STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Living & Rehabilitation Center	**1624 Highland Drive , Washington, North Carolina, 27889**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/2/25 through 9/5/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D242E-H1.	E0000		09/15/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/2/25 though 9/5/25. Event ID#1D242E-H1. The following intakes were investigated 2607191, 831752 and 831751. 1 of the 7 complaint allegations resulted in deficiency.	F0000		09/15/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews with staff, pharmacy consultant, pharmacy accounts receivable clerk, and Medical Director, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 6 residents reviewed for medications (Resident #22). The findings included: A review of the facility's policy titled "Abuse and Neglect Protocol" dated 9/24/18 and last revised on 6/13/21 revealed in part "Misappropriation of resident property is defined as the deliberated misplacement,	F0602	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 06/22/2025, the Director of Nursing (DON) and a Licensed Nurse corrected the affected medication card and reconciled the count with the declining inventory sheet. On 06/22/2025, a Licensed Nurse completed and documented a pain assessment at the bedside; no unmanaged pain or withdrawal symptoms were identified. On 06/22/2025, a Licensed Nurse notified the attending practitioner and the resident's pain management plan was reviewed and remained appropriate. On 07/04/2025, the Licensed Practical Nurse associated with the incident was terminated. On 09/04/2025, the pharmacy corrected the billing to ensure the facility—not the resident's insurance—was charged for the missing medication (oxycodone $3.24 and buspirone $0.37). Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 06/22/2025, the DON and a Licensed Nurse counted all controlled-medication cards and inspected the backs of cards for integrity; no additional concerns were identified. On 06/22/2025, the DON reviewed 65	09/20/2025

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F0602 SS = D	Continued from page 1 exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent". Resident #22 was admitted to the facility on 4/30/24. A physician ordered dated 9/25/24 written by the Medical Director read Oxycodone (controlled pain medication used to treat moderate to severe pain) 5mg (milligram tablet). Take one tablet by mouth every 4 hours as needed. A physician ordered dated 9/25/24 written by the Medical Director revealed Buspirone (a medication used to treat anxiety) 5mg tablets. Give 1 tablet by mouth two times a day for mild neurocognitive disorder. This order was discontinued on 7/1/25. A delivery slip from the pharmacy dated 6/13/25 revealed 30 Oxycodone 5mg tablets were delivered to the facility on 6/13/25. A review of the Medication Administration Record (MAR) dated June 1, 2025-June 30,2025 revealed Nurse #8 was the last to sign off as administering the Oxycodone on 6/19/25 at 10:06 PM. Attempts to reach Nurse # 8 who last signed out the oxycodone were unsuccessful. The facility reported incident dated 6/23/25 revealed the Director of Nursing (DON) and Administrator were notified by Nurse #7 that the back of a controlled narcotic card had been taped. The reporting hall nurse observed that six pills in the card had been replaced with similar looking pills and taped closed. The resident did not miss any doses of the prescribed pain medication. Review of the facility reported investigation dated 6/30/25 and signed by the DON and Administrator read in part the facility did not substantiate abuse and or neglect. A telephone interview was conducted with Nurse #7 on 9/4/25 at 10:00 AM. She revealed Resident #22 called out for a pain pill on 6/22/25, when she went to get Resident #22's oxycodone card she noticed the size and shape of the pill did not look like an oxycodone. Nurse #7 then used her cellphone to look up the pill in the card and it was Buspirone. Nurse #7 then looked at the back of the narcotic card and noticed 7 oxycodone pills had been removed and replaced with Buspirone. There was a small incision in the foil like covering on the back	F0602	Continued from page 1 controlled-medication declining inventory sheets for suspicious or unusual documentation; no additional concerns were noted. On 06/23/2025, Licensed Nurses assessed all residents with controlled-medication orders for pain control/efficacy and receipt of medication; no pain-management concerns were identified. On 09/16/2025, the Licensed Nursing Home Administrator (LNHA) reviewed all reportables for misappropriation to ensure appropriate reimbursement of funds/goods occurred; no concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/15/2025, the LNHA/designee initiated a facility-wide education campaign on the Abuse Policy with emphasis on misappropriation of resident property (medications), Between 09/15/2025 and 09/19/2025, the Staff Development Coordinator (SDC) , LNHA, DON and SW conducted in-services and 1:1 make-ups on all shifts (day, evening, and night); sign-in sheets were maintained . Effective 09/19/2025, staff not yet educated were removed from the schedule and not permitted to work until education was completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will audit two medication carts three times weekly for four weeks, then weekly for four weeks, then monthly for three months, verifying that controlled-medication counts reconcile with declining inventory sheets and that the backs of medication cards show no holes, tape, or tampering. Discrepancies will be corrected immediately with re-education provided at the time of finding. Audits will occur on all shifts . The DON will present audit results and trends at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and determination of any further actions. Final completion date: 09/20/2025	

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F0602 SS = D	Continued from page 2 of the card covered up by tape. She then reported what she found to Nurse #5. She went on to say Resident #22 rarely asks for her Oxycodone medication and did not feel Resident #22 experienced pain due to this issue as it was an as needed medication and Resident #22 had plenty. Nurse #7 did say when she began this shift, she and Nurse #10 did complete a narcotic count and neither one of them noticed the pills were different or the tape on the back of the card. Nurse #7 added that typically a nurse would not look at the back of the narcotic card when counting. She did not remember what happened to the Buspirone that was diverted into the oxycodone card. Attempts to reach Nurse #10 who counted the narcotics with Nurse #7 were unsuccessful. An interview with Nurse #5 was conducted on 9/4/25 at 10:30 AM. She stated Nurse #7 called her on her mobile phone and she came to the facility. Nurse #7 told her the oxycodone had been replaced with Buspirone. She revealed Nurses were documenting that Resident #22 often refused her Buspirone, she did not know how many had been replaced. Resident #22 did have more Buspirone available to her in the medication cart. An interview with the DON was held on 9/4/25 at 11:10 AM. She revealed she did not remember who notified her of the incident. After notification she went to the facility and spoke with Nurse #7. Nurse #7 told her the Oxycodone had been replaced with Buspirone and taped closed with medical tape. The DON then reported it to the Administrator. Drug tests were administered to everyone that had worked on that medication cart. The DON also stated she did not feel the resident was ever in pain or had anxiety due to the pills being taken. She said Nurse #5 and herself wasted the 7 Buspirone pills. The DON notified the pharmacy about the missing Oxycodone and wasted Buspirone. A delivery slip from the pharmacy dated 6/28/25 revealed 7 oxycodone 5 mg tablets were delivered on 6/28/25. An interview was held with the Pharmacy Director on 9/4/25 at 11:20 AM. She stated she did not see any notes that the incident had been reported but did see on 6/28/25, 7 oxycodone pills were dispersed to the facility for Resident #22. She could not tell me who requested the pills or paid for them. An interview with the Pharmacy Accounts receivable clerk on 9/4/25 at 11:35 AM revealed on 6/28/25, 7 oxycodone pills were dispersed for Resident #22.	F0602		

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F0602 SS = D	Continued from page 3 Resident #22's insurance was billed and paid for the medication. There were no Buspirone ordered or sent out for Resident #22 in the month of June 2025. . An interview with Resident #22 was conducted on 9/4/25 at 11:50 AM, she was lying in bed in her room. She stated that if she was in pain she asks for pain medication, she also said when she asks for pain medication the nurses did give it to her. An interview was conducted with the Administrator on 9/4/25 at 2:00 PM. She stated she was notified by the DON and Nurse #5 of the missing pills. Local law enforcement was notified. She also stated the facility paid to replace the oxycodone. When asked, she stated she was not aware Resident #22's oxycodone was billed to and paid for by Resident #22's insurance. She also stated education, and systems had been put into place to keep the incident from recurring. The Administrator and DON completed the investigation including drug tests for Nurse #7 and Nurse #8 both of which were positive for Oxycodone. The facility did not substantiate abuse or neglect. An interview with the Medical Director was held on 9/5/25 at 8:00 AM. He stated he was made aware of the incident of drug diversion. He also stated he did not feel the resident was adversely affected by the drug diversion. A follow up interview with the Pharmacy Director on 9/5/25 at 10:30 AM revealed she vaguely remembered the situation but felt there was a conversation with someone at the facility around payment of the oxycodone and the billing of Resident #22's insurance was a pharmacy error as the facility should have been billed. A review of the email to the Administrator from the Pharmacy Director dated 9/4/25 at 2:35 PM, revealed the pharmacy reversed the charges to Resident #22's insurance and billed the facility.	F0602		
F0641 SS = D	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	F0641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Minimum Data Set (MDS) for Resident #74 was modified by an MDS Coordinator to correct the coding of the number of falls, and the modified assessment was submitted on 09/08/2025. Address how the facility will identify other residents	09/15/2025

