STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Nursing and Rehabilitation	200 Short St Williamsport, IN 47993

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's shower preferences were upheld for 1 of 24 residents reviewed for choices (Resident 54). Findings include: During an interview, on 6/9/25 at 11:16 a.m., Resident 54 indicated she wanted a shower every day but had never been asked how often she wanted one. Resident 54's record was reviewed on 6/12/25 at 11:08 a.m. Census information indicated the resident was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 4/1/25, indicated the resident had a moderate cognitive impairment, it was very important for her to choose the type of bath she received, and she required partial/moderate staff assistance with bathing. A preferences for customary routines and activities observation, dated 4/8/25, indicated the resident was interviewed to obtain the information in the document. The resident indicated it was very important for her to choose the type of bath she received, and she preferred to be bathed more than twice per week in the AM. An undated shower schedule indicated the resident was scheduled for showers on evening shift twice weekly despite the resident's stated preference of showering more than twice per week in the morning. Shower reports, dated April, May, and June 2025, indicated the resident was offered a shower on 4/3/25, 4/5/25, 4/9/25, 4/10/25, 4/11/25, 4/15/25, 4/21/25, 4/24/25, 4/27/25, 4/28/25, 5/6/25, 5/9/25, 5/16/25, 5/20/25, 5/23/25, 5/27/25, 5/30/25, 5/31/25, and 6/10/25. Of those dates, the resident refused the offered showers on 4/3/25, 4/9/25, 4/10/25, 4/11/25, 5/16/25, 5/23/25, 5/27/25, 5/30/25, and 6/10/25. The shower reports lacked documentation the resident's shower preference was reassessed due to refusals or what shift the showers were offered on as the resident's stated time preference was morning, but she was scheduled for evening showers. Progress notes, dated May and June 2025, lacked documentation the resident was offered a shower daily or the resident's shower preference was reassessed. A care plan, goal target dated, 7/7/25, indicated the resident enjoyed spending time with animals (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and pets, crocheting, visiting with family and friends, reading, listening to music, and going outside. Interventions included, but were not limited to, the resident preferred to shower every day. During an interview, on 6/12/25 at 11:37 a.m., the Director of Nursing Services (DNS) indicated the Activity Director interviewed residents to determine their preferences and it was documented on the customary routines and activities observation. The resident's shower schedule should have been based on the resident's preference obtained from the customary routines and activities observation. If the resident stated she wanted to be showered more than twice per week then the Activity Director should have followed up to determine how many days a week she preferred to shower. Once the resident's shower preference was determined then the Activity Director should have communicated the preference to the scheduler to add to the resident's shower schedule. During an interview on 6/12/25 at 12:03 p.m., the DNS indicated the resident was scheduled for showers twice weekly. The resident refused showers, but showers should have been scheduled more than twice per week since that was her stated preference. Ideally, if the resident stated a preference, but then refused showers, the resident should have been re-interviewed or reassessed to determine if the resident wanted to be offered a shower daily. The DNS indicated she reviewed the resident's record but was unable to find documentation the resident's shower schedule or preferences had been reassessed or updated. On 6/12/25 at 12:07 p.m., the DNS provided a document titled, Preferences for Daily Routine, last revised in December 2015, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To identify and develop a plan of care that reflects the resident's past and current daily customary routines .Procedure: 1. Activity Director or designee will complete the Preferences for Daily Customary Routines worksheet upon admission of a new resident .3. The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences. 