STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265807	A. BUILDING _____ B. WING _____	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW HOME	1313 SOUTH 25TH ST BETHANY, MO 64424

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F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Hetchall	Administrator	04-10-25

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.

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure that Advance Directives for three Residents (Resident #3, #19, and #32) were lawful when a Designated Power of Attorney signed an out of hospital Do Not Resuscitate (OHDNR) form prior to two residents (Residents #3 and #19) being declared incapacitated to sign. Additionally, the facility failed to ensure that one resident (Resident #32) had 2 physician letters of incapacitation prior to the Power of Attorney designee making decisions for him/her. There were 12 total sampled residents. The facility census was 40.

The facility did not provide the requested policy on Advance Directives.

1. Review of Resident #3's Quarterly minimum data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/07/25, showed:
-Severe cognitive impairment;
-Dependent on staff for transfers, bathing, locomotion, toileting and eating;
-Incontinent of bowel and bladder;
-Diagnoses included dementia, high blood pressure, and urinary tract infection.

Review of the resident's care plan, dated 02/20/25, showed:
-Assistance for activities of daily living (ADLs);
-Visual impairment;
-The resident is a DNR (Do not resuscitate) code status.

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Review of the resident's medical record showed:
-Durable power of attorney (DPOA) document signed by the DPOA 02/02/19;
-The DPOA did not indicate if one or two physicians were needed to determine incapacity;
-Capacity verification form dated 11/16/22 signed by only one physician, the DPOA and the Social Service Director (SSD);
-The capacity form showed the resident had no capacity on 11/16/22;
-Incapacitation letter, dated 05/08/24, that was signed by two physicians;
-OHDNR signed by DPOA on 01/15/22 before the resident was deemed incapacitated.

2. Review of Resident #19's Quarterly MDS, dated 02/07/25, showed:
-Severe cognitive impairment;
-Partial assistance for transfers, bathing, locomotion, toileting and eating;
-Incontinent of bowel and bladder;
-Diagnoses included dementia, depression, and anxiety.

Review of the resident's care plan, dated 02/20/25, showed:
-Assistance for ADLs;
-The resident had dementia;
-The resident was a DNR code status.

Review of the resident's medical record showed:
-DPOA document signed by DPOA on 11/27/18;
-The DPOA document did not indicate if one or two physicians were needed to determine incapacity;
-Incapacitation letter dated 01/24/19 that was signed by two physicians;
-OHDNR signed by DPOA on 01/07/19 before the resident was deemed incapacitated.

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3. Review of Resident #32 Quarterly MDS, dated 1/23/25, showed:
-Brief Interview of Mental Status (BIMS) of 99 indicated significant cognitive loss.
-Dependent on staff for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself, such as bathing, eating, and personal hygiene).
-Diagnoses of Cerebral Infarction (a condition where blood flow to part of the brain is interrupted,causing cells to die), chronic pain, Anxiety Disorder (excessive feelings of fear, worry and nervousness), Chronic Obstructive Pulmonary Disease (COPD: a lung disease that causes air flow obstruction and breathing difficulty), Dementia (a decline in mental ability that effects memory , thinking and behavior), Malignant Neoplasm of the Liver (cancerous tumor that originated in the liver).

Review of the Resident Comprehensive Care Plan, dated 10/10/24, showed:
-He/She had lost his/her decisional capacity and is invoked as of 4/6/2023.
-He/She depended on the Durable Power of Attorney(DPOA) for health and finance to carry out wishes.

Review of the resident electronic and paper medical record showed:
-The DPOA document did not indicate if one or two physicians were needed to determine incapacity.
-Letter of incapacity dated 1/31/23 signed by one physician.
-No second letter of incapacity signed by another physician.

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F 578	Continued From page 4 4. During an interview on 02/27/25 at 12:28 P.M., the Quality Assessment Nurse said: - 2 physicians should sign the letter of incapacitation unless the Power of Attorney form says otherwise. -A Do Not Resuscitate (DNR) form should not be signed by the Power of Attorney designee unless the resident has been declared incapacitated. During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -Incapacity letters require two physician signatures unless otherwise stated; -She would not expect a DNR signed by the DPOA prior to the signature of the incapacitation letter.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

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F 584	Continued From page 5 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the walls, hallways, ceilings and floors in a clean and homelike environment. Furthermore the facility failed to ensure furnishings were in good repair and temperatures in the dining room remained at a comfortable level. This had the potential to effect all residents. The facility census was 40. The facility did not provide a policy for cleaning, maintenance of the facility and care of furnishings, or temperatures. 1. Observations on 2/19/25 at 10:30 A.M., showed: -Main dining room thermostat read 61 degrees Fahrenheit;	F 584		

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-All doors to the main dining room were closed;
-Window blinds in the dining room and attached hallways were drawn;
-White blankets were rolled up and placed at the threshold of the doors leading to the courtyard.