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F0641 SS = D	Continued from page 4 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: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls. This was for 1 of 5 residents (Resident #74) reviewed for accidents. Findings included: Resident #74 was admitted to the facility on 2/20/2019. Resident #74's hospital record dated 7/19/25 revealed she was being seen after a fall from bed at the facility. She had a significant scalp laceration which measured 15 centimeters in length. Her laceration was repaired using 7 staples and 9 sutures (stiches). Resident #74's annual MDS assessment dated 7/25/25 revealed she had one fall with no injury and one fall with injury since her prior MDS assessment. Resident #74's medical record revealed no other falls since her prior MDS assessment dated 5/15/25.	F0641	Continued from page 4 having the potential to be affected by the same deficient practice. MDS Coordinators conducted a 60-day lookback audit of all submitted MDS assessments to verify the coding of falls. Six assessments were found to be coded incorrectly; modifications were completed and submitted by the MDS Coordinators on 09/09/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. MDS Coordinators were educated on coding Sections J1800 and J1900, as outlined in the Resident Assessment Instrument (RAI) Manual, by the Regional Director of Clinical Reimbursement on 09/15/2025. All newly hired MDS coordinators will be trained by the Regional Director of Clinical Reimbursement during the orientation period . Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. MDS Coordinators will audit 10 completed MDS assessments (Sections J1800 and J1900) weekly for four weeks, then five completed MDS assessments weekly for four additional weeks. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the MDS coordinators and further actions will be determined as needed. Completion Date: 09/15/2025	

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F0641 SS = D	Continued from page 5 On 09/05/2025 at 8:03 AM an interview with MDS Nurse #1 indicated she coded the falls section of Resident #74's MDS assessment dated 7/25/25. She reported on 7/19/25 Resident #74 had one fall with injury. She stated her coding on Resident #74's MDS assessment dated 7/25/25 that Resident #74 also had one fall with no injury was an error. MDS Nurse #1 stated when she reviewed Resident #74's incident reports prior to coding her 7/25/25 MDS assessment, there was one for a fall dated 7/12/24 directly above the one for her fall with injury on 7/19/25, and she looked at the date wrong. On 9/5/25 at 2:37 PM an interview with the Director of Nursing indicated that resident's MDS assessments should be coded accurately. On 9/5/25 at 2:55 PM an interview with the Administrator indicated MDS assessments should be accurately coded.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for Resident #5 was corrected on 09/04/2025 to accurately reflect the need for bilateral bed-attached grab bars. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of the care plans for all residents with grab bars was completed on 09/12/2025 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers. Six resident care plans were updated on 09/12/2025 to reflect the correct use of grab bars. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Minimum Data Set (MDS) Coordinators were educated on care-plan completion consistent with the Resident Assessment Instrument (RAI) Manual on 09/15/2025 by the Regional Director of Clinical Reimbursement. Indicate how the facility plans to monitor its	09/16/2025

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F0656 SS = D	Continued from page 6 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of side rails for 1 of 2 residents reviewed for side rails (Resident #5). Findings included: 1.Resident #5 was admitted to the facility on 8/24/24 with diagnoses that included chronic kidney disease stage 5 and generalized muscle weakness. Review of Resident #5's electronic record revealed an assessment titled bed rail/assist device dated 8/24/24 and completed by Nurse #9 that indicated Resident #5 did not need or use side rails. A care plan with the latest review date of 9/9/24 revealed no reference to use of side rails for Resident #5. A quarterly Minimum Data Set Assessment (MDS) dated 6/22/25 revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 required partial to moderate assistance with bed mobility, substantial/maximal assistance with lying to sitting on	F0656	Continued from page 6 performance to make sure that solutions are sustained. MDS Coordinators will audit five residents with grab bars twice weekly for four weeks, then five residents weekly for four additional weeks to ensure the care plan accurately reflects grab-bar use. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the MDS coordinators. Completion date: 09/16/2025	

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F0656 SS = D	Continued from page 7 the side of the bed and was non-ambulatory. The MDS revealed Resident #5 had no impairment to her upper or lower extremities. The MDS indicated Resident #5's siderails were not used as a restraint. An observation and interview were conducted on 9/3/25 at 3:56 PM. Resident #5 was observed lying in bed with bilateral grab bars in the up position on the bed. Resident #5 indicated she used the grab bars to help her roll over in bed during care. The grab bars were approximately 12 inches x 12 inches square. An interview with MDS Nurse #2 was conducted on 9/3/25 at 4:19 PM. MDS Nurse #2 stated she was responsible for updating care plans with information she received from the nursing assessments or verbal directive given to her by nursing. In an interview with the Director of Nursing (DON) on 9/5/25 at 10:08 AM she stated the MDS Nurse was responsible for updating the care plan to include side rail usage. In an interview with the Administrator on 9/5/25 at 10:10 AM she stated side rail usage should be included in the resident's care plan.	F0656		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident, staff and physician interviews, the facility failed to provide care in a safe manner when Resident #74 a) rolled out of bed during care sustaining a left front scalp hematoma (an injury with swelling caused by blood pooling under the skin) requiring evaluation in the	F0689	"Past Noncompliance - no plan of correction required"	09/15/2025

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F0689 SS = G	Continued from page 8 emergency room and b) rolled out of bed during care sustaining a 15 centimeter scalp laceration (cut) requiring evaluation in the emergency room and wound closure with 9 sutures (stiches) and 7 staples. This was for 1 of 5 residents reviewed for accidents (Resident #74). Findings included: 1a. Resident #74 was admitted to the facility on 2/20/2019 with a diagnosis of muscle weakness. Resident #74's physician's orders revealed she was not receiving any anti-coagulant (blood thinning) medication. A nursing progress note for Resident #74 dated 7/12/24 at 12:30 PM written by Nurse #2 revealed he had been called to Resident #74's room. Resident #74 was on the floor with a bump on her head. Resident #74 told Nurse #2 she fell out of bed stating, "I just kept rolling". Nurse Aide (NA) #2 reported that while she was providing care to Resident #74, Resident #74 rolled off the bed. Resident #74 was sent to the hospital. On 9/5/25 at 12:29 PM a telephone interview with Nurse #2 indicated he was caring for Resident #74 on 7/12/24 on the 7AM-3PM shift. He stated NA #2 reported to him she had been assisting Resident #74 with her bath that morning, had rolled Resident #74 away from herself when providing the care and Resident #74 kept rolling off her bed. Nurse #2 stated when he entered Resident #74's room, he observed Resident #74 on her back on the floor beside her bed. He reported the bed was elevated about 2 feet off the floor. He indicated Resident #74 had not been complaining of pain but had a "knot" on the side of her head. He stated Resident #74 had been sent to the hospital for an evaluation. The hospital Emergency Room record for Resident #74 dated 7/12/24 revealed she was being evaluated after a fall in the facility. She had no open wound. She was complaining of right arm pain and a headache. She had a left frontal scalp hematoma with no fractures or brain bleeding. A "Teachable Moment" statement dated 7/12/24 signed by NA #2 revealed the issue was Resident #74 rolled off her bed when NA #2 was bathing her. NA #2 was instructed post-incident to roll residents towards herself when providing care or to obtain the assistance of a second person when providing care. NA #2 no longer worked at the facility. She was not	F0689		

