F 0550 Resident Rights/Exercise of Rights

The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

This requirement was not met as evidenced by: Based on observations and interviews, the facility failed to fully serve one table at a time, ask if resident wanted plates/cups removed from serving trays, ensure all residents were served prior to assisting other residents to consume their meal.

1. How corrective action will be accomplished for those residents found to have been affected: ***The staff received "on the spot reinforcement education" related to dining experience immediately at time of observation. Policy education provided on 9/15/25 and All-staff education conducted on 9/26/25.***
2. How the facility will identify other residents having the potential to be affected: ***Visual Audits for resident centered dining preference performed on random mealtimes.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Audits provided by Dietary Director or designee to observe compliance and/or need for education enhancement. Staff education provided 9/15/25 to appropriate department staff members.***
4. How the facility will monitor its corrective actions: ***The Dietary Director or designee will audit weekly X 4 weeks then monthly X 3 months. The results reported through the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Date corrected: Completion target date will be no later than November 1, 2025.

F 0558 Reasonable Accommodations Needs/Preferences

The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

This requirement was not met as evidence by: Based on record reviews and interviews, the facility failed to ensure that a resident's call bell was within reach for 4 of 25 sampled residents.

1. How corrective action will be accomplished for those residents found to have been affected: ***Residents # 5, # 54, #7 and # 67 as identified were immediately provided call bells in reach at their current sitting/laying position.***
2. How the facility will identify other residents having the potential to be affected: ***An audit of other resident rooms and current positions was conducted 9/22/25 to ensure proper placement of call bells, hand bells or rounding checks by staff if resident unable to use a call bell.***

3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Nursing staff received education 9/16/25 regarding the adherence to call bells within reach at all times when appropriate or rounding checks when appropriate. All staff education provided on 9/26/25.***
4. How the facility will monitor its corrective actions: ***The Director of Nurses or designee will audit call bell placement weekly X 4 weeks then monthly x 3 months. The results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Date corrected: will be no later than November 1, 2025.

F 0578 Request/Refuse/Discontinue Treatment/Formulate Advanced Directives

This requirement was not met as evidenced by: Based on observations and interviews, the facility failed to adequately Based on record reviews, and interviews, the facility failed to provide evidence to show Advanced Directives were offered or reviewed with the resident and/or resident representative or that the resident and/or resident representatives were provided with written information concerning the right to formulate an Advanced Directive for 8 of the 25 residents reviewed for the advanced directives (Residents #4, #8, # 29, # 57, # 68, # 52, # 34, # 50)

1. How corrective action will be accomplished for those residents found to have been affected: ***Resident and/or Resident's representatives were contacted for Residents #4, #8, #29, # 57, # 68, # 52, # 34 and # 50 to offer written information regarding advanced directives to accept or decline. Information documented in their records.***
2. How the facility will identify other residents having the potential to be affected: ***A full house audit will be completed of each resident's records to identify potential for to be affected by 11/01/25.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Staff education provided for Advanced Directives Policy review on 9/18/25 for Social Worker and Unit managers.***
4. How the facility will monitor its corrective actions: ***The Director of Nursing, Social Worker or designee will audit the new admissions weekly X 4 weeks then monthly X 3 months. The results reported through the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Date corrected: will be no later than November 1, 2025.

F 0584 Safe/Clean/Comfortable/Homelike Environment

This requirement was not met as evidenced by: Based on observations and interviews, the facility failed to adequately based on observations and interviews, the facility failed to adequately provide maintenance service necessary to maintain the building in a sanitary orderly, and comfortable environment on 2 of 3 units (100 and 200).