Observation on 2/19/25 at 11:22 A.M., showed:
-Main dining room thermostat read 60 degrees Fahrenheit

During an interview on 2/19/25 at 10:05 A.M., Resident #9 said:
-He/She did not mind eating in the lobby because it was a comfortable temperature;
-The main dining room was too cold to eat there, for a few weeks.

During an interview on 2/19/25 at 11:15 A.M., Resident #92 said:
-The dining room had been too cold to eat meals in for weeks;
-He/She missed eating and visiting with her friends in the dining room.

During an interview on 2/19/25 at 12:32 P.M., Resident #18's family member said:
-The heat in the dining room had not worked for over a week.

During an interview on 2/19/25 at 3:00 P.M., the Administrator said:
-The facility has not employed a maintenance supervisor for a month or more;The transportation driver assists with maintenance where he/she can;
-The heat in the dining room had been checked by the Maintenance Director for the facility management company;
-The dining room heater cannot keep up with the

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cold weather;
-Residents eat in their rooms and assist diners eat in the lobby area;
-She does not know when the heat will be fixed.

2. Observations beginning on 2/25/25 at 12:37 P.M., showed:
-The dining room floor tile cracked, with missing pieces, tiles loose with jagged edge;
-Dead bugs, dust and debris in light fixtures;
-Packaged Terminal Air Conditioner (PTAC: which is a self-contained heating and cooling system designed to be mounted through a wall), in courtyard hall had dust and debris inside the vent, pieces of the plastic vent cover were missing and broken;
-Fire doors to 100 hall had chipped covering, with exposed wood underneath and white water damage like staining to lower half of the door;
-Fire doors to service hall had large chips in Formica, with exposed wood underneath;
-Corner sheetrock at service hall had large slash and gouge in sheetrock with peeling paint.

Observation on 02/27/25 at 8:58 A.M., showed:
-Television room at the end of the 400 hall had multiple gouges and scratches in the lower 1/3 of the sheetrock.
-Glass table lamp had visible layer of dust and debris;
-400 hallway had multiple gouges and scratches in the pain and sheetrock along the entire hall;
-Hand rail end cap off at room 421 caused sharp edge;
-Hand rail end cap loose at room 419 and opposite end cap was missing causing sharp edge;
-Hand rail end cap missing at room 416;
-Hand rail end cap missing at room 414;

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-Hand rail end cap loose at room 412;
-The small handrail at the corner of the dining hall and 400 hall was loose;
-The handrail between room 408-410 was loose;
-Hand rail end cap was missing at room 503, caused a sharp edge;
-Hand rail end cap at room 504 was missing, and caused a sharp edge;
-Hand rail end cap at room 517 was off and laying on top of the handrail;
-Hand rail at end of 500 hall with red, U shaped, sharp pronged metal piece with exposed two inch screw in the middle, was lying on top of the handrail.

Observation on 02/27/25 at 9:06 A.M., showed:
-Nurse station TV area had multiple gouges and scratches in the dry wall and paint;
-Lobby area light fixtures had dead bugs, dust, and debris in lights;
-PTAC unit had dust and debris in the vent and on the unit;
-Multiple ceiling can lights had cobwebs;
-Second PTAC unit had a broken grate and dust and debris in the vent;
-The glass billboard had dried, white drips on the glass;
-Long fluorescent lights had exposed bulbs;
-The nurses station had scuffed and chipped paint,
-The flooring carpet had multiple stained and discolored areas,
-The seams of the carpet are approximately 1/4 inch apart with dust and debris in them.
-The shower room on the 500 hall had dark, black mold like substance that covered 1/4 of the lower shower wall and grout of the shower and floor, exposed wires with ends capped in outlet cutout by tub, the ceiling had multiple brown water