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F0689 SS = G	Continued from page 9 available for interview. Resident #74's current comprehensive care plan revealed a focus area for Activities of Daily Living (ADL) care. The goal was for Resident #74 to allow care to be provided through the next review. An intervention dated last revised on 7/12/24 was Resident #74 preferred bed baths and required total assistance of 2 staff for this. Resident #74's quarterly Minimum Data Set (MDS) assessment dated 7/19/24 revealed she was severely cognitively impaired. She had no behaviors or rejection of care. She had functional limitation in range of motion on one side of her upper extremities, and both sides of her lower extremities. She was dependent to roll left to right in bed and for bathing. Resident #74 had no pain in the last 5 days. She had one fall with injury since her last MDS assessment. In an interview on 9/2/25 at 3:13 PM Resident #74 stated she did recall falling once and hurting her left side. She reported she did not recall what happened. She indicated that she felt safe during care. On 9/5/25 at 9:06 AM in an interview the Director of Nursing stated she did not recall much about Resident #74's fall on 7/12/24. She reported she did recall doing some audits and updating resident's care guides. On 9/5/25 at 11:14 AM in an interview the Administrator stated she participated in the investigation and the corrective action plan for Resident #74's fall from bed on 7/12/24. She reported NA #2 had rolled Resident #74 away from herself instead of towards herself and turned to grab a towel. She stated Resident #74 slid off the side of the bed. The Administrator reported at the time of the incident on 7/12/24 Resident #74's assessed level of bed mobility was one person dependent assistance. She stated this was updated to 2 person dependent assistance after the incident. She went on to say Resident #74 should not have experienced a fall during the provision of care. On 9/5/25 at 12:17 PM a telephone interview with the Medical Director indicated Resident #74 should not have experienced a fall during the provision of care. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	F0689		

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F0689 SS = G	Continued from page 10 On 07/12/2024, during Activities of Daily Living (ADLs) care, Nursing Assistant (NA) #2 turned the Resident #74 away from her; when NA #2 turned to grab a towel, the resident slid off the side of the bed. On 07/12/2024 Nurse #2 assessed the resident post-fall; edema to the forehead was noted. Nurse #3 notified the physician, obtained an order for Emergency Department (ED) evaluation, and the resident was sent to the ED. The Responsible Party (RP) was notified by nursing staff. The Director of Nursing (DON) completed immediate 1:1 education with NA #2 on proper bed-mobility and transfer technique, including log-rolling the resident toward the caregiver and proper repositioning techniques. The DON validated NA #2's competency to provide assistance with bed mobility using proper technique. The unit manager updated the electronic plan of care with the intervention: two-person assist for bed mobility, and reinforced use of proper technique during bed mobility and transfers. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who require assistance with bed mobility are at risk. On 07/12/2024 the DON/Assistant DON (ADON)/unit manager audited all residents' electronic plans of care to confirm that bed-mobility and transfer instructions emphasized proper technique. Audit results: 8 care plans were updated to ensure they reflected the appropriate level of care and emphasized proper technique for bed mobility and transfers. On 7/12/24 the administrator (or clinical designee) audited all incident reports for the prior 30 days for falls from bed; no additional concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 7/12/24 the DON initiated education for all staff nurses and Certified Nursing Assistants (CNAs) together on bed mobility and transfers, with emphasis on log-rolling toward the caregiver and proper repositioning techniques; competency validation was performed. No staff were permitted to work after	F0689		

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F0689 SS = G	Continued from page 11 07/12/2024 without completing the education. On 7/12/24 the DON added this content to orientation for newly hired staff to be completed prior to assignment. Education/competency specifics: All staff nurses and CNAs completed the education by 07/12/2024; competency validations were completed 07/12/2024 and directly observed: %Ë Correctly accessing/reading the electronic plan of care to verify technique requirements for bed mobility and transfers %Ë Performing log-rolling toward the caregiver and proper repositioning techniques %Ë Safe technique/body mechanics during bed mobility/repositioning %Ë Clear handoff/communication of the resident's current technique requirements Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON/ADON or designee will observe 10 bed-mobility/repositioning occurrences per week for 4 weeks, then 5 per week for 4 additional weeks, to verify that proper technique is used in alignment with the electronic plan of care, including residents requiring two-person assist. The decision to observe occurrences of bed mobility on all shifts was made on 7-12-24. The DON and/or administrator will review observation/audit results to identify trends and adjust the plan as needed to sustain compliance. Findings will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI); continued audits will occur at the discretion of the QAPI committee. The facility's corrective action plan was validated on 9/5/25. This validation included a reviews of the facility's initial audits, the facility's in-service education record and sign in sheets titled "Bed Mobility and Transfers" which including the educational materials for log rolling residents and repositioning,	F0689		

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F0689 SS = G	Continued from page 12 the facility's orientation competency checklist for which included repositioning and log rolling technique, checking the resident's care plan and communication system to determine the resident's specific needs and the number of staff required to complete the procedure, the facility's follow up audits and QAPI, interviews with Nurses and NAs regarding education and knowledge of repositioning and log rolling technique, checking the resident's care plan and communication system to determine the resident's specific needs daily and the number of staff required to complete the procedure and observations of NA's using the log rolling technique to turn resident's towards themselves when providing care with 1 person assistance. b) Resident #74's current comprehensive care plan revealed a focus area for Activities of Daily Living (ADL) care. The goal was for Resident #74 to allow care to be provided through the next review. An intervention dated last revised on 7/12/24 was bed mobility total dependence on 2 staff. Resident #74's physician's orders revealed she was not receiving any anti-coagulant (blood thinning) medication. Resident #74's quarterly Minimum Data Set (MDS) assessment dated 5/15/25 revealed she was severely cognitively impaired. She had no behaviors or rejection of care. She was dependent for toileting hygiene and for rolling left to right in bed. She was always incontinent of bowel and bladder. She had no falls since the prior assessment. A Nursing Progress note for Resident #74 dated 7/19/25 at 7:27 PM written by Nurse #1 revealed Nurse #1 was called to Resident #74's room by Nurse Aide (NA) #1. Resident #74 was lying on the floor, with a large area on her forehead that was opened wide, and an area on the back of her head which was bleeding. She was sent to the hospital. On 9/3/25 at 5:35 PM an interview with NA #1 indicated when she went in to provide incontinence care to Resident #74 on 7/19/25 on the 3PM-11PM shift, she had not asked anyone for help. She reported she had not seen anyone in the hall to ask. She stated although she had known how to and could access resident's care plans and Kardex since coming back to work at the facility in December of 2024, she had not checked Resident #74's prior to providing care to her. She indicated she did not know why. She stated Resident #74 had a large bowel movement and she wanted to get her cleaned up right away. NA #1 stated she pulled Resident #74 closer to	F0689		

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F0689 SS = G	Continued from page 13 herself using the draw sheet and when she went to turn Resident #74 to remove Resident #74's incontinence brief, Resident #74 rolled off the bed onto the floor. NA #1 stated that she could see that Resident #74 had a cut on the right side of her forehead and there was a lot of blood. She stated Resident #74 was quiet and she kept apologizing to Resident #74. NA #1 reported she called for the nurse, the nurse came and cleaned and bandaged Resident #74's wound. NA #1 stated she felt if she had asked someone to assist her with providing care to Resident #74 on 7/19/25, someone would have helped her. In a follow up interview with NA #1 on 09/04/2025 at 3:33 PM she indicated she and NA #3 usually worked together on the 3PM-11PM shift providing care to Resident #74, but on 7/19/25 NA #3 had been late coming to work. On 9/3/25 at 5:19 PM a telephone interview with Nurse #1 indicated she was in the hallway near Resident #74's room on 7/19/24 when NA #1 came out to say she needed help. Nurse #1 stated when she entered Resident #74's room she observed Resident #74 lying on the floor on her back. She indicated Resident #74's bed was elevated about 3 feet from the floor. She reported Resident #74 had a large "gash" on her forehead which was bleeding. She stated she could also see there was blood coming from the back of Resident #74's head. Nurse #1 indicated Resident #74 was complaining of pain to the right side of her body. She reported Resident #74 was sent to the hospital for an evaluation. She indicated she was familiar with Resident #74, and at the time of her fall on 7/19/25, 2 person assistance with bed mobility was listed on her Kardex which is the care guide NAs had access to. She stated when she asked NA #1 why she had not used a second person to provide care to Resident #74, NA #1 told her Resident #74 had a large bowel movement, and she wanted to get her cleaned up right away. Nurse #1 reported NA #1 had not asked her for help with providing care to Resident #74, or she would have assisted her. Resident #74's hospital record dated 7/19/25 revealed she was being seen after a fall from bed at the facility. She was unable to provide any history other than that she fell, and her head went "boom". She had a significant scalp laceration which measured 15 centimeters in length. She was complaining of pain in her head. Her laceration was repaired using 7 staples and 9 sutures (stiches). She had no fractures or brain bleeding. She returned to the facility on 7/19/25. In an interview on 9/2/25 at 3:13 PM Resident #74 stated she did recall falling once and hurting her left side. She reported she did not recall what happened.	F0689		