1. How corrective action will be accomplished for those residents founds to have been affected by the deficient practice: **On 9/16/25, the footboard on resident #57's bed was replaced. The ceiling tiles in room 105 &107's shared bathrooms were also replaced on; 9/16/25.**
2. How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected by this deficient practice. A walkthrough of the facility was conducted on; 9/24/25 to identify any additional stained ceiling tiles or footboards that need to be repaired/replaced. Replacement footboards were ordered on; 9/29/25.**
3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur: **The Maintenance Director or designee will select 5 random rooms to be audited weekly for 4 weeks, then monthly audits for 3 months.** ***All staff education provided on 9/26/25.***
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur**: Audit results will be reported at quarterly QAPI meetings**

The date the deficiency will be corrected: **10/15/25**

F 0657 Care Plan Timing and Revision MDS

The requirement was not met as evidenced by: Based on interview and record review, the facility failed to hold an Interdisciplinary Team Meeting I=(IDT) withing 7 days of a completed Minimum Data Set (MDS) for 6 of 6 residents reviewed for Minimum Data Set (MDS) (Resident's # 4, # 13, # 57, # 5 and # 16).

1. How corrective action will be accomplished for those residents found to have been affected:

Resident #4's Annual MDS with completion date of 5/23/25 and Quarterly MDSs with completion dates of 3/24/25, 12/20/24 have been reviewed and the associated care plans have been reviewed for accuracy and completion. All forthcoming IDT meetings and care plan updates will be done within 7 days of the completion of the MDS.

Resident # 8's Quarterly MDSs with completion dates of 7/31/25, 4/29/25, and 1/27/25 have been reviewed and the associated care plans have been reviewed for accuracy and completion. all forthcoming IDT meetings and care plan updates will be done withing 7 days of the completion of the MDS.

Resident # 13's Significant Change MDS with completion date of 3/31/25 and Quarterly MDS with completion date of 12/31/24 has been reviewed and the associated care plans have been reviewed for accuracy and completion. All forthcoming IDT meetings and care plan updates will be done within 7 days of the completion of the MDS.

Resident # 57's Quarterly MDS with completion date of 11/29/24 has been reviewed and the associated care plans have been reviewed for accuracy and completion. All forthcoming IDT meetings and care plan updates will be done withing 7 days of the completion of the MDS.

Resident # 5's Quarterly MDS with completion date of 8/7/25 has been reviewed and the associated care plans have been reviewed for accuracy and completion. All forthcoming IDT meetings and care plan updates will be done withing 7 days of the completion of the MDS.

Resident # 16's Admission MDS with completion date of 11/12/24 and Quarterly MDSs with completion dates of 3/15/25 and 8/15/25 have been reviewed and the associated care plans have been reviewed for accuracy and completions. All forthcoming IDT meetings and care plan updates will be done within 7 days of the completion of the MDS.

2. How the facility will identify other residents having the potential to be affected:
   Full house audit will be completed by 11/01/25 of each resident's last two scheduled MDSs to Determine an IDT meeting has held status post completion of the MDS assessment and that The care plan is accurate and reflective of the resident's current status. This audit will be Completed and tracked on a spreadsheet.

3. What measures will be put into place, to ensure, the deficient practice will not recur:
   The IDT members have been educated on the process assuring the resident's Comprehensive care plan is developed and/or updated within 7 days of the completion of the MDS assessment. This includes, to the extent practicable, the participation of the resident and the resident's representatives. The education will include the that this process is inclusive of comprehensive and quarterly review assessments.

4. How the facility will monitor its corrective actions: ***The Director of Nurses, MDS Nurse or designee will audit all MDS's completed during the week, weekly X 4 weeks then monthly X 3 months. Audit results will be reviewed through the facility Quality Assurance and Performance Improvement Process until compliance is achieve and maintained for a period of six months.***

   Completion target date will be no later than November 1st, 2025.

F 0689 Free of Accident Hazards/Supervision/Devices

The resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.

This requirement was not met as evidence by: Based on record reviews and interviews, the facility failed to ensure a smoking assessment of resident capabilities and deficits to determine resident safety was completed for 1 of 1 resident reviewed for smoking. (Resident # 48).

1. How corrective action will be accomplished for those residents found to have been affected:
   Resident was assessed 9/17/25 and care plan updated with resident's input.

