #28 was placed on 1:1 observation. The Director of Nursing (DON) notified the local police department and the Department of Adult Protective Services. The report was signed by the Administrator on 3/22/25.

A progress note dated 3/22/25 at 4:55 PM for Resident #98 written by Nurse #8 indicated a physical altercation was observed between Resident #98 and Resident #28. According to the progress note, Resident #98 was sitting in his geri-chair in their shared room when Resident #28 was trying to exit the room. Resident #28 informed the nurse the other resident was in his way, so he hit him. The documentation noted Resident #98 received a small knot on the left side of his forehead. The note further indicated both residents were separated, and Resident #98 was taken to the nurse's station for observation. Per the progress note, neurological checks were already in place for Resident #98 from a previous fall and remained unremarkable. Resident #98's wife was notified of the incident and Nurse Practitioner (NP) #1 was also notified. Resident #28 was moved to another room according to the nurse's note.

An additional progress note dated 3/23/25 at 1:47 PM for Resident #98 written by Nurse #8 revealed the resident had returned from the emergency room where he was evaluated for head trauma. The note indicated there were no new orders, and the CT scan was negative per the hospital report. According to the progress note, when Resident #98 returned to the facility, he was alert and cooperative with care. The knot on the left side of his forehead was "much improved" and "almost resolved". The progress note indicated the resident was fed lunch by the staff and did not determine trends and/or issues that may need further investigations and/or the need for additional monitoring.

Date of Compliance 6/27/2025

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demonstrate any signs of pain or physical discomfort.

Nurse #8 was interviewed on 6/3/25 at 2:39 PM and stated on the day of the altercation, Resident #98 was in his room which he shared with Resident #28. According to Nurse #8, Resident #98 resided in bed A which is closest to the door of the shared room. Resident #98 was sitting in his geri-chair by the door when Resident #28 tried to exit the room but couldn't get around him. Nurse #8 stated she and another staff member were walking past the shared room when they witnessed Resident #28 hit Resident #98 on the head with his fist. She stated they immediately separated the residents. When she assessed Resident #98, she noted he had a small knot on the left side of his forehead as well as some skin discoloration at the site. Nurse #8 indicated she informed the DON, Administrator, and NP #1 of the incident and then called Resident #98's spouse. Nurse #8 stated she was unaware of any altercations or arguments between the two residents in the past.

Nurse Aide #4, who had assisted with separating the residents according to Nurse #8, was called for an interview regarding the altercation but was unable to be reached after multiple attempts.

An interview was conducted with Resident #28 on 6/2/25 at 8:40 AM. His speech was jumbled, but he stated, "I hit somebody" (he was unable to recall who), "he was ignoring me, so I just swung on him. He was in the way so I finally . . ." Resident #28 then made a fist and mimicked the act of hitting.

On 6/2/25 at 1:00 PM an interview was conducted

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F 600	Continued From page 5 with Resident #98's representative who stated Resident #28 "had jumped her husband three times". She indicated she requested Resident #98 to be sent to the emergency room to have a CT scan (computed tomography-a medical imaging of the body) to check for damage after the altercation that occurred on 3/22/25. She further stated the other resident had been moved to another room after the incident. The Director of Nursing was interviewed in conjunction with the Administrator on 6/5/25 at 9:05 AM. The DON stated she spoke with Resident #98's spouse at least monthly, and she had never mentioned any other time when Resident #98 and Resident #28 had an argument or altercation. She indicated that other than the incident that occurred on 3/22/25 the residents had always gotten along well together. The Administrator agreed that there had never been a previous argument or altercation between the two residents. On 6/5/25 at 10:43 AM Nurse Practitioner #1 was interviewed. He stated he was notified of the altercation between Resident #28 and Resident #98 after it occurred. The NP stated he had never known of the two residents being involved in any arguments or altercations other than the one reported to him on the date of the event 3/22/25. The facility submitted a draft plan of correction that was not accepted by the state agency as evidence of past non-compliance.	F 600		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		6/27/25