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F0689 SS = G	Continued from page 14 She indicated that she felt safe during care. On 9/3/25 at 4:09 PM an observation of incontinence care was conducted for Resident #74 with NA #1 and NA #4. Both NAs confirmed access to Resident #74's Kardex and her need for 2 person assistance with bed mobility and ADL care prior to the provision of this care. On 9/5/25 at 7:55 AM an interview with the Medical Director indicated Resident #74 should have been provided with the appropriate level of staff assistance in accordance with her assessed need and her plan of care. He stated she should not have experienced a fall during the provision of care. He reported Resident #74's laceration had healed well, and she had not suffered any lasting harm from the incident. On 9/4/25 at 2:44 PM an interview with the Administrator indicated on 7/19/25, NA #1 was providing incontinence care to Resident #74 by herself. She reported this would not have been in accordance with Resident #74's plan of care or the information NA #1 would have had access to on Resident #74's Kardex at the time. The Administrator indicated although there were other staff available, NA #1 had not asked anyone else to assist her. She stated as a result, Resident #74 had experienced a fall from bed. She reported she felt if NA #1 had used the level of assistance indicated on Resident #74's Kardex, this fall could have been avoided. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 7/19/25 Resident #74 fell during staff-assisted repositioning; Nurse Aide (NA) #1 did not ensure the required level of assistance per Kardex. On 07/19/2025, a licensed nurse (Nurse #1) assessed the resident post-fall for injury; a laceration from the top of the head extending to the back of the head was noted. On 07/19/2025, the practitioner/MD was notified by the licensed nurse, and the resident was sent to the Emergency Department (ED) for treatment. On 07/19/2025, the responsible party was notified by the licensed nurse.	F0689		

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F0689 SS = G	Continued from page 15 On 07/19/2025, the involved Nursing Aide (NA #1) was re-educated by the unit manager on the resident's bed-mobility status and appropriate electronic plan of care use; the unit manager completed skill validation with the NA on safe assistance with bed mobility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who require two-person assistance with repositioning are at risk of being affected. On 07/20/2025, the unit manager/designee audited all residents' electronic plan of care entries to ensure the correct level of staff assistance was noted. Twenty-five Kardex's were updated by the MDS nurse on 7/21/2025 to reflect appropriate bed-mobility required assistance. The administrator reviewed risk reports involving staff assist with bed mobility for the prior three months; no other incidents were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 07/19/2025, Administrator, Director of Nursing, and Unit Managers conducted targeted education for staff on (a) confirming Activities of Daily Living (ADL) status and required assistance in the electronic plan of care before providing care and (b) using the correct number of staff for bed mobility/repositioning per electronic plan of care. All direct-care staff completed education by 07/22/2025. 26 licensed nurses and 62 NAs were educated, as verified by signed attendance logs. No staff were permitted to work after 07/22/2025 without completing the education. Staff returning from leave/orientation are required to complete the same education prior to receiving an assignment. The facility completed competency validation for all licensed nurses and NAs. Competencies directly observed: %ï Correctly accessing and reading the electronic plan of care to verify ADL status and assistance level. %ï Selecting and using the correct number of staff for all ADL care and in-bed repositioning per electronic plan of care.	F0689		

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F0689 SS = G	Continued from page 16 %Ï Safe technique and body mechanics during bed mobility/repositioning. %Ï Clear handoff/communication that reinforces the resident's current assist level. Education for newly hired NAs (and licensed nurses, as applicable) will be provided by the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/nurse manager or charge nurse upon hire and prior to receiving an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON/ADON or designee will observe 5 occurrences of bed-mobility/repositioning weekly for 8 weeks to verify that the method used matches the electronic plan of care. These observations will include residents requiring two-person assist. The decision to observe occurrences of bed mobility on all shifts was made on 7-19-25. The DON and/or Administrator will review audits/observations to identify patterns/trends and will adjust the plan as necessary for continued compliance. The DON and/or Administrator will review the plan and findings during monthly Quality Assurance and Performance Improvement (QAPI); continued audits will occur at the discretion of the QAPI committee. Completion date 7/23/25 The facility's corrective action plan was validated on 9/5/25. This validation included a reviews of the facility's initial audits, the facility's in-service education record and sign in sheet titled "Accessing Kardex/ADL Status/Assist Required", the facility's orientation competency checklist for which included repositioning and log rolling technique, checking the resident's care plan and communication system daily to determine the resident's specific needs and the number of staff required to complete the procedure, the facility's follow up audits and QAPI, interviews with Nurses and NAs regarding education and knowledge of checking the resident's care plan and communication system daily to determine the resident's specific needs and the number of staff required to complete the procedure and observations of NA's accessing resident's Kardex and the provision of care with the number of staff and level of assistance specified.	F0689		

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F0689 SS = G	Continued from page 17 The facility's completion date of 7/23/25 for the corrective action plan was validated.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff and Medical Director interviews, the facility failed to maintain the sterility of tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) care when Nurse #4 failed to perform hand hygiene and don (put on) sterile gloves after touching and disposing of a soiled split gauze pad and inner cannula and before placing the new sterile inner cannula and clean split gauze as well as donning sterile gloves over soiled gloves prior to suctioning. This was for 1 of 1 resident reviewed for tracheostomy care (Resident #9). Findings included: Resident #9 was admitted to the facility on 8/6/2018 with diagnoses that included persistive vegetative state and tracheostomy status. Resident #9's care plan last revised on 7/12/24 revealed him to have a tracheostomy. Resident #9's Annual Minimum Data Set (MDS) Assessment dated 6/8/25 revealed he was unable to be assessed for cognition due to comatose state. He was documented to receive tracheostomy care in the facility. A continuous observation of tracheostomy care was observed on 9/3/25 at 11:53 AM with Nurse #4. At 11:53 AM she performed hand hygiene and donned clean gloves	F0695	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 09/03/2025, the involved Licensed Nurse was educated on proper tracheostomy care procedure by the Director of Nursing (DON). On 09/15/2025, the DON directly observed tracheostomy care and suctioning for the affected resident during the next scheduled procedure; care was performed according to policy. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 09/15/2025, the DON observed tracheostomy care and suctioning for all residents requiring this procedure; care was performed according to policy and no additional deficits were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/15/2025, all Licensed Nurses were educated on tracheostomy care and suctioning. As of 09/19/2025, absent or newly hired staff will be educated by the DON or designee prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will audit tracheostomy care and suctioning for all residents requiring this procedure twice weekly on all shifts for four weeks and then weekly for four additional weeks. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the DON. Completion Date: 09/20/2025	09/23/2025

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F0695 SS = D	Continued from page 18 retrieved from her pocket. She poured normal saline onto clean gauze. Nurse #4 then removed the trach cap (sits on the end of the inner cannula) and soiled gauze from behind the tracheostomy flange, picked up clean gauze soaked with normal saline and cleaned around the stoma site behind the tracheostomy flange. Nurse #4 proceeded to change the tracheostomy tie that holds the flange in place and replaced the split gauze that sits behind the flange with a clean split gauze. Next, Nurse #4 removed the soiled inner cannula and inserted the sterile inner cannula. Nurse #4 then removed her gloves and washed her hands to prepare to suction Resident #9. Nurse #4 donned clean gloves taken from her pocket, opened a new container of normal saline, dated the bottle and poured some into a sterile cup. She then put the main suction tube under the resident's blanket at his chest and donned sterile gloves over the gloves she was already wearing. Nurse #4 then opened the sterile suction tubing, attached it to the main tubing that had been under the blanket and suctioned the resident. When finished, Nurse #4 removed both pairs of gloves, threw away the trash and washed her hands. In an interview with Nurse #4 on 9/3/25 at 12:18 PM she stated she should have removed the cap, soiled inner cannula and soiled split gauze, performed hand hygiene, donned sterile gloves and then handled the sterile inner cannula and clean split gauze. In an interview with the Director of Nursing (DON) on 9/3/25 at 12:25 PM, she stated Nurse #4 should have performed all tasks involving soiled items such as removing the used split gauze and used inner cannula and performed hand hygiene and donned sterile gloves before touching the sterile inner cannula and placing the clean gauze behind the flange. The DON indicated Nurse #4 should have removed her soiled gloves, performed hand hygiene and then donned sterile gloves before suctioning. An interview was conducted with the Administrator on 9/3/25 at 2:05 PM. She indicated Nurse #4 should not have touched the sterile inner cannula and clean gauze without performing hand hygiene and donning sterile gloves first. She stated bacteria could have been transferred from the soiled gloves to the sterile cannula and then to Resident #9's respiratory system potentially causing a respiratory infection. She further stated putting sterile gloves over soiled gloves was not acceptable.	F0695		