2. How the facility will identify other residents having the potential to be affected: ***An audit conducted 9/18/25 of other residents to identify any known smokers within our non-smoking facility.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Nursing staff received education 9/17/25 regarding updated Smoking Policy and a designated "resident smoking area" identified. All staff education on 9/26/25. Resident screening on admission/yearly and PRN.***
4. How the facility will monitor its corrective actions: ***The Director of Nurse or designee will audit resident records monthly X 3 months for those residents that elect to smoke in our non-smoking facility to ensure they have had a Smoking Safety Screen at least annually or as clinically indicated. Screening results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Date corrected: will be no later than November 1st, 2025.

F 695 Respiratory/Tracheostomy Care and Suctioning

The facility must ensure that a resident who needs respirator care, including tracheostomy care and tracheal suction, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents goals and preferences.

The requirement was not met as evidenced by: Based on record review. Interview, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respirator care for 3 of 3 residents reviewed for respiratory care. (Resident's # 31, #19, and # 57).

1. How corrective action will be accomplished for those residents found to have been affected: ***The O2 tubing was updated/ labeled immediately as identified for Resident # 19. Order for O2 maintenance obtained for Resident # 31. Resident # 57 Care plan updated to reflect resident's preference to maintain her own C-PAP machine, have it serviced by her own Respiratory therapy company and not have equipment bagged.***
2. How the facility will identify other residents having the potential to be affected***: Audits conducted 9/30/25 for other residents who use respiratory devices currently in usage.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Nursing staff received education reinforcement 9/18/25 on Respiratory Care Procedures and following the Respiratory ancillary items protocols for Infection prevention.***
4. How the facility will monitor its corrective actions: ***The Director of Nurses or designee will audit the resident's records for completion of O2 tubing changes, doctor's orders for O2 maintenance and Care plans interventions related to respiratory devices weekly X 4 weeks, then monthly X 3 months. Audit results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Completion target date will be no later than November 1st, 2025.

F 0699 Trauma Informed Care

The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization on the resident.

The requirement was not met as evidenced by: Based on interview and record review, the facility failed to identify a resident's past history of trauma to determine what trigger(s) might cause re-traumatization and failed to revise the care plan to include trauma informed care for 1 of 1 resident.

1 How corrective action will be accomplished for those residents found to have been affected: ***The Trauma interview had been previously conducted for Resident # 38 and care plan was immediately updated 9/18/2025 to reflect specifics of known triggers to prevent re-traumatization.***

2 How the facility will identify other residents having the potential to be affected ***Audits conducted 9/24/25 to identify all residents potentially requiring trauma informed interventions/support.***

3 What measures will be put into place, to ensure, the deficient practice will not recur: ***Social Worker and Nurses received education regarding Policy and Procedures of development of comprehensive care plan that includes trauma informed care interventions. Health Care Academy education provided on Trauma Informed Care.***

4 How the facility will monitor its corrective actions: ***The Director of Nurses or designee will audit all new admissions weekly X 4 weeks and monthly X 3 months. Audit results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Completion target date will be no later than November 1st, 2025.

F 0757 Drug Regiment is Free from Unnecessary Drugs

Each resident's drug regiment must be free from unnecessary drugs Without adequate monitoring indications for use.

The requirement was not met as evidenced by: Based on observations, record review, and interviews, the facility failed to monitor and document targeted behaviors and side effects of psychotropic medication to support the use of psychotropic medications for 3 of 5 residents reviewed for unnecessary medications. (Resident #4, #6, and # 31).

1. How corrective action will be accomplished for those residents found to have been affected: ***Medication Record was corrected to reflect the appropriate side effects and targeted behaviors to monitor for regarding Residents. #4, # 6, # 31.***

2. How the facility will identify other residents having the potential to be affected: ***Audit conducted 9/24/25 to identify any residents using medications that potentially require documentation of specific side effects or targeted behaviors to monitor for.***
3. What measures will be put into place to ensure, the deficient practice will not recur: ***Nursing staff & C.N.A./Med techs received education on monitoring side effects and targeted behaviors for residents with psychotropic medication 9/24/25. Pharmacy consultant Inservice on 10/8/25.***
4. How the facility will monitor its corrective actions: ***The Director of Nurses or designee will audit PCC for newly order Antipsychotic medications to ensure targeted behaviors and side effects are monitored and documented weekly X 4 weeks and monthly X 3 months. Audit results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Completion target date will be no later than November 1st, 2025.