3.1-3(u)(1)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the accurate coding of a Minimum Data Set (MDS) assessment for 1 of 22 residents reviewed for MDS assessment accuracy (Resident 55). Findings include: Resident 55's record was reviewed on 6/11/25 at 11:58 a.m. A quarterly MDS assessment, dated 4/15/25, indicated the resident received an anticoagulant (blood thinner) medication during the look-back period. A Medication Administration Record (MAR), dated April 2025, lacked documentation the resident received an anticoagulant medication. During an interview, on 6/13/25 at 10:17 a.m., the Director of Nursing Services (DNS) indicated she reviewed the MDS assessment, dated 4/15/25, and the resident's record. At the time of the MDS assessment, the resident was not on an anticoagulant medication. He was on an anticoagulant previously, but it was discontinued prior to the MDS assessment's look-back period. The assessment was coded in error. On 6/13/25 at 10:16 a.m., the DNS provided the Centers for Medicare and Medicaid Services (CMS), Resident Assessment Instrument (RAI) manual, section N, and indicated it was the policy currently being used by the facility. The RAI manual indicated, .Steps for Assessment 1. Review the resident's medication administration records for the 7-day look-back period .N0415 High-Risk Drug Classes: Use and Indication: 1. Is taking: Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days .E. Anticoagulant 3.1-31(c)(13)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During an interview, on 6/9/25 at 2:15 p.m., Resident 31 indicated she did not remember being invited to or attending a care plan meeting regularly. She did not recall when the last one was. Resident 31's record was reviewed on 6/11/25 at 11:29 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/30/25, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on [DATE]. A Care Plan Summary note, dated 12/12/24, indicated a care plan meeting was conducted on this day for Resident 31. A Care Plan Summary note, dated 6/13/24, indicated a care plan meeting was conducted on this day for Resident 31. Resident 31's record lacked documentation of a quarterly care plan meeting being conducted for the last year from June 2024 to June 2025. The resident had two care plan meetings for the entire year. During an interview, on 6/11/25 at 1:28 p.m., the Social Service Director (SSD) indicated she would document a care plan summary note in the residents' chart when the care plan meetings were conducted, and she would conduct a care plan meeting every 3 months with the resident and or resident representative. She was unable to provide documentation that care plan meetings were conducted quarterly for Resident 31. On 6/11/25 at 2:17 p.m., the Director of Nursing (DON) provided a document with a revised date of 8/23, titled, IDT Comprehensive Care Plan Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being .Resident, resident's representative, or others as designated by resident will be invited to care plan review. The care plan review may be conducted face to face, via phone conference, video conference, or through written communication per resident and/or representative preference. Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment 3.1-35(a) 3.1-35(e) Based on record review and interview, the facility failed to develop a care plan for the long-term use of an antibiotic for 1 of 22 residents reviewed for care plans (Resident 55), and the facility failed to ensure care plan meetings were held and documented for 2 of 22 residents reviewed for care plan meetings (Residents 11 and 31). Findings include: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident 55's record was reviewed on 6/11/25 at 11:58 a.m. Diagnosis on the resident's profile included, but were not limited to, extended spectrum beta lactamase (ESBL) (multi-drug resistant organism). A quarterly Minimum Data Set (MDS) assessment, dated 4/15/25, indicated the resident had a moderate cognitive impairment, a UTI in the last 30 days, and received an antibiotic during the look-back period. A progress note, dated 3/26/25, indicated the Nurse Practitioner (NP) called about the resident potentially having a peripherally inserted central catheter (PICC) line placed for antibiotic treatment for ESBL. The NP wanted to talk with the resident's wife and the infectious disease doctor before making a decision. The resident had an appointment scheduled with infectious disease on 4/1/25. A written physician's order from the infectious disease doctor, dated 4/1/25, indicated continue Macrobid (antibiotic) twice daily until 4/5/25, and then start Macrobid daily from 4/6/25 for six months for urinary tract infection (UTI) prevention. A physician's order, dated 4/6/25, indicated Macrobid 100 milligrams (mg) by mouth daily for six months for prevention of UTI. The resident's comprehensive care plan lacked documentation a care plan was developed due to the resident's long-term use of the antibiotic for UTI prevention and the resident's history of UTIs and ESBL. During an interview, on 6/12/25 at 9:38 a.m., the