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F 641	Continued From page 6 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility and hospital record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of: 1) Preadmission Screening and Resident Review (PASRR) Level II status (Resident #80); 2) Impairment of range of motion (Resident #25); 3) Use of an antibiotic medication (Resident #76); and 4) The residents' discharge location prior to his/her admission to the facility (Resident #52). This occurred for 4 of 21 residents whose MDS assessments were reviewed. Findings included: 1. Resident #80 was admitted on 12/18/23 with diagnoses that included schizoaffective disorder, bipolar type, depression and anxiety disorder. Documentation provided by the facility's Social Service Director on 6/3/25 at 2:00 PM from the North Carolina PASRR determination authority web portal (known as NC MUST) was reviewed. The PASSR details dated 6/25/24 indicated Resident #80 had a PASSR Level II determination with no limitation unless there was a change in condition. It also indicated the resident must stay at a Skilled Nursing Facility or Hospital Level of Care and should receive specialized services. Resident #80's most recent comprehensive Minimum Data Set (MDS) was a modified annual assessment dated 12/14/24. The assessment did not indicate Resident #80 had a PASRR Level II determination.	F 641	Resident #76 no longer resides in the facility. Residents #80, 25, and 52 continue to reside in the facility and remain in stable condition. Resident# 76s 5/21/2025 2025 Minimum Data Set (MDS) Section N sub-section N0415 J was modified on 6/4/2025 and resubmitted. Resident #80 12/14/2024 MDS Section A sub-section A1510 was modified on 6/5/2025 and resubmitted. Resident #25s 3/8/2025 MDS section C sub-section 0500 was modified on 6/5/2025 and resubmitted. Resident #52s 4/11/2025 Section A sub-section A1805 was modified on 6/4/2025 and resubmitted. MDS Coordinators modified and resubmitted residents # 76, 80, 25, and 52 sections A, C, and N pertaining to Preadmission Screening and Resident Review (PASRR), Entry From, Cognition Pattern, and Medications. On 6/6/2025 the Regional Director of Clinical Services (RDCS) completed an audit of recently completed MDS for current residents to ensure MDS sections A1510, A1805, C0500, and N0415(J) pertaining to Preadmission Screening and Resident Review (PASRR), Entry From, Cognition Pattern, and Medications are reflected accurately. Any concerns identified were corrected by the MDS Coordinator. On 6/6/2025 the Regional Director of	

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F 641	Continued From page 7 The resident's care plan included the following area of focus: Resident # 80 has PASRR Level II related to serious mental illness/related condition due to Schizophrenia (Initiated 1/27/25; Revised 4/23/25). An interview was conducted on 6/4/25 at 2:57 PM with MDS Nurse #2 related to Resident #80's annual assessment dated 12/14/24. Upon review, MDS Nurse #2 indicated the assessment was completed by a remote MDS staff. MDS Nurse #2 confirmed the resident's assessment was inaccurate and it should have noted the resident had a PASRR Level II status due to serious mental illness. During an interview on 6/5/25 at 1:23 PM, the Administrator stated she would expect the residents' PASRR Level to be coded accurately on the MDS assessments. The MDS staff should be reviewing the resident's face sheet and checking the PASSR information to ensure the information was entered correctly. The Administrator confirmed they had remote staff completing MDS assessments and recently hired a new staff member for MDS. 2. Resident #25 was admitted to the facility on 4/24/17 with diagnoses that included dementia without behavioral disturbance, contractures to left wrist, contractures to left hand, and history of traumatic brain injury (TBI). The resident's care plan (reviewed date 3/6/25) revealed Resident #25 was care planned for impaired Activities of Daily Living (ADL) function due to TBI, limited physical mobility left side paralysis with left upper extremities (LUE)	F 641	Clinical Services completed education with the MDS Coordinators and Social Service regarding accurately completing MDS Sections A1510, A1805, C0500, and N0415(J) pertaining to PASRR, Entry From, Cognitive Pattern, and Medications. After 6/6/2025, any newly hired MDS Coordinators will be educated during orientation by the Staff Development Coordinator (SDC). The RDCS will conduct audits of 5 MDS assessments weekly for eight (8) weeks to ensure MDS Sections A1510, A1805, C0500, and N0415(J) reflect PASRR, Entry From, Cognitive Pattern, and Medications are coded accurately for corresponding Assessment Reference Date (ARD). Any concerns identified will be addressed by the MDS Coordinator. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (2) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Compliance Date: 6/27/2025	

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contracture.

Resident's most recent quarterly Minimum Data Set (MDS) assessment dated 3/8/25, revealed Resident #25 was assessed as severely cognitively impaired. The assessment indicated the resident had no impairment to both upper extremities and impairment on the one side for lower extremities. The assessment indicated the resident was dependent on staff for her Activities of Daily Living (ADL) Care.

During an observation on 6/2/25 at 9:40 AM, Resident #25 was observed lying in her bed. She had contractures on her left hand and was not observed to be wearing any splint.

During an interview on 6/4/25 at 2:57 PM, MDS Nurse #2 stated it was an oversite on her part that the resident's Range of Motion (ROM) was marked incorrectly to indicate Resident #25 had no impairments with her upper extremities. She further stated the resident had contracture to her upper extremity.

During an interview on 6/5/25 at 1:19 PM, the Administrator stated Resident #25's MDS was incorrectly coded as lower extremities having limited ROM. The resident had limited range of motion in the upper extremities.

3. Resident #76 was admitted to the facility on 5/15/25. The resident's cumulative diagnoses included diabetes and cirrhosis (advanced scarring) of the liver.

The resident's electronic medical record (EMR) included his Physician's Orders. These orders included, in part, 550 milligrams (mg) rifaximin to

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be given as one tablet by mouth two times a day for cirrhosis (Start Date 5/16/25). Rifaximin is classified as an antibiotic. It is sometimes used to treat hepatic encephalopathy (brain dysfunction caused by impaired liver function).