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F0695 SS = D	Continued from page 19 In an interview with the Infection Preventionist (IP) on 9/5/25 at 9:17 AM she stated that Nurse #4 should have removed the soiled gauze and soiled inner cannula, discarded them, performed hand hygiene and then donned sterile gloves before handling the sterile inner cannula and clean split gauze. The IP indicated keeping the procedure as sterile as possible was important to prevent the spread of bacteria to Resident #9's respiratory system. In an interview with the Medical Director on 9/5/25 at 8:05 AM he stated the respiratory tract was not a sterile space and he did not feel Nurse #4 put Resident #9 at risk by not following professional standards of practice and infection prevention measures.	F0695		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing siderails, complete siderail	F0700	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #4 was hospitalized on 09/13/2025 and remains hospitalized; no bed-attached grab bars are in use at the facility for this resident. Upon return to the facility, Resident #4 will not use bed-attached grab bars until Nursing completes the Bed Rail Assessment and Device Decision Tree (including the nursing entrapment-risk evaluation), a therapy screen for alternatives is completed, informed consent is obtained, and the physician order and care plan are updated prior to any installation. Resident #5 was reassessed and grab bars were removed on 09/19/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing (DON), Unit Managers, and a Registered Nurse completed a house-wide assessment using the Bed Rail Assessment and Device Decision Tree. Residents with an indicated need for side rails or grab bars were referred to Therapy between 09/16/2025 and 09/19/2025 for recommendations on alternatives and positioning plans. Sixty residents had bed-attached grab bars removed based on assessment findings. For all residents requiring grab bars, Nursing completed the Bedrail assessment and decision tree (including the nursing entrapment-risk evaluation), Informed consent was obtained, and physician orders and care plans were updated to reflect device use and safety precautions. Address what measures will be put into place or systemic changes made to ensure that the deficient	09/20/2025

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F0700 SS = D	Continued from page 20 assessments, assess entrapment risk, review the risks and benefits of siderails with the resident /resident representative and obtain informed consent prior to siderail use for 2 of 2 residents reviewed for siderails (Resident #5, Resident #4). Findings included: 1. Resident #5 was admitted to the facility on 8/24/24 with diagnoses that included chronic kidney disease stage 5 and generalized muscle weakness. Review of Resident #5's information face sheet revealed she was her own Responsible Party. Review of Resident #5's electronic medical record revealed an assessment titled bed rail/assist device dated 8/24/24 and completed by Nurse #9. The response to the question, "Bed rails/assist devices are indicated for the resident at this time?" was no. In an interview with Nurse #9 on 9/5/25 at 10:29 AM he stated he completed the assessment in Resident #5's room on 8/24/24. Nurse #9 indicated the grab bars were on the bed when he completed Resident #5's bed rail/device assessment. Nurse #9 further stated he was unaware grab bars were considered side rails. He did not try alternatives to grab bars, did not assess for entrapment risk or review risks and benefits or obtain consent for grab bars from Resident #5. A care plan with the latest review date of 9/9/24 revealed no reference to use of grab bars for Resident #5. A quarterly Minimum Data Set (MDS) assessment dated 6/22/25 revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 required partial to moderate assistance with bed mobility, substantial/maximal assistance with lying to sitting on the side of the bed and was non-ambulatory. The MDS further revealed Resident #5 had no impairment to her upper or lower extremities. The MDS indicated Resident #5's grab bars were not used as a restraint. An observation and interview were conducted on 9/3/25 at 3:56 PM. Resident #5 was observed lying in bed with	F0700	Continued from page 20 practice will not recur. All Licensed Nurses were educated on the facility Bed-Rail/Grab-Bar policy on 09/15/2025 by the Director of Nursing (DON), including requirements to attempt alternatives, complete the Bed Rail Assessment and Device Decision Tree (nursing entrapment-risk evaluation), obtain informed consent prior to installation, secure a physician order, and update the care plan the same day. Staff hired after 09/19/2025 will receive this education during orientation prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will audit five residents with bed-attached grab bars weekly for eight weeks, then monthly for four months, verifying that the Bed Rail Assessment and Device Decision Tree is completed by Nursing, alternatives were evaluated, informed consent is on file, and physician orders and care plans are aligned with actual device use. Any variance will be corrected on the same day with staff re-education as indicated. The DON will bring the findings to the monthly Quality Assurance and Performance Improvement (QAPI) meeting . Final Completion Date: 09/20/2025 REJECTION RESPONSE	

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F0700 SS = D	Continued from page 21 bilateral grab bars in the up position on the bed. Resident #5 indicated she used the grab bars to help her roll over in bed during care. The grab bars were approximately 12 inches x 12 inches square. In an interview with Nurse Aide (NA) #3 on 9/3/25 at 4:01 PM she indicated Resident #5 utilized the bilateral grab bars to assist with turning and repositioning. In an interview with the Unit Manager (UM) #1 on 9/3/25 at 4:15 PM, she indicated the admitting nurse completed the initial bed rail/assist device assessment and MDS completes a new one after that if needed. UM #1 stated they did not try alternatives before using side rails/grab bars and the assessment for entrapment was included in the bed rail/assist device assessment. UM #1 further stated the bed rail/assist device assessment had a place at the bottom for the nurse to sign that they reviewed the risks and benefits of grab bar usage with the resident or the resident representative. UM #1 revealed grab bars are kept on the beds between admissions but are strapped down with zip ties until it was determined if the resident needed them or not. UM #1 was unaware that Resident #5 had bilateral grab bars on her bed. A follow-up observation was conducted on 9/4/25 at 2:49 PM. Resident #5 was lying in bed with both grab bars raised. In an interview with the Director of Nursing (DON) on 9/5/25 at 10:08 AM she stated the admissions nurse completed the first bed rail/assist device assessment and MDS completed one quarterly and as needed, such as if therapy recommends grab bars or the resident or resident representative requests grab bars. The DON further stated entrapment risk was included in the bed rail assessment and the nurse reviews risks and benefits with the resident on the resident's family on a separate paper consent form. The DON indicated she was unaware that alternatives to grab bars needed to be tried and documented before using them and was also unaware that Resident #5 had bilateral grab bars on her bed. The DON revealed grab bars were left on the beds between admissions, but they are supposed to be zip tied down until it was decided if the resident needed them or not.	F0700		

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F0700 SS = D	Continued from page 22 An observation was conducted with the DON on 9/5/25 at 12:14 PM to locate the form that reviewed risks and benefits and gained consent for grab bars in the hard chart. The DON was unable to locate a consent form for the use of grab bars. In an interview with the Administrator on 9/5/25 at 10:10 AM she stated she was unaware alternatives to grab bars needed to be tried before they were used and was unaware grab bars were considered side rails. The Administrator indicated the paper consent form that reviews risks and benefits was probably kept in the hard charts behind the nurse's station. 2. Resident #4 was admitted to the facility on 6/23/25 with diagnoses that included diabetes mellitus Type II and generalized muscle weakness. Review of Resident #4's care plan last revised 7/11/24 revealed an intervention of a right sided grab bar x 1 (side rail)/assist device to allow increased mobility, aid in repositioning and/or transfers. A review of Resident #4's electronic record revealed an assessment titled bed rail/assist device dated 6/23/25 and completed by Nurse #6 indicated Resident #4 did not need or use grab bars. The response to the question, "Bed rails/assist devices are indicated for the resident at this time?" was no. An interview with Nurse #6 was completed on 9/4/25 at 3:09 PM. Nurse #6 indicated she completed the bed rail/assist device assessment for Resident #4 on her most recent admission. Nurse #6 stated completed the assessment in Resident #4's room and she marked Resident #4 as not using or needing side rails as Resident #4 had what the facility called grab bars on her bed. She further stated alternatives to grab bars were not tried before a resident used them. Nurse #6 did not assess for entrapment risk or review risks and benefits and obtain consent for grab bars from Resident #4's Responsible Party as she was unaware grab bars were considered side rails. Review of Resident #4's quarterly Minimum Data Set Assessment (MDS) dated 6/29/25 revealed she was severely cognitively impaired. The MDS indicated Resident #4 required partial to moderate assistance	F0700		