Director of Nursing Services (DNS) indicated a care plan should have been developed related to the resident's long-term antibiotic use. 2. During an interview, on 6/9/25 at 11:03 a.m., Resident 11 indicated she did not remember having a care plan meeting. Resident 11's record was reviewed on 6/11/25 at 2:31 p.m. Census information indicated the resident was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) Assessment, dated 5/21/25, indicated the resident was cognitively intact. Progress Notes, dated 12/1/24 to 6/11/25, lacked documentation the resident or resident representative were invited to a care plan meeting, a response to any invitation, or a care plan meeting was held. On 6/12/25 at 10:40 a.m., the Social Services Director (SSD) provided copies of invitations for a care plan meeting on 5/21/25 at 10:30 a.m. One invitation was addressed to the resident's representative and one had the resident's name on it. The invitations did not indicate if the resident or the representative accepted the invitation, refused, or documentation the care plan meeting was held at the indicated time. During an interview, on 6/12/25 at 10:43 a.m., the SSD indicated she reviewed the resident's chart and was unable to find documentation the resident or the representative responded to the invitation or documentation the care plan meeting was held. She was only able to provide documentation an (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	invitation was mailed. The SSD indicated the resident or representative's response to the invitation should have been documented. The care plan meeting should have been documented when it was completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents were administered showers and shaved per resident preference for 2 of 24 residents reviewed for Activities of Daily Living (ADL), (Resident 50), (Resident 29). Findings include: 1. On 6/10/25 at 10:32 a.m., during initial observation and interview, Resident 50 observed to have extensive facial hair. The resident indicated he preferred to be shaved but the staff does not shave him, and due to poor vision he is unable to shave himself. The resident indicated he was scheduled to receive a shower on Monday and Friday, but he was not being administered regular showers. On 6/10/25 at 10:45 a.m., during an interview the Assistant Director of Nursing (ADON) indicated she was unsure how often the residents were shaved. On 6/10/25 at 10:46 a.m., during interview Certified Nurse Aide (CNA) 5, indicated residents were shaved on the days they received a shower. She indicated they record administered showers on a shower sheet. On 6/11/25 at 1:45 p.m., the medical record of Resident 50 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but were not limited to Hypertension (high blood pressure), Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and Hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body). A Minimum Data Assessment (MDS) dated [DATE] indicated the resident was cognitively intact and required assistance for Activities of Daily Living (ADL) (activities related to personal care such as bathing and grooming). A care plan dated 8/30/24 indicated the resident required assistance with ADLs including bed mobility, transfers, eating and toileting related to: CVA (stroke), and hemiplegia. Intervention included but were not limited to assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Current preference for bathing/shower/bed bath and AM/PM. The record indicated the resident was scheduled to be administered two showers per week, on Mondays and Fridays. The point of care documentation in the medical record (documentation recorded by the CNA indicating care that was provided to the resident), indicated the resident was scheduled to have 22 showers administered from 4/1/25 to 6/11/25. The record indicated the resident was administered a shower 10 times. The record lacked documentation the resident refused showers. On 6/12/25 at 10:45 a.m., during a routine observation the resident was laying down in his room. The resident indicated he still had not been shaved. Resident noted to have full beard facial hair. 2. On 6/9/25 at 10:15 a.m. during initial observation Resident 29 was sitting in a wheelchair in his room. The resident was dressed, and clothing was clean. The residents fingernails observed with brown debris under the nails, and a heavy beard growth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 12:00 p.m., during a second observation, resident was in the assistant dining room. The resident had not been shaved, and brown debris were under the nails. On 6/10/25 at 11:30 during a third observation. Resident sitting in wheelchair in his room. The resident had