A review of Resident #76's May 2025 Medication Administration Record (MAR) revealed the resident received rifaximin daily as order from 5/16/25 through 5/21/25.

The resident's admission Minimum Data Set (MDS) was dated 5/21/25. The "Medications" section of this MDS assessment indicated Resident #76 received insulin, an antidepressant, and anticoagulant. It did not indicate the resident received an antibiotic medication during the 7-day look back period.

An interview was conducted on 6/4/25 at 9:02 AM with MDS Nurse #1 and MDS Nurse #2 related to Resident #76's admission MDS. At that time, the MDS nurses reviewed the resident's admission MDS assessment and electronic medical record (EMR). When asked, MDS Nurse #2 confirmed the resident received an antibiotic during the look back period and reported the MDS should have included it. MDS Nurse #2 stated she would need to correct Resident #76's MDS to indicate he received an antibiotic.

An interview was conducted on 6/5/25 at 11:16 AM with the facility's Administrator in the presence of the Regional Nurse Consultant. During the interview, a concern about the inaccurate reporting of Resident #76's antibiotic on the MDS was discussed. Upon inquiry, the Administrator reported she would expect the MDS assessments to be coded accurately.

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4. Review of Resident #52's hospital Progress Notes dated 4/1/25 revealed the resident was admitted to the hospital on 3/31/25 for a principle problem of sepsis (the body's extreme reaction to an infection). The resident was discharged from the hospital and re-entered the facility on 4/3/25.with cumulative diagnoses which also included dysphagia, and anxiety.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/11/25. The "Identification Information" section of this MDS assessment indicated Resident #52 "Entered From" a Nursing Home (long-term care facility).

An interview was conducted on 6/4/25 at 9:02 AM with MDS Nurse #1 and MDS Nurse #2 related to Resident #52's quarterly MDS dated 4/11/25. At that time, the MDS nurses reviewed the resident's quarterly MDS assessment and electronic medical record (EMR). When asked, MDS Nurse #2 confirmed the resident did go out to the hospital with re-entry to the facility on 4/3/25. The nurses agreed the MDS assessment would need to be corrected to accurately reflect that Resident #52 re-entered the facility from a hospital.

An interview was conducted on 6/4/25 at 9:42 AM with the facility's Social Service Director. The Social Service Director was identified as the staff member who frequently completed part of the "Identification Information" section of residents' MDS assessments. During the interview, concerns related to the inaccuracies as to where a resident "Entered from" upon entry to the facility were discussed. At that time, the Social Service Director stated that the "Entered from" question

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F 641	Continued From page 11 was frequently pre-populated. The Director reported she did not know this information may be incorrect and that she may need to correct it. An interview was conducted on 6/5/25 at 11:16 AM with the facility's Administrator in the presence of the Regional Nurse Consultant. During the interview, the concern identified regarding the inaccurate reporting of the resident's discharge location prior to his re-entry to the facility was discussed. Upon inquiry, the Administrator reported she would expect the MDS assessments to be coded accurately.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		6/27/25

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F 657	Continued From page 12 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, and resident and staff interviews the facility's Interdisciplinary Team (IDT) failed to review the care plans after residents' annual and quarterly Minimum Data Set (MDS) assessments and failed to involve residents and/or resident representatives in the care planning process for 2 of 2 sampled residents reviewed for care plan revision and participation (Resident # 80 and Resident #16). Findings included: a. Resident #80 was readmitted on 1/18/25 with diagnoses that included diabetes mellitus type 2, and congestive heart failure. A record review of the most recent quarterly Minimum Data Set (MDS) dated 4/23/25 revealed Resident #80 was admitted to the facility on 12/8/23. The resident was assessed as cognitively intact and needed substantial/ maximal assistance for most of the activity of daily living. Review of the resident's care plan revealed a start date of 4/23/25 and target completion date of 7/22/25. There was no indication that care plan review by the Interdisciplinary team (IDT) was completed. There was no indication that the resident or resident's family participated in the care plan meeting or in the development of Resident #80's plan of care.	F 657	Residents #80 and 16 continue to reside in the facility and remain in stable condition. The Care Plan review date was updated for both residents and care plan reviews will be completed at least quarterly, and an invitation will be sent to the resident and/or resident representative of upcoming care plan meeting dates/times. Care plan meetings have been scheduled for Residents #16 and 80 on 6/26/2025. On 6/5/2025 the Director of Nursing (DON) and Minimum Data Set (MDS) Nurse completed a review of current resident care plans to ensure care plans have been reviewed at least quarterly and review completion date is set for 15 days post Assessment Review Date (ARD) completion. Several resident care plan review dates were identified as dated incorrectly. Corrections were made to each by the DON and MDS Nurse. On 6/5/2025 the Regional Director of Clinical Services (RDCS) educated the Social Service regarding care plan meeting timing to include, but not limited to, baseline care plan meeting, quarterly care plan meeting, and annual care plan meeting. Education also included sending invitations out to residents and/or resident representatives for date and time to attend resident care plan meetings and	