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F0700 SS = D	Continued from page 23 with bed mobility, was dependent on staff for lying to sitting on the side of the bed and was non-ambulatory. The MDS revealed Resident #4 had impairment to both her upper and lower extremities. The MDS indicated Resident #4's grab bars were not used as a restraint. An observation of Resident #4 was conducted on 9/3/25 at 3:56 PM. Resident #4 was observed lying in bed with bilateral grab bars in the raised position. The grab bars were metal and approximately 6 inches wide and 18 inches tall. A follow-up observation was conducted on 9/4/25 at 2:48 PM. Resident #4 was observed lying in bed with bilateral grab bars in the raised position. Resident #4's Responsible Party was not available for interview. In an interview with Nurse Aide (NA) #3 on 9/4/25 at 2:52 PM she indicated Resident #4 used bilateral grab bars to help turn and reposition during care. In an interview with the Unit Manager (UM #1) on 9/3/25 at 4:15 PM, she indicated the admitting nurse completed the initial bed rail/assist device assessment and MDS completes a new one after that if needed. UM #1 stated they did not try alternatives before using grab bars and the assessment for entrapment was included in the bed rail/assist device assessment. UM #1 further stated the bed rail/assist device assessment had a place at the bottom for the nurse to sign that they reviewed the risks and benefits of grab bar usage with the resident or the resident representative. UM #1 revealed grab bars are kept on the beds between admissions but are strapped down with zip ties until it was determined if the resident needed them or not. UM #1 was unaware that Resident #4 had bilateral grab bars on her bed. In an interview with the Director of Nursing (DON) on 9/5/25 at 10:08 AM she stated the admissions nurse completed the first bed rail/assist device assessment and MDS completed one quarterly and as needed, such as if therapy recommends grab bars or the resident or resident representative requests grab bars. The DON further stated entrapment risk was included in the bed rail assessment and the nurse reviews risks and benefits with the resident on the resident's family on a separate paper consent form. The DON indicated she	F0700		

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F0700 SS = D	Continued from page 24 was unaware that alternatives to grab bars needed to be tried and documented before using them and was also unaware that Resident #4 had bilateral grab bars on her bed. The DON revealed grab bars were left on the beds between admissions, but they are supposed to be zip tied down until it was decided if the resident needed them or not. An observation was conducted with the DON on 9/5/25 at 12:14 PM to locate the form that reviewed risks and benefits and gained consent for grab bars in the hard chart. The DON was unable to locate a consent form for the use of grab bars. In an interview with the Administrator on 9/5/25 at 10:10 AM she stated she was unaware alternatives to grab bars needed to be tried before they were used and was unaware grab bars were considered side rails. The Administrator indicated the paper consent form that reviews risks and benefits was probably kept in the hard charts behind the nurse's station.	F0700		
F0880 SS = D	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	F0880	On 09/03/2025, the involved Licensed Nurse was educated on Enhanced Barrier Precautions (EBP) by the Director of Nursing (DON). Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 09/15/2025, the Infection Preventionist (IP) completed an audit of all residents to review the need for EBP; no new residents were identified to require EBP. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/15/2025, all nursing staff were educated on the EBP policy, including indications for EBP, personal protective equipment (PPE) requirements, examples of high-contact resident care, and recognition of EBP doorway signage; education was provided by the DON and IP. As of 09/19/2025, absent or newly hired staff will be educated by the DON or designee prior to accepting an assignment.	09/23/2025

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F0880 SS = D	Continued from page 25 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 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 observation, record review, staff and Medical	F0880	Continued from page 25 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will observe high-contact resident care for five residents on EBP each week for eight weeks to verify that required PPE is used. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the DON. Completion Date: 09/20/2025	

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F0880 SS = D	Continued from page 26 Director interviews, the facility failed to follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) when Nurse #4 provided tracheostomy care without wearing a gown. This was for 1 of 12 staff observed for infection control practices (Nurse #4). Findings included: The facility policy titled Enhanced Barrier Precautions (EBP) dated 4/24/24 stated in part: EBP's are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Gloves and gowns are applied prior to performing high-contact resident care activities such as tracheostomy care. Observation of Resident #9's door on 9/3/25 at 11:53 AM revealed signage for EBP. The signage indicated that staff providing high contact care to Resident #9 were required to wear gowns and gloves. Further observation revealed a caddy hanging Resident #9's door that contained Personal Protective Equipment (PPE) including gowns and gloves. A continuous observation of tracheostomy care was observed on 9/3/25 at 11:53 AM with Nurse #4. At 11:53 AM she performed hand hygiene and donned clean gloves retrieved from her pocket. Nurse #4 did not don a gown. She proceeded to provide tracheostomy care and suctioning to the resident. In an interview with Nurse #4 on 9/3/25 at 12:18 PM she stated she never wore a gown while performing tracheostomy care as she thought EBP was only needed for incontinence care. Nurse #4 was observed reading the EBP sign located on Resident #9's door after which she stated she saw that she should have been wearing a gown while performing tracheostomy care. In an interview with the Infection Preventionist (IP) on 9/5/25 at 9:17 AM she stated that Nurse #4 should have worn a gown while providing tracheostomy care. The IP indicated following EBP policy was important to prevent the spread of bacteria to Resident #9's respiratory system.	F0880		

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F0880 SS = D	Continued from page 27 In an interview with the Director of Nursing (DON) on 9/3/25 at 12:25 PM, she stated Nurse #4 should have worn a gown and gloves while providing tracheostomy care to prevent the spread of infection from one resident to another. An interview was conducted with the Administrator on 9/3/25 at 2:05 PM. She indicated Nurse #4 should have followed the EBP policy and donned a gown in addition to the gloves before entering Resident #9's room to provide tracheostomy care. In an interview with the Medical Director on 9/5/25 at 8:05 AM he stated the respiratory tract was not a sterile space and he did not feel Nurse #4 put Resident #9 at risk by not following the EBP policy.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F0883	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #6 was educated, offered, and received the pneumococcal vaccine on 09/19/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of pneumococcal vaccinations for all residents was completed by the Regional Clinical Director on 09/10/2025 and identified 73 residents as eligible. All identified residents and/or family representatives were educated and offered the pneumococcal vaccine from 09/12/2025 through 09/19/2025, and orders were obtained from 09/12/2025 through 09/19/2025 for residents who consented to vaccination. 12 residents received the pneumococcal vaccination on 9/22/25, 17 residents received the pneumococcal vaccination on 9/23/25. 20 residents will receive their vaccination 4 weeks after covid vaccination per pharmacy recommendation. DON/IP will be responsible for administration at that time. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	09/24/2025

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F0883 SS = D	Continued from page 28 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident, Responsible Party (RP), staff and physician interview the facility failed to provide education regarding the benefits and possible side effects of a pneumococcal immunization, offer a pneumococcal immunization, and then document either a refusal or the administration of a pneumococcal immunization for 1 of 5 residents reviewed for immunizations (Resident #6). Findings included: The facility's undated policy titled "Pneumococcal Vaccine" revealed in part: "All residents will be offered pneumococcal vaccines to aid in the preventing pneumonia/pneumococcal infections….7. Administration of the pneumococcal vaccines or vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination."	F0883	Continued from page 28 All licensed staff were educated on 09/15/2025 on the pneumococcal vaccination policy, including Centers for Disease Control and Prevention (CDC) guidelines for vaccination; education was provided by the Director of Nursing (DON) and the Infection Preventionist (IP). As of 09/19/2025, absent or newly hired staff will be educated by the DON or designee prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will review ten resident medical records weekly for eight weeks to ensure the pneumococcal vaccine is offered and, if consent is obtained, administered and documented. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the DON. Further actions will be determined as needed. Completion Date: 09/24/25	

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F0883 SS = D	Continued from page 29 The CDC document titled “Summary of Risk-based Pneumococcal Vaccine Recommendations” dated 5/24/2025 revealed in part the following: “Adults aged 19-49 years old; The following guidance applies to adults younger than 50 years old who have a risk condition [risk conditions listed included chronic lung disease including chronic obstructive pulmonary disease (COPD) and cigarette smoking]. Never received any pneumococcal vaccine; give one dose of PCV 15 (Pneumococcal 15-valent Conjugate Vaccine), PCV 20 (Pneumococcal 20-valent Conjugate Vaccine) or PCV 21 (Pneumococcal 21-valent Conjugate Vaccine).” Resident #6 was admitted to the facility on 4/17/2019 with a diagnosis of COPD. Resident #6’s annual Minimum Data Set (MDS) assessment dated 1/1/25 revealed she was 46 years old. She was moderately cognitively impaired. She was a current tobacco user. Her pneumococcal vaccine was not up to date. Resident #6’s current comprehensive care plan revealed she was a supervised smoker. Resident #6’s medical record did not reveal any documentation she had been educated on the benefits and possible side effects of a pneumococcal vaccine or refused the vaccine. Additionally, there was no documentation indicating a pneumococcal vaccine had ever been administered to her. On 9/4/25 at 9:29 AM a telephone interview with Resident #6’s RP indicated he was not aware of Resident #6 ever having a pneumococcal vaccine. He stated he did not recall the facility ever providing him with education on the risks versus the benefits of the pneumococcal vaccine or offering a pneumococcal vaccine for Resident #6. He reported if the vaccine had been offered, he would have accepted it. On 9/4/25 at 10:39 AM an interview with Resident #6 indicated she did not recall ever receiving a pneumococcal vaccine. She stated if one was offered to her, she would want to have it. On 9/4/25 at 12:15 PM an interview with the facility’s Infection Preventionist (IP) indicated she was aware there was an issue with some residents not being up to date with their pneumococcal vaccine. She stated she was trying to get it under control. She reported she had spoken to the pharmacy about some residents who had one step of pneumonia vaccine and had been instructed	F0883		