F 0761 Labeling of Drugs and Biologicals

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate e accessory ad cautionary instructions, and the expiration date when applicable.

The requirement was not met as evidenced by: Based on observations, record review, and interviews, the facility failed to maintain adequate pharmaceutical services to ensure that expired medications were removed from the supply available for use and failed to ensure that medications were stored properly as manufactures' recommendations for 2 of 3 medication rooms review for medication storage. (100 unit and 300 unit).

1. How corrective action will be accomplished for those residents found to have been affected: ***The expired medications were appropriately disposed of as identified to remove from available stock on the 100 unit and 300 unit. Audits conducted 9/19/25 to identify specific staff for completion of Refrigerator temperature logs for corrections.***
2. How the facility will identify other residents having the potential to be affected: ***Review of all other medication carts and rooms revealed no further medications that were expired. Refrigerator logs audited 9/19/25 and logs will be checked 2 times per day ongoing.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Nurse Managers and Nursing staff received education 9/19/25 regarding ensuring no expired medications are available to dispense and requirement to remove. Refrigerator temps education provided on 9/16/25 and temps are to be obtained 2 times per day to ensure proper storage. Pharmacy consultant in servicing on 10/8/25 for additional education.***
4. How the facility will monitor its corrective actions: ***The Director of Nurse or designee will audit medication storage for expired medications and refrigerator temperature logs weekly X 4 weeks and Monthly X3 month. Audit results will be reviewed though the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months.***

Completion target date will be no later than November 1st, 2025.

F 0812 Food Procurement, Store/Prepare/Serve-Sanitary

Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a cleaned and sanitary manner for 1 of 1 walk in refrigerators on 1 of 3 survey days.

1. How corrective action will be accomplished for those residents founds to have been affected by the deficient practice: **On 9/15/25, the fan in the walk-in refrigerator was cleaned.**

2. How the facility will identify other residents having the potential to be affected by the same deficient practice: **All residents have the potential to be affected by this deficient practice. On 9/15/25, fan cleanliness inspections were added to the AM Cook routine tasks in the kitchen. On 9/23/25, Dan Libby refrigeration cleaned the refrigerator fans.**

3. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur: **The Certified Dietary Manager or designee will conduct random audits of the cleanliness of the fan bi-weekly for 4 weeks, then monthly audits for 3 months.**

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur**: Audit results will be reported at quarterly QAPI meetings**

The date the deficiency will be corrected: **9/23/25**

F 0842 Resident Records- Identifiable information

In accordance with accepted professional standards and practices the facility must maintain medical records on each resident that are -Complete, accurately documented, readily accessible and systemically organized.

The requirement was not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure records were complete ad contained accurate information for 1 of 1 resident reviewed for pacemaker. (Resident # 13)

1. How corrective action will be accomplished for those residents found to have been affected: ***The medical provider saw resident # 13 and updated orders reflecting wishes as a hospice patient to discontinue any active pacemaker monitoring due to terminal illness status.***
2. How the facility will identify other residents having the potential to be affected: ***Review of all other residents with pacemakers revealed no required interventions or order changes.***
3. What measures will be put into place, to ensure, the deficient practice will not recur: ***Nurse Managers and Nursing staff received education regarding providing accurate orders/ care plans and follow up appointments when appropriate for pacemakers/Hospice residents. Hospice Agency Inservice will be provided 10/29/25.***
4. How the facility will monitor its corrective actions: ***The Director of Nurse or designee will audit medical records for resident Hospice interventions and follow up weekly X 4 weeks and monthly X 3 months. Audit results will be reviewed though the facility Quality Assurance and***

Performance Improvement Process until compliance is achieved and maintained for a period of six months.

Completion target date will be no later than November 1st, 2025