not been shaved. On 6/11/25 at 2:00 pm the medical record of resident 29 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included but not limited to Parkinsons disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A quarterly Minimum data set assessment dated [DATE] indicated the resident was not cognitively intact and was dependent for all personal care. A care plan dated 1/14/25 indicated the resident required assistance with ADLs including bed mobility, transfers, eating and toileting related to Parkinson's disease. Intervention included but was not limited to assist with bathing as needed per resident preference. Offer showers two times per week. Assist with dressing/grooming/hygiene as needed. The point of care documentation indicated the resident was scheduled to have been administered 22 showers from 4/1/25 to 6/11/25. The documentation indicated that the resident was administered 6 showers. The medical record lacked documentation of the resident refusing showers. On 6/11/25 at 2:30 p.m. the Director of Nursing (DON) provided copies of shower sheet records for the residents. She indicated the shower sheets were an internal document and were not retained as part of the medical record. She indicated the residents were scheduled for a shower two times weekly. On 6/12/25 at 10:40 a.m., during a fourth observation the resident observed sitting in a wheelchair in his room. The resident nails observed to have brown debris under nails and had not been shaved. On 6/12/2025 at 11:04 a.m., the Director of Nursing (DON) provided a document, titled, AM Care, dated, 3/2023 and indicated it was the policy currently being used by the facility. The policy indicated, .6. Assist resident to ash face, hands .8. Shave resident, if needed or requested On 6/12/2025 at 11:04 a.m., the DON provided a document, titled, Fingernail care, dated, 9/2023 and indicated it was the policy currently being used by the facility. The policy indicated, .9. Clean under nails with orange stick The DON did not provide a policy specific to administering showers or bathing. 3.1-38(a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to prevent potential accidents by ensuring medications were administered and disposed of according to medication professional standards for 2 of 5 residents reviewed (Residents 8 and 20). Findings include: 1. On 6/9/25 at 11:15 a.m., during an initial observation and resident interview, Resident 8 sat on side of bed. Two plastic medication cups containing several pills were observed. The resident indicated she had a rough night, and the nurse did not want to wake her up and left her medications on her overbed table. On 6/10/25 at 2:33 p.m., the medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but not limited to chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), alcoholic cirrhosis (a severe liver condition where healthy liver tissue is replaced by scar tissue due to long-term, excessive alcohol consumption), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), gastroesophageal reflux disease (GERD) (a condition where stomach contents flow back up into the esophagus, causing irritation and discomfort), and heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). A physician order, dated 5/23/25, indicated to administer acetaminophen 1000 mg (milligrams), three times daily for pain. A physician order, dated 6/27/25, indicated to administer adult low does aspirin 81 mg, daily for aftercare. A physician order, dated 5/8/25, indicated to administer clopidogrel 75 mg daily for aftercare. A physician order, dated 4/21/25, indicated to administer docusate sodium 100 mg twice daily for aftercare. A physician order, dated 3/29/25, indicated to administer famotidine 20 mg twice daily for GERD. A physician order, dated 5/3/25, indicated to administer Jardiance 25 mg once daily for diabetes. A physician order, dated 3/29/25, indicated to administer Metoprolol ER 12.5 mg twice daily for hypertension. A physician order, dated 4/11/25, indicated to administer Omeprazole 20 mg once daily for GERD. A physician order, dated 4/18/25, indicated to administer Oxybutynin 5 mg twice daily for aftercare. A physician order, dated 4/30/25, indicated to administer Propranolol 10 mg twice daily for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension. A physician order, dated 5/8/25, indicated to administer Sertraline 100 mg once daily for depression. A physician order, dated 5/3/25, indicated to administer Spironolactone 25 mg once daily for hypertension. A Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact. A care plan, dated 1/23/23, indicated the resident had behaviors which included rejection of medications and hiding medications in her top