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F 657	Continued From page 13 During an interview on 6/3/25 at 7:09 AM, Resident #80 stated the facility had not invited her to any care plan meeting or to participate in developing her plan of care. During an interview on 6/3/25 at 12:20 PM, the Social Worker Director indicated she was hired in November 2024 and had been conducting only initial care plan meetings for new admission residents with residents and/or resident representatives. She indicated that it was only recently that she was made aware that quarterly and annual care plan meetings needed to be conducted with residents and/or resident representatives. The Social Worker Director stated Resident #80 was a long-term care resident and no care plan meetings were conducted for long term residents or their representatives. During an interview on 6/3/25 at 1:22 PM, MDS Nurse #3 stated she worked part time and was assisting the newly hired MDS staff. MDS Nurse #3 stated when the IDT team updated or reviewed the care plans after the MDS assessments, they signed off the care plans as completed. MDS Nurse #3 indicated after all IDT members had signed as completed, the MDS staff also marked the care plan as completed. MDS Nurse#3 stated Resident #80's care plan was not signed by IDT team members as completed or updated. MDS Nurse #3 indicated she was unsure if the care plan was reviewed by the team and/or if the resident had a care plan meeting. b. Resident #16 was readmitted to the facility on 8/12/24 with diagnoses that included	F 657	documenting corresponding progress notes in the resident's medical record. After 6/5/2025 any newly hired Social Service staff will be educated by the Staff Development Coordinator (SDC) during orientation. On 6/23/2025, the SDC completed education with the Interdisciplinary Team (IDT) regarding setting accurate dates for resident care plan review and with review completion date no later than 15 days post Assessment Review Date (ARD) completion. After 6/5/2025 any MDS nurse, UM, dietitian, social services, activities director who was not inserviced, will be inserviced by the SDC prior to beginning their next scheduled shift. After 6/5/2025 any newly hired MDS nurse, UM, dietitian, social services, activities director will be educated by the SDC during orientation. The DON/SDC will complete an audit weekly for eight (8) weeks of five (5) resident care plans to ensure1) care plans have been reviewed at least quarterly and the review completion date is set for 15 days post Assessment Review Date (ARD) completion; and 2) ensuring invitations are sent to the resident and/or resident representative regarding care plan meeting date and time and documentation in the resident's record is completed. Any areas of concern will be addressed by the MDS Coordinator and Social Service. The DON will present the findings of the	

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F 657	Continued From page 14 poly-osteoarthritis, dementia, and hypothyroidism. Review of the care plan conference dated 10/17/24 indicated that a care plan meeting was conducted with the resident on 10/17/24. The resident participated in the care plan meeting with the Interdisciplinary Team (IDT). A record review of the most recent comprehensive annual Minimum Data Set (MDS) dated 4/10/25 revealed Resident #16 was admitted to the facility on 6/18/24. The resident was assessed as cognitively intact and dependent on staff assistance for most of the activity of daily living. Review of the resident's care plan revealed a start date of 3/9/25 and a target completion date of 6/7/25. There was no indication that care plan review by the interdisciplinary team was completed. There was no indication that the resident or resident's family participated in the care plan meeting or in the development of Resident #16's plan of care. During an interview on 6/4/25 at 10:40 AM, Resident #16 indicated she had not attended a care plan meeting since October 2024. She stated that the facility used to have care conferences every 3 months until October 2024 and later stopped having any meetings. Resident #16 indicated she preferred these meetings as she was updated on her goals and medical progress. During an interview on 6/5/25 at 9:20 AM, the Social Worker Director indicated she was hired in November 2024 and has been conducting only initial care plan meeting for new admission	F 657	audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Compliance Date 6/27/2025	

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F 657	Continued From page 15 residents with residents and resident representative. The Social Worker Director stated Resident #16 was a long-term care resident and no care plan meetings were conducted for long term residents. During an interview on 6/5/25 at 10:00 AM, MDS Nurse #2 stated the Resident #16's care plan was not signed off by IDT team as reviewed and/or updated. When the IDT completed their review the care plan was marked as completed. During an interview on 6/3/25 at 1:05 PM, the Director of Nursing stated all interdisciplinary team were responsible for reviewing and/or updating the care plan related to their area. The MDS staff also updated the care plan when any resident had a fall, or new interventions needed to be placed. The interdisciplinary staff should sign off once the care plan was reviewed or updated. During an interview on 6 /5/25 at 9:39 AM, The Administrator stated the expectation was that care plan meetings and notifications were per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each MDS assessment, including comprehensive and quarterly assessments or if there was any change in condition. He further stated residents and/or resident representatives should be involved in the care plan meeting and make decisions about their care.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		6/27/25