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F0883 SS = D	Continued from page 30 just to go ahead and use the PCV 20 because that would cover anyone. She reported she had started the process of getting residents up to date beginning with the new admissions because they were the easiest due to already having their consents with education. From there she was taking it chart by chart and was also using a report that showed her everyone's immunizations. She indicated she had not gotten to Resident #6 yet. The IP stated the process should include documentation of education on the risks versus the benefits of the vaccine, consent or refusal and if there was consent then documentation of administration of the vaccine. On 9/4/25 at 1:11 PM an interview with the Director of Nursing indicated she did not have any documentation Resident #6 had been educated on the benefits and possible side effects of a pneumococcal vaccine and refused the vaccine. She reported there was no documentation indicating a pneumococcal vaccine had ever been administered to Resident #6. In an interview on 9/5/25 at 7:51 AM the Medical Director stated that Resident #6's COPD was not oxygen dependent or really a significant risk factor. He reported it was a diagnosis she had, and she probably should have been offered a pneumococcal vaccine. On 9/5/25 at 2:55 PM an interview with the Administrator indicated there should be documentation Resident #6 had been educated on the benefits and possible side effects of a pneumococcal vaccine and refused the vaccine or documentation indicating a pneumococcal vaccine had been administered to her. She reported she thought because of Resident #6's age, this might have gotten missed.	F0883		
F0887 SS = E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the	F0887	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 09/08/2025, Resident #71 was provided education on the risks and benefits of the COVID-19 vaccination by the Infection Preventionist (IP) and declined. On 09/12/2025, all staff were educated on the risks and benefits of the COVID-19 vaccination; 19 staff consented and 142 staff declined. On 09/15/2025, Resident #71 was educated again by the Director of Nursing (DON) and consented. Resident # 71 received the covid-19 vaccine on 9-22-25. On 09/16/2025, Resident #54 was provided education on the risks and benefits of the COVID-19 vaccination by the DON and declined.	09/23/2025

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F0887 SS = E	Continued from page 31 benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident, staff and physician interviews the facility 1) failed to provide	F0887	Continued from page 31 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents and/or family representatives were educated on the risks and benefits of the COVID-19 vaccine; 67 residents consented to vaccination. Orders were placed in the medical record from 09/12/2025 through 09/15/2025 for consenting residents. Nineteen staff consented to receive the Covid -19 vaccination, and the facility is obtaining the vaccine supply for administration. 49 covid -19 vaccines were received from the pharmacy and were administered on 9-22-25. LNHA spoke with pharmacy director to obtain staff vaccinations on 9-10-25. LNHA was informed on 9-17-25 that the staff Vaccinations would be ordered. LNHA received confirmation from the pharmacy on 9-22-25 that all remaining vaccines for residents and staff have been ordered by the pharmacy, once received will be sent to the facility. DON/SDC will be responsible for administration on arrival at the facility. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All Licensed Nurses were educated on the facility COVID-19 vaccination policies for residents and staff on 09/15/2025 by the Director of Nursing (DON) and the Infection Preventionist (IP). As of 09/19/2025, absent or newly hired staff will be educated by the DON or designee prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will audit five resident records weekly for eight weeks to ensure that COVID-19 vaccination education was provided and that vaccination was offered and, if consented, ordered and documented. The Human Resources Director will audit five employee files weekly for eight weeks to ensure that employee education and the vaccination offer are documented. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the DON/IP/HR further actions will be determined as needed.	

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F0887 SS = E	Continued from page 32 education regarding the benefits and possible side effects of a COVID-19 vaccination, offer a COVID-19 vaccination, and then document either a refusal or the administration of a COVID-19 vaccination in the past 14 months in the resident's medical record for 2 of 5 residents (Resident #54 and Resident #71) and 2) failed to maintain documentation that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine and were offered the COVID-19 vaccine or information on obtaining a COVID-19 vaccine in the past 14 months for 156 of 156 facility staff reviewed for COVID-19 immunization. Findings included: A review of the facility's policy titled "COVID-19 Vaccine" dated 12/28/21 revealed in part the following: "COVID-19 Vaccine Education for Staff and Resident 1. COVID-19 vaccinations shall be offered to all staff and residents (or applicable POA [Power of Attorney]/Guardian) … per CDC [Centers for Disease Control and Prevention] guidance... 2. All staff and residents (applicable POA/Guardian) shall receive education regarding COVID-19 vaccine in a manner they can understand including information on the benefits and risk consistent with the CDC and/or FDA [Food and Drug Administration] information. The education, at a minimum shall include the FDA, EUA [Emergency Use Authorization] Fact Sheet or VIS [Vaccine Information Statement] for the vaccine being offered…" A review of the CDC document titled "Staying Up to Date with COVID-19 Vaccines" dated 6/6/25 revealed in part the following: "CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 and older…The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death… Vaccine protection decreases over time…Getting the 2024–2025 COVID-19 vaccine is especially important if you: never received a COVID-19 vaccine, are ages 65 years and older…are living in a long-term care facility." 1a. Resident #54 was admitted to the facility on 6/25/19 with a diagnosis of depression. Her quarterly Minimum Data Set (MDS) Assessment dated 7/17/25 revealed she was 76 years old. She was cognitively intact. Her COVID-19 vaccine was not up to date. Resident #54's medical record did not reveal any documentation indicating she had been provided education regarding the benefits and possible side effects of a COVID-19 vaccination, offered a COVID-19	F0887	Continued from page 32 completion date :9-23-25	

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F0887 SS = E	Continued from page 33 vaccination or a refusal or the administration of a COVID-19 vaccination in the past 14 months. On 9/4/25 at 12:42 PM an interview with Resident #54 indicated she thought she recalled being offered a COVID-19 vaccine in the facility after being educated on the risks versus the benefits of the vaccine recently, and she gave her consent. She stated she had not received the vaccine yet but thought she might in the next month or two. b. Resident #71 was admitted to the facility on 4/19/22 with a diagnosis of chronic obstructive pulmonary disease (COPD). Resident #71's annual MDS assessment dated 7/15/25 revealed she was 78 years old. She was cognitively intact. Her COVID-19 vaccine was not up to date. Resident #71"s medical record did not reveal any documentation indicating she had been provided education regarding the benefits and possible side effects of a COVID-19 vaccination, offered a COVID-19 vaccination or documentation of either a refusal or the administration of a COVID-19 vaccination in the past 14 months. On 9/4/25 at 10:25 AM an interview with Resident #54 indicated she thought she recalled being offered a COVID-19 vaccine in the facility in the last year. She stated she recalled she refused, because the last 2 times she received a COVID-19 vaccine she got sick with COVID-19. On 9/4/25 at 12:51 PM an interview with the Infection Preventionist indicated she was not sure what the current CDC recommendation was for the COVID-19 vaccine. She stated she was not aware of any education or offer of the COVID-19 vaccine since the last round of boosters for residents which was in October of 2024. She reported the facility did have access to the COVID-19 vaccine and could get it from the pharmacy. In an interview on 9/4/25 at 1:11 PM the Director of Nursing (DON) stated the facility had access to the COVID-19 vaccine and had provided this to some residents in October of 2024. She indicated Resident #54, and Resident #71 should have documentation of education regarding the benefits and possible side effects of a COVID-19 vaccination, an offer of a COVID-19 vaccination, and then documentation of either a refusal or the administration of a COVID-19 vaccine in the past 14 months in their medical record.	F0887		