drawer. On 6/10/25 at 2:37 p.m., during an interview Registered Nurse (RN) 6, indicated she did not leave medications at a resident's bedside. She indicated if a resident refused to take medications she advised the resident she could not leave them and would bring them back later. On 6/10/25 at 2:43 p.m. during an interview, the Licensed Practical Nurse (LPN) 7 indicated she did not leave medications at a resident's bedside. She indicated she would explain to the resident she was unable to leave medications at the bedside and would bring them to the resident later. On 6/11/25 at 9:43 a.m., during an interview the Director of Nursing (DON) indicated the nurses were not permitted to leave medications at the residents' bedside. 2. On 6/11/25 at 9:20 a.m., observed medication administration with Licensed Practical Nurse LPN 17. The nurse attempted to administer Sertraline HCL 100 mg 2 tablets, Amlodipine 5 mg 1 tablet, Benazepril 10 mg 1 tablet, Centrum Silver Vitamin 1 tablet, Memantine HCL 10 mg 1 tablet, Senna tablet 8.6 mg 2 tablets to Resident 20. The resident refused to take the medications. The nurse disposed of medications into the sharps (used needles) container. On 6/11/25 at 9:30 a.m., during an interview Nurse 17 indicated she only disposed of narcotic medications in the Drug Buster disposal system (a solution to neutralize the active chemicals in medications). She acknowledged she should have disposed of refused medications into the disposal solution. On 6/11/2025 at 9:45 a.m., the DON provided a document, titled, Medication Pass Procedure, dated 4/2025, and indicated it was the policy currently being used by the facility. The policy indicated, .14. Wasted, dropped or discarded medications disposed of in Drug Buster disposal system 3.1-45

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure a resident had received a requested medication for muscle spasms (sudden involuntary powerful contraction of a muscle or muscle group) for 1 of 1 resident reviewed for pain management (Resident 112). Findings include: During the initial pool interview, on 6/9/25 at 2:22 p.m., Resident 112 indicated she had requested an as needed (PRN) dose of her tizanidine (medication to treat muscle spasms) earlier in the morning when she had been given her pain medication. The nurse asked if she would consider waiting until after lunch due to the high risk of falling as the medication was known to lower blood pressure. The resident was confused as to why the nurse was concerned about her falling as she was in a wheelchair and was non-weight bearing (when no weight should be placed on an affected limb, usually after a surgical procedure). She indicated she reluctantly agreed, and requested, and was given, a Xanax (anti-anxiety medication). The nurse had not returned, after lunch, to check on her and offer the tizanidine, and now her spasms were increasing, and she was in pain. She believed the nurse had already left for the day. At the same time, the resident was observed with facial grimacing and clutching at her lower back area. During a telephone interview, by the Director of Nursing (DON), on 6/10/25 at 2:38 p.m., Licensed Practical Nurse (LPN) 4, indicated after lunch, she went back to the resident and offered her the tizanidine. The resident did not want the tizanidine but wanted a Xanax instead. During an interview, on 6/11/25 at 9:39 a.m., the DON indicated she had placed a follow-up call to LPN 4 later in the afternoon of 6/10/25, because the LPN had told her when she initially spoke with her on the phone, she had a headache. During the follow-up call, the LPN admitted she had failed to return to the resident, on the date in question, to see if she had needed the tizanidine. At the same time, the DON indicated the expectation was, if a resident requested medication to help with muscle spasms causing pain, and the nurse didn't give it, the nurse should have come back to follow up to see if the resident still wanted the medication. LPN 4 should have followed up to see if the resident still wanted the tizanidine. Resident 112's record was reviewed on 6/11/25 at 10:05 a.m. The profile indicated the resident's diagnoses included, but were not limited to, stress fracture of right ankle (small crack in the bone due to repetitive stress or overuse) and stage 3 chronic kidney disease (moderate damage to the function of the kidneys). A care plan, dated 6/10/25, indicated the resident was at risk for pain. Interventions included, but were not limited to, administer medications as ordered and observe for non-verbal signs of pain. A care plan, dated 6/10/25, indicated the resident was non-weight bearing status due to stress fracture of right ankle. A physician's order, dated 6/6/25, indicated to administer 1 tablet of 5-325 milligram (mg) hydrocodone-acetaminophen (pain medication) every 4 hours PRN for moderate to severe pain. The June 2025 Medication Administration Record (MAR) indicated the resident had received her hydrocodone-acetaminophen tablet at 1:02 a.m., 8:44 a.m., and 6:07 p.m., on 6/9/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Nursing and Rehabilitation	200 Short St Williamsport, IN 47993