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F 688	Continued From page 16 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, records review, and staff interviews, the facility failed to apply a left-hand splint for 1 of 1 resident (Resident #25) reviewed for contractures. Findings included: Resident #25 was admitted to the facility on 4/24/17 with diagnoses that included dementia without behavioral disturbance, contractures to left wrist, contractures to left hand, and history of traumatic brain injury (TBI). Review of the physician order start dated 11/13/21 read in part "Remove left resting hand splint (4-6 hrs, remove at 4 pm). Skin checks around area of splint after removal (Document: Is skin intact- yes/no?)." Occupation Therapy (OT) discharge summary dated 10/18/24 indicated Resident #25 received	F 688	Resident #25 continues to reside in the facility and remains in stable condition. On 6/5/2025 Occupational Therapy (OT) added the resident to caseload five (5) times a week for eight (8) weeks for continued contracture/splint management. On 6/5/2025 the order for resting hand splint was updated to apply splint for four (4) to six (6) hours a day and check skin upon removal. On 6/6/2025 the Director of Rehabilitation (DOR) completed an audit of current residents' splints to ensure 1) splint order is current, applied per therapy recommendation, and order for wearing schedule is placed in the resident's medical record. Any concerns identified were addressed by the DOR. On 6/6/2025, the DOR developed binders	

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F 688	Continued From page 17 OT services from 8/28/24 to 10/18/24. Resident #25 at discharge was able to tolerate left resting hand splint for straps and frame adjustment for 4 to 5 hours. Discharge recommendations included recommending splint/braces. Restorative staff were trained on splint and brace program. Splinting for 5 hours for contracture management. Care plan (reviewed date 3/6/25) revealed Resident #25 was care planned for impaired Activities of Daily Living (ADL) functions related to TBI, limited physical mobility left side paralysis with left upper extremities (LUE) contracture. Resident #25 had order to wear a splint to her left wrist for 4-6 hours a day. Goal included maintaining current level of mobility with no further development of contractures. Interventions included applying and removing splint as ordered. Applying splint to left hand during the day and to be removed in the evening. Review of the quarterly Minimum Data Set (MDS) assessment date 3/8/25, revealed Resident #25 was assessed as severely cognitively impaired, with no behaviors exhibited. Assessment indicated the resident had no impairment to upper extremities and impairment on the one side for lower extremities. Assessment indicated the resident was dependent on staff for her Activities of Daily Living (ADL) Care. Review of the Medication Administration Record (MAR) for May 2025 and June 2025 revealed the document was marked as "Yes", indicating the resident's skin was intact when checked around area of splint after removal of the splint. The document was initialed by the nurses. During an observation on 6/2/25 at 9:40 AM,	F 688	for each nursing station that include the resident name, type of splint utilized, instructions for applying splint, and wearing schedule. Education was provided by the DOR to the nursing and therapy staff regarding binders, updating of binders, and location of each. On 6/23/2025 the DOR/Staff Development Coordinator (SDC) initiated education with the therapy and nursing staff regarding the role of splints to increase and/or prevent the development of contractures, correctly applying splints, and adhering to recommended wearing schedule. Education included reiteration of the addition of splint binder to each unit nurse station and includes Resident name, type of splint, instructions for applying splint, and wearing schedule. Following therapy education, Certified Nurse Aides (CNAs) will be responsible for applying splints per therapy recommendations. Education will be completed on 6/25/2025. After 6/25/2025 any therapy or nursing staff that were not educated will be educated prior to beginning their next scheduled shift. After 6/25/2025 any newly hired therapy or nursing staff will be educated by the DOR/SDC during orientation. The DOR or designee will complete an audit of splint wearing two (2) times a week for twelve (12) weeks ensuring residents with orders for splints have the splint on, splint is applied correctly, and splint is removed per recommended timeframes; as well as ensuring splint binders are up to date. Any concerns	

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F 688	Continued From page 18 Resident #25 was observed lying in her bed. She had contractures on her left hand and was not observed to be wearing any splint. The resident's fingernails were trimmed, and no skin issues were noted on her palm. During an interview on 6/2/25 at 9:45 AM, Nurse #6 indicated she was assigned to the resident. Nurse #6 stated Resident #25 had contractures to her left hand. Nurse further stated the splint was applied on the left hand usually after breakfast. Nurse #6 indicated the resident did not have any skin issue to her left hand. During an observation on 6/2/25 at 1:04 PM, Resident #25 was observed sitting in the wheelchair in the hallway. The resident did not have a splint applied to her left hand. On 6/3/25 observations were made at 12:58 PM, and at 3:14PM. Resident #25 was observed lying in her bed. The resident did not have splint applied to her left hand that had contractures. On 6/4/25 at 11:30 AM, Resident #25 was observed in the hallway, sitting in her wheelchair. No splint was applied to her left hand. During an interview and observation on 6/4/25 at 11:35 AM, Nurse Aide (NA) #1 indicated she was frequently assigned to the resident. Nurse aide stated Resident #25 had contractures to her left hand and splint on her left hand was applied by therapy staff. NA #1 indicated the resident's left palm was cleaned with wet towel daily and had no skin issues. During the interview, Resident #25 was observed in her bed with no splint applied to her hand. NA #1 searched the resident's room and found a blue colored splint inside the	F 688	identified will be addressed by the DOR. The DOR will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Compliance Date 6/27/2025	

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F 688	Continued From page 19	F 688		

nightstand drawer. NA #1 did not place the splint on Resident #25, nor did she notify anyone about the splint.