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F0887 SS = E	Continued from page 34 In an interview on 9/4/25 at 1:13 PM the facility's Regional Director of Clinical Operations stated the COVID-19 vaccine should be offered annually. On 9/4/25 at 2:44 PM an interview with the Administrator indicated she was not sure what the current CDC recommendation was for the COVID-19 vaccine but she though it was recommended annually. She reported there should be documentation in resident's medical record that they received education regarding the benefits and possible side effects of a COVID-19 vaccination, an offer a COVID-19 vaccination, and then documentation of either a refusal or the administration of a COVID-19 in the past 14 months. On 9/05/2025 at 7:51AM in an interview the Medical Director stated there had been a new COVID-19 vaccine available in October 2024. He reported based on the new guidelines the facility would need to look into what the current COVID-19 vaccine recommendation was. He indicated the facility had 7 residents test positive for COVID in January 2025. He stated 2 roommates of positive residents had been vaccinated and had not tested positive. 2. In an interview on 9/4/25 at 12:51 PM the Infection Preventionist stated she was not sure what the current CDC recommendation was for the COVID-19 vaccine. She indicated she was not aware of any education or offer of the COVID-19 vaccine for staff in the past 14 months. An interview on 9/4/25 at 1:11 PM with the Director of Nursing (DON) indicated she thought the facility had done education for staff in the past 14 months regarding the benefits and potential risks associated with the COVID-19 vaccine and were offered the COVID-19 vaccine or information on obtaining a COVID-19 vaccine, but she could not find any documentation. In an interview on 9/4/25 at 1:13 PM the facility's Regional Director of Clinical Operations stated the COVID-19 vaccine should be offered annually. On 9/4/25 at 2:44 PM an interview with the Administrator indicated she was not sure what the current CDC recommendation was for the COVID-19 vaccine, but she thought it was recommended annually. She reported she was not aware of any education regarding the benefits and possible side effects of a COVID-19 vaccination, an offer a COVID-19 vaccination or information on obtaining one for staff in the past 14 months. In a follow-up interview on 9/5/25 at 3:37 PM the Administrator stated the facility had 156	F0887		

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F0887 SS = E	Continued from page 35 regular and contract staff.	F0887		
F0925 SS = B	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, staff and pest control contractor interviews, the facility failed to maintain an effective pest control program to prevent brown crawling bugs in 1 of 1 laundry room. The findings included: A review of the Pest Control Service Agreement dated 4/16/25 revealed the company would provide pest control services monthly and every week on 2 out of the 4 halls. An observation was conducted of the facility laundry room on 9/5/25 at 8:40 AM. The area in which the 2 washing machines were located revealed water standing on the floor covered by a flattened cardboard box. There were also 2 brown crawling bugs on the laundry room wall between the laundry chute and the laundry bin that receives soiled laundry. The observation also revealed 3 brown crawling bugs on the floor near the washing machines. An interview with the Housekeeping and Laundry Director was held on 9/5/25 at 8:50 AM. She stated the flattened cardboard box covering the standing water on the floor draining from the washing machines was to prevent the staff from slipping. She also stated she sees pests often and reports it to the maintenance department. She also enters the requests into the electronic maintenance tracking system. She went on to say she thought pest control representative came every other Tuesday. An interview with the Maintenance Director on 9/5/25 at 9:30 AM revealed he was aware there were pests in the laundry room, both water bugs and roaches. He stated the pest control representative started coming every week in June 2025. He stated when someone reports a pest sighting to him, he notes it in a log and enters it into the electronic maintenance tracking system. He went on to say the common areas are treated weekly and thought the laundry room was part of the common areas.	F0925	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 09/05/2025, upon visual sighting, a licensed pest-control contractor performed immediate treatment of the entire laundry area. On 09/15/2025, the contractor performed treatment again per the weekly schedule. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 09/18/2025, the facility conducted a facility-wide visual inspection of each hall, resident rooms, and common areas. Additional areas with visual sightings were treated by the pest-control company on 09/19/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/15/2025, all staff were educated on pest-control practices and immediate reporting of any pest sighting through the maintenance work-order system; education was provided by the Licensed Nursing Home Administrator (LNHA), Infection Preventionist (IP), and Director of Nursing (DON). As of 09/19/2025, absent or newly hired staff will be educated by the LNHA or designee prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director or designee will conduct and document a visual inspection of the laundry area weekly for eight weeks, including baseboards, corners, and areas under equipment, for any signs of pest activity. Professional treatment will continue and be increased if sightings warrant additional treatment. Findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the LNHA. Further actions will be determined as needed.	09/20/2025

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F0925 SS = B	Continued from page 36 Review of the pest control logbook dated June 2025-August 2025 revealed no pest control service requests were logged for the laundry area. An interview was conducted with the pest control service representative on 9/5/25 at 10:00 AM, he revealed he went to the facility on a weekly basis and treated the halls, he treated the laundry area monthly. He did not have documentation to show what areas he treats. He went on to say the water draining from the washing machines onto the floor was sometimes covered with flattened cardboard, these items could harbor pests and encourage pest growth. An interview was conducted with the Administrator on 9/5/25 at 1:00 PM. She stated the Assistant Maintenance Director shadows the pest control person when they were onsite. She went on to say her expectation was that the laundry room be treated by pest control services every week. An interview with the Assistant Maintenance Director was held on 9/5/25 at 1:30 PM. He stated the pest control service comes every Monday. There were no records of which areas were treated. He added, pest control services had not treated the laundry room, only the laundry chute that carries the soiled linen from the 4th floor hallway down into the basement laundry room. He stated he goes to the laundry area a couple times a week and had not seen pests. He went on to say the standing water covered with flattened cardboard could cause the growth of pests.	F0925	Continued from page 36 Completion Date: 09/20/25	
F0947 SS = E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined	F0947	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. NA #6 received abuse and dementia training on 09/15/2025. NA #7 received abuse and dementia training on 09/15/2025. NA #5 received 12 hours of education including abuse and dementia training on 9-19-25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 09/08/2025, the Staff Development Coordinator (SDC) audited all nurse aide (NA) education records and identified 42 NAs who did not meet the 12-hour annual requirement, including abuse/neglect and dementia	09/23/2025

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F0947 SS = E	Continued from page 37 in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to ensure nurse aides (NAs) received 12 hours of in-service training annually which included abuse and dementia training. This was for 3 of 5 NA files reviewed (NA#5, NA #6, and NA #7). Findings included: 1a. A review of the employee file and training information for NA #5 indicated a hire date of 2/1/24. There was no dated training to provide evidence NA #2 received 12 hours of in-service training including abuse and dementia training in the previous 12 months. b. A review of the employee file and training information for NA #6 indicated a hire date of 7/11/24. There was no dated training to provide evidence NA #6 received in-service training on abuse and dementia training in the previous 12 months. c. A review of employee file and training information for NA #7 indicated a hire date of 6/20/24. There was no dated training to provide evidence NA #7 received abuse training in the previous 12 months. On 09/5/2025 at 1:06 PM an interview with the Staff Development Coordinator (SDC) indicated she was responsible for tracking NAs in-service training. She reported all training for NAs was done in person. She stated she was not aware that 12 hours of in-service training annually to include abuse and dementia training was mandatory for NAs. On 9/5/25 at 2:45 PM an interview with the Director of Nursing indicated she was not aware NAs needed to have 12 hours of in-service education annually that included abuse and dementia training. In an interview on 09/05/2025 at 2:55 PM the Administrator stated that she knew the facility was lacking in the required education for NAs. She reported that the facility had some turnover in the SDC position, and now hopefully would get back on track	F0947	Continued from page 37 training. Training covering abuse/neglect and dementia was provided to all NAs on 09/15/2025, with an additional session on 09/17/2025. Effective 09/19/2025, any NA who does not meet the training requirement will be removed from the schedule until completion is documented. Absent or newly hired staff will be educated by the SDC or designee prior to accepting an assignment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/15/2025, the Director of Nursing (DON) educated the SDC and all NA staff on the facility's in-service training program for nurse aides, including required modules on dementia care and abuse prevention. As of 09/19/2025, absent or newly hired staff will be educated by the DON or designee prior to accepting an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator will audit ten employee training records weekly for eight weeks to verify completion of at least 12 hours of annual in-service education, including dementia care and abuse prevention; findings will be presented at the monthly Quality Assurance and Performance Improvement (QAPI) meeting by the LNHA. Further actions will be determined as needed. Completion date:9-20-2025	

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F0947 SS = E	Continued from page 38 with this.	F0947		