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 6/6/25, indicated to administer a 1 mg tablet of Xanax three times a day PRN, for anxiety. The June 2025 MAR indicated the resident had received her Xanax at 10:20 a.m., and 6:07 p.m., on 6/9/25. A physician's order, dated 6/6/25, indicated to administer one, 4 mg capsule of tizanidine every 8 hours PRN for muscle spasms/cramping. The June 2025 MAR indicated the resident had received a dose of tizanidine on 6/9/25 at 1:02 a.m., but lacked documentation that the resident had received any further doses of the medication on 6/9/25. A nurse progress note, dated 6/9/25 at 10:21 a.m., LPN 4 indicated the resident had requested a Xanax. The note lacked documentation of that the nurse had followed up with the resident on her need for the tizanidine. On 6/11/25 at 10:12 a.m., the DON provided a document, with a revision date of 7/2024, titled, Pain Management Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure .3 .Pain medication will be .given based on the intensity of the pain .11. The licensed nurse will monitor the efficacy .as it relates to the resident's pain management 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to ensure medication was labeled properly for 1 of 2 medication storage rooms reviewed for medication storage. Findings include: On 6/11/25 at 9:15 a.m., observed the North Hall medication storage room with Licensed Practical Nurse (LPN) 17. The refrigerator observed with an opened, undated vial of tuberculin solution. On 6/11/25 at 9:20 a.m., during an interview LPN 17 indicated medications must be dated when opened. On 6/11/25 at 11:30 a.m., during an interview the Director of Nurses (DON) indicated tuberculin solution must be dated when opened. On 6/11/2025 at 10:12 a.m., the DON provided a document, titled, Medication Storage and Expiration policy, dated 11/2024, and indicated it was the policy currently being used by the facility. The policy indicated, .9. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened 3.1-25(j) 3.1-25(m) 3.1-25(n)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that was palatable and failed to serve food at the proper temperature for 1 of 1 test tray. This had the potential to affect all residents who received food from the kitchen. Findings include: 1. During an observation of the lunch service, on 6/9/25 at 11:50 a.m., The residents in the dining room were served a chicken salad sandwich, slice of lettuce, slice of tomato, beets, and sliced pears. This menu differed from what was to be served that day. The residents were to be served a bowl of tomato basil soup, hot tuna and cheese sandwich, pickled beets and sliced pears. During a dining room observation, on 6/9/24 at 12:27 p.m., Resident 31 was served her lunch tray, and she indicated she was tired of chicken salad, and they just had a chicken salad sandwich a couple of days ago. The resident also questioned the staff why they were also having chicken again for dinner. During an interview, on 6/10/25 at 2:44 p.m., the Dietary Manager was unsure why there were different foods served on the previous day's menus. She knew they were allowed to serve substitutes if necessary. The chicken salad sandwich, beets, and pears were not enough of a caloric intake for the residents that day, indicated by the manager. The dietary manager indicated she was still trying to get the food council up and running and she knew there were concerns about repeated items on the menu. During an interview, on 6/10/25 at 2:45 p.m., Culinary Aide 18 indicated she saw where soup was to be served with the sandwich, and she was told there was no soup to be served. 