On 6/4/25 at 11:07 PM, Medication Aide (MA) #1 was observed outside Resident #25's room. MA #1 stated Resident #25 had contractures to her left hand, however, the splint was applied by the therapy staff.

During an interview on 6/4/25 at 11:10 PM, Nurse #4 stated the resident's splint was applied by the therapy staff and nursing staff did not place splint on the resident's left hand.

During an interview on 6/3/25 at 1:09 PM, Certified Occupation Therapy Assistant (COTA) stated he had frequently worked with Resident #25 while the resident was under occupation therapy service. Resident #25 had contractures to her left hand. While under therapy service, the splint was applied to the left-hand to check for tolerance and for comfort during use. The resident at discharge was able to tolerate splint for 4- 6 hours a day. The COTA indicated when the resident was discharged from therapy (date unknown) the restorative program staff were educated and trained on how to place splint on the resident's hand. The resident had limited Range of Motion (ROM) to her left hand and required passive stretch to her left hand prior to applying the splint. At discharge the resident was able to tolerate her left-hand splint without any pain. COTA further indicated once any resident was discharged from therapy, it was the restorative program staff and nursing staff responsibility for apply splints, check for tolerance and skin impairment. If there was any concern or if the resident was in pain when splints were

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F 688	Continued From page 20 placed, then therapy would reevaluate the resident for new splints. COTA stated the resident was discharged with recommendations to wear splint for 4-6 hours daily to help with her left-hand contracture. The Therapy Director was interviewed on 6/4/25 at 3:34 PM. The Therapy Director indicated that the Occupational Therapist who had worked with Resident #25 was no longer employed at the facility. She further stated she was newly hired and was not familiar with the resident. The Occupational Therapist who worked Resident #25 was unavailable for an interview. During an interview on 6/5/25 at 8:30 AM, the Director of Nursing (DON) indicated the Nurse aides assigned to the resident could apply the splints. Nurses should ensure the splints were applied appropriately. The residents' skin should be checked when the splints were removed by the nurses to ensure they do not have any skin issues. DON stated Resident #25 had contractures and splints should be applied by nursing daily. During an interview on 6/5/25 at 9:18 AM, the Administrator stated splints should be applied to the resident as ordered. Nursing staff, when trained by therapy for splints, were responsible for applying splints for the resident. The Administrator indicated Resident #25 was re-evaluated by the therapy staff and would be under therapy services for her contractures.	F 688		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		6/27/25

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F 727	Continued From page 21 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 3 of 92 days reviewed for staffing (11/10/24,11/30/24, and 12/01/24). Findings included: A review of the PBJ (Payroll Based Journal) staffing data report for quarter 1, 2025 (October 1 - December 31, 2024) indicated the facility did not have RN Coverage on 11/10/24, 11/30/24, and 12/01/24. Review of the daily assignment sheets for the non-covered dates revealed the RN who was originally scheduled to work 7:00 AM - 7:00 PM on the dates of 11/10/24, 11/30/24, 12/01/24, and 12/27/24 had called out. The facility had not replaced the RN who called out. An interview was conducted with the Director of Nursing (DON) and the Administrator on 06/05/25 at 9:06 AM. The DON stated the nurse who was	F 727	F 727 – RN 8 Hrs/7 days a week The facility failed to have a Registered Nurse (RN) scheduled for at least 8 consecutive hours a day for three (3) of 92 days (11/10/2024, 11/30/2024, 12/1/2024). Current residents have the potential to be affected by deficient practice. On 3/20/2025 an RN was hired as the weekend supervisor. This has since corrected the lack of RN for eight (8) consecutive hours a day/seven (7) days a week. On 6/6/2025 the Director of Nursing (DON) reviewed staffing schedules through the remainder of June 2025 ensuring there were eight (8) consecutive hours of RN coverage 7 days a week. No areas of concern were identified. On 6/6/2025, the DON completed education with current RNs and the	

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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 727	Continued From page 22 scheduled to work on the non-covered dates called off work. She stated the facility only had two RNs at the time, and the other RN was unavailable to cover. The DON verified there was no RN coverage for the 24 hour period on 11/10/24, 11/30/24 and 12/01/24. During an interview with the Administrator on 06/05/25 at 9:08 AM she stated she expected staff to work on the dates they were scheduled. She stated she had since hired a weekend nurse to assist with RN coverage.	F 727	staffing coordinator regarding requirement for eight (8) hours of RN coverage seven (7) days a week and the importance of replacing RN call outs when needed. After 6/6/2025 any RNs who were not educated will be educated by the DON prior to beginning their next scheduled shift. Any newly hired RNs or staff coordinators will be educated by the Staff Development Coordinator (SDC) during orientation. The DON and staffing coordinator will meet two (2) days a week for three (3) months to review upcoming staffing schedules to ensure eight (8) consecutive hours of RN coverage is captured seven (7) days a week. The DON or Staffing Coordinator will email schedules to the Regional Director of Clinical Services (RDCS) weekly for review. The staffing coordinator will be responsible for replacing any RN call outs. The DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Compliance Date 6/27/2025	
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		6/27/25

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	345227	A. BUILDING _____ B. WING _____	C 06/05/2025

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F 812	Continued From page 23 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 interviews with the facility staff and the Regional Director of Dietary Services, the facility failed to: 1) Label, date, and seal food items stored in the Dietary Department's walk-in cooler, dry food storage room, and walk-in freezer; 2) Dispose of expired food items observed in food storage areas; 3) Store food products in accordance with the manufacturer's storage instructions; 4) Cover facial hair for 2 of 2 Dietary staff observed with facial hair and working in food preparation (Dietary Manager and Dietary Aide #1); and 5) Keep the kitchen food service equipment clean within the Dietary Department. These practices had the potential to affect food being served to residents. The findings included:	F 812	On 6/2/2025, the Dietary Manager corrected items identified during the regulatory kitchen survey. Expired, open, and thawed items were disposed, large kitchen fan was cleaned, and men working in the kitchen placed beard guard nets. Current residents residing in the facility have the potential to be affected by deficient practice. On 6/2/2025 the Regional Director of Dietary Services educated the Dietary Manager regarding the importance of maintaining a clean and orderly kitchen and storage areas and the need for staff working in the kitchen to wear hair nets and beard guards. After 6/2/2025 any newly hired Dietary Managers will be educated by the Staff Development	

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F 812	Continued From page 24 1) An initial tour was conducted of the Dietary Department on 6/2/25 at 7:00 AM. The Dietary Manager was not available to join the initial tour of the Department. Observations made at the time of the initial tour identified the following concerns in the Dietary Department's walk-in cooler: --A 1-pound bag of parsley was opened to air (not sealed). The plastic bag was dated 5/8/25. The parsley in the bag appeared to be dark green and brown, showing signs of wilting. --Approximately 1-pound of sliced, cooked ham was stored in an unsealed, zippered plastic bag that was open to air. The plastic bag was not dated as to when it had been opened. --A 5-pound plastic bag of shredded cheddar cheese with approximately 2 pounds remaining in the bag was observed to be stored in the walk-in cooler. The plastic bag was left open to air (not sealed). The bag was dated as opened on 5/23/25. --A package originally containing 160 slices of pasteurized processed American cheese with approximately 120 slices remaining in the package was loosely wrapped with its original plastic covering and placed in an unsealed, zippered plastic bag that was open to the air. 6 slices of American cheese were placed on top of the original plastic covering within the unsealed, zippered plastic bag that was open to air. The plastic bag was not dated as to when it had been opened. --A 1-pound block of margarine was opened and loosely wrapped in its original wrapping (not sealed). Additionally, a 2-ounce piece of margarine was also loosely wrapped in its original wrapping (also, not sealed). Neither of the margarine packages were dated as to when they had been opened.	F 812	Coordinator (SDC) during orientation. The Nursing Home Administrator (NHA) will conduct a kitchen audit weekly for twelve (12)weeks to ensure there is no expired food, no food open to air and/or thawed, and the kitchen is clean and orderly and ensure hair nets and beard guards are being worn by any staff member who enters the kitchen. Any areas of concern will be addressed by the NHA. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Compliance Date 6/27/2025	

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F 812	Continued From page 25 An observation made at the time of the initial tour identified the following concern in the dry food storage room: --A 9-ounce packet of Taco Seasoning Mix had one corner of the packet cut away, leaving the contents of the packet open to air. The packet was dated as having been received on 5/6/25 and dated as opened on 5/15/25. Additional observations were made during a brief follow-up tour of the Dietary Department conducted on 6/2/25 at 1:50 PM. Observations made at the time of this tour identified the following concerns in the Dietary Department's walk-in freezer: --An opened cardboard box containing 15-pounds of frozen chicken breast strips was dated 3/20/25. One of two plastic bags inside the box was observed to be open to air (not sealed). The chicken breast strips appeared to have light edges around the strips, potentially indicative of freezer burn. The opened bag of the chicken breast strips was not dated as to when it had been opened. --An unsealed plastic bag containing 8 frozen breadsticks was observed to be stored in the walk-in freezer. The plastic bag containing the breadsticks was not dated as to when it had been opened. An interview was conducted on 6/2/25 at 1:55 PM with the facility's Dietary Manager and Regional Director of Dietary Services. At that time, the findings of the Dietary Department's initial and follow-up tours were shared. Upon inquiry, the Regional Director reported she would expect that all food containers should be sealed and "not open to air at all."	F 812		

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2) Observations made during the initial tour of the Dietary Department conducted on 6/2/25 at 7:00 AM identified the following food items were expired in the dry food storage room:
--3 boxes of 46 fluid ounces of "Thickened Sweetened Tea with Lemon Flavor" were observed to have a "Best if used by 4/17/25." These boxes of thickened tea were dated as having been received on 12/12/24.
--1 box of 100-portion control cups of a "Steakhouse Honey Mustard" dressing with approximately 85 portions remaining in the box was observed to be on a shelf in the Dry Storage Room. The box was dated as having been received on 1/23/25 and it read, "Exp: 24 May 25" [Expired 5/24/25].