2. During an interview, on 6/9/25 at 2:17 p.m., Resident 31 indicated the food was often cold and they had a lot of repeated items on the menu and were not palatable. The resident indicated that she ate most of the time in the dining room and the food was even cold when served from there. During an interview, on 6/10/25 at 9:55 a.m., Resident 12 indicated the food served from the kitchen was the same items week after week and the food was often cold and not palatable. The resident indicated most of the time she ate in the dining room but not always. During an interview, on 6/10/25 at 10:25 a.m., Resident 50 indicated the food from the kitchen was always cold. The resident ate most of his meals in his room and received a hall tray. During an interview, on 6/12/25 at 11:11 a.m., the Dietary Manager indicated she was aware of the cold food complaints from the residents, and she had just started at the facility a few weeks before and was still trying to find out what the issue was. They do not have insulated food carts for the hall trays. A test tray was obtained on 6/12/25 at 1:10 p.m., the food temps were as follows: a. [NAME] dog 130.6 degrees F(Fahrenheit) b. Potato Wedges 113.4 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. [NAME] Slaw 49.6 degrees F d. Watermelon 48.4 degrees F The potato wedges were noted to not be cooked thoroughly and were crunchy in sections. The warm food was noted to be lukewarm. During an interview, on 6/12/25 at 1:10 p.m., the Dietary Manager indicated the food was not to the correct temperature and the warm food items were too cold and the cold items were too warm per state regulation. On 6/12/25 at 2:10 p.m., the Dietitian Assistant provided a document with a revised date of 5/25, titled, Food Temperatures, and indicated it was the policy currently being used by the facility. The policy indicated, .The facility will maintain proper food temperature control to prevent food borne illness .1. Hot foods will be held for service at or above 135F, and cold foods at or below 41F. 2. All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food .9. Hot food will be held at or above 135F. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165F for 15 seconds before serving .11. Cold food will be held at or below 41. If cold food temperature is not maintained food item will need to be chilled to less than 41F before serving 3.1-21(a)(1) 3.1-21(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the kitchen was in a sanitary condition and the facility failed to ensure cleaning logs were completed and kept up to date for 1 of 1 initial kitchen observations. This had the potential to affect 64 out of 64 people who consumed food out of the kitchen. Findings include: During the initial kitchen tour on 6/9/25 at 10:00 a.m., the Dietary Cooperate Consultant was present during the initial tour. The convention oven burners were noted to have dark/chard particles caked on them. The grill next to the convention oven had food particles all around the outside rim of the grill. There was no food currently being cooked on the grill or oven at the time. The piping and wall behind the convention oven appeared dirty with old grease. The kitchen floor was dirty with food crumbs and pieces of paper towel throughout. Walk-in freezer contained food crumb/particles on the floor and shelving. During an interview, on 6/9/25 at 10:10 a.m., the Dietary Cooperate Consultant indicated the kitchen had a new dietary manager and she was not aware if the kitchen staff had been following a cleaning schedule. The Consultant opened a binder that had the cleaning schedule logs in it. The logs were dated April 2025 and were completely blank. She was unable to provide documentation that the kitchen cleaning logs were completed for April, May, or June 2025. During an interview, on 6/10/25 at 2:44 p.m., the Dietary Manager indicated she was aware that there were no kitchen cleaning logs completed for the last few months. She started at the facility a few weeks ago and she was aware that some tasks were not being completed as they should have by staff. She was still learning where the breaks in the system were and what staff needed to be re-educated on the tasks. The dietary manager indicated she would just instruct staff to clean something when she noted it needed attention. They had not been following an actual daily or deep cleaning schedule. During an interview, on 6/11/25 at 1:21 p.m., the Director of Nursing (DON) indicated she was aware that the kitchen cleaning logs were not kept up to date and that they have had several changes in management during the last year in the kitchen. On 6/11/25 at 1:25 p.m., the Director of Nursing (DON) provided a document with a revised date of 5/24, titled, Cleaning Schedules, and indicated it was the policy currently being used by the facility. The policy indicated, .The culinary staff will maintain the sanitation of the culinary department through compliance with a written, comprehensive cleaning schedule .2. The cleaning schedule will be posted for all cleaning tasks, and employees will initial tasks as completed. 4. Cleaning schedules are kept on file for a minimum of twelve months but if the time between annual surveys is longer than 12 months, the cleaning schedules must be held until completion of annual survey 3.1-21(i)(3)