Accompanied by the facility's Dietary Manager and Regional Director of Dietary Services, an observation and interview were conducted on 6/2/25 at 1:55 PM of the dry food storage room. At that time, the findings of the Dietary Department's initial and follow-up tours were shared and observations conducted to confirm the findings. Upon inquiry, the Regional Director reported she would expect all opened food containers to be dated with two dates: the date received and the date the container was opened.

3) Observations made during the initial tour of the Dietary Department conducted on 6/2/25 at 7:00 AM identified the following food items were not stored in accordance with the product's storage instructions:
--3 boxes of hot dog buns (each containing 12 packages of 12-count of buns) were stored in the walk-in cooler. The boxes each read, "Keep frozen at 0 oF [degrees Fahrenheit] or below."

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--4 boxes (containing 15-pounds each) of bread loaves were stored in the walk-in cooler. The boxes read, "Keep frozen at 0 oF or below."
--1 unopened box labeled as containing, "Margarine 2.5 oz [ounce] curved sliced croissant frozen fully baked" with 60 count of croissants was observed placed on a shelf in the dry food storage room. Each side of the cardboard box noted, "Keep frozen." Instructions on one side of the box read, "Thaw at room temperature for 20-30 minutes." The box was unopened and not dated as to when it had been taken out of freezer storage and placed at room temperature.

An interview was conducted on 6/2/25 at 1:55 PM with the facility's Dietary Manager and Regional Director of Dietary Services. At that time, the findings of the Dietary Department's tour was shared. When asked about the bread products' instructions to be kept frozen, the Regional Director reported those instructions were correct and the bread products were supposed to be stored in the freezer.

4) During the initial tour conducted on 6/2/25 at 7:00 AM of the Dietary Department, Dietary Aide #1 was observed to have facial hair (beard) without using a beard restraint. The Dietary Aide was observed as he was preparing food and beverages for tray line service.

On 6/2/25 at 7:45 AM, Dietary Aide #1 was also observed to be working on the breakfast tray line without a beard restraint.

On 6/2/25 at 7:45 AM, the facility's Dietary Manager entered the kitchen. The Dietary Manager was observed to have long hair, a beard and mustache. The Dietary Manager was

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observed to put on a hairnet. However, the hairnet did not cover all his hair, and no beard restraint was used by the Dietary Manager.

An interview was conducted on 6/2/25 at 1:55 PM with the facility's Dietary Manager and Regional Director of Dietary Services. At that time, the findings of the Dietary Department's observations were shared. Upon inquiry, the Regional Director reported she would expect all hair to be covered by employees working in the Dietary Department. Additionally, she stated that all Dietary employees with facial hair were expected to wear a beard restraint.

Accompanied by the Regional Director of Dietary Services, an additional observation was conducted on 6/4/25 beginning at 11:47 AM as the lunch tray line began. On 6/4/25 at 12:12 PM, the Dietary Manager was observed as he assisted with the tray line. However, he was also observed to have his beard restraint down under his mouth, exposing his mustache. When the Regional Director of Dietary Services was asked what she thought about the positioning of the Dietary Manager's beard restraint, the Regional Director was observed as she reminded the Dietary Manager to pull his beard restraint up over the facial hair.

5) An initial observation made on 6/2/25 at 7:00 AM identified concerns with the cleanliness of equipment used within the Dietary Department. These included:
--The free-standing deep fat fryer was observed to have a dark brown grease build-up on the surfaces of 3 (of the 4) of its sides visible at the time of the observation.
--The visible side of the stove/oven was observed

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to have a dark brown grease build-up that was sticky to the touch.

An interview was conducted on 6/2/25 at 1:55 PM with the facility's Dietary Manager and Regional Director of Dietary Services. At that time, the findings of the Dietary Department's observations were shared. When asked, the Regional Director reported the equipment in the Dietary Department should be cleaned and any concerns identified during the observations should have been cleaned in accordance with the cleaning schedule and/or caught by the daily rounds of the department.

An interview was conducted on 6/5/25 at 11:16 AM with the facility's Administrator in the presence of the Regional Nurse Consultant. During the interview, the Administrator stated she had been informed of the results of the kitchen observations but requested a brief review of the concerns. The findings of the Dietary Department observations were reviewed with her. The Administrator stated she had no questions.