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stains, and the lights had dead bugs, dust, and debris in them;
-The 500 hall had multiple gouges, scratches, and chips in the paint and drywall along the entirety of the hall;
-Treatment cart had rhinestone gems in partial star and curve shapes on the back of the cart, some gems were missing and a sticky/gummy substance was left behind, and had glitter letters half peeled off on the back of the cart and left a sticky/gummy uncleanable surface;
-Hallway from lobby to dining room had black scuff marks along lower third of the wall;
-Windows in halls to dining room had cobwebs, dust and debris;
-Hallway from lobby to dining room PTAC unit had dirt and debris in the vent, cracked plastic vent cover; the wall above the unit had broken wooden trim, leaving a sharp edge, peeling sheetrock and chipped/flaking paint;
-Dining room windows had dirt, dust, debris and cobwebs; lower third of the walls had nicks and scratched paint; the rolling stools (used to sit on to assist resident with meals) had cracked vinyl covering and exposed padding underneath; cabinet doors were sprung and hanging crookedly; the tile grout was black in multiple areas with a thick crusty substance; the small serving bowls/dishes, on the prep cart, had dust and debris in them and on the storage tray, the steam table had white crusty/dusty substance on the bottom shelf; the storage chart had white crusty/dusty substance on the bottom shelf and legs; the white prep table had cobwebs, dirt and debris on it and hanging from the legs and corners.

During an interview on 2/19/25 at 12:32 P.M. Resident #18 family member said:

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-Nothing gets fixed around the facility;
-There is no maintenance personnel.

During an interview on 02/26/25 02:52 P.M., Housekeeping/Laundry Aide A said:
-High dusting (such as lights, and corners) should be completed by any housekeeping staff who have time to get it done.
-High dusting was not assigned to anyone specifically.
-The staff assigned to the hall were responsible for all cleaning.
-There was no deep cleaning list for common areas of the building.
-The Dining room was deep cleaned weekly; spot cleaning was done after each meal;
-Carpets are vacuumed daily if there was time to do it.
-He/She did not know when carpets were shampooed or who was responsible for that.

During an interview on 02/19/25 at 3:00 P.M., the Administrator said:
-The facility had been without a Maintenance supervisor or staff for over a month;
-The transportation driver helps fix things as he/she has time to do it.

During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said:
-The facility was having maintenance struggles and there was no current maintenance staff.
-The Administrator looks at things as she can.
-The part time van driver can work on work orders as time allows;
-She would expect communication between the administrator and maintenance to complete work orders.

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F 584	Continued From page 11 During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -The Maintenance Director is responsible for upkeep and repairs. -There was not a Maintenance Director for over a month; -The van driver completes things as times allows and that he can do; -Staff fill out work order; the van driver picks them up and does what he can to complete them; -High dusting in the dining room would be maintenance; the rooms and halls would be housekeeping; -Carpets would cleaned when there was a stain; the housekeeping supervisor runs a carpet cleaner on different halls on different days. MO#249706	F 584		
F 656 SS=E	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	F 656		

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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.
(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, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents, for five of 12 sampled residents (Residents #28, #92, #11, #15, and #36). The facility census is 40.

Review of the facility provided, undated, policy Care Planning showed the facility Care

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Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

Review of the facility provided, undated policy Care Area Assessments showed Care Area Assessments (CAAs) will be used to develop individualized care plans.

1. Review of Resident #28 Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by facility staff), dated 1/3/25, showed:
-Brief Interview of Mental Status (BIMS) of 0 indicated severe cognitive impairment;
-No behaviors;
-Moderate assistance for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);
-No falls;
-No pressure areas;
-Chair alarm used daily;
-Bed alarm not used;
-Diagnoses of: Memory Deficit after cerebral infarction (loss of memory after stroke: when blood flow to a part of the pain is blocked, causing loss of cells), Sick Sinus Syndrome (a condition where the heart's natural pacemaker does not function properly), Need for assistance with personal care, History of falling, Delirium (a sudden change in mental state).

Review of the resident's medical record showed:
-9/26/24 Elopement Assessment completed with a score of 8, indicated an increased risk for elopement;
-1/09/2025 progress note showed the resident had an open area to his/her buttock.

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Review of the resident's Comprehensive Care Plan, dated 2/25/25, showed:
-The resident had a risk for falls: keep his/her call light within reach, ensure appropriate non-skid footwear, encourage him/her to ask for assistance;
-No care plan for use of an alarm;
-No care plan for elopement;
-No care plan for pressure ulcers.

During an interview on 02/24/25 at 10:36 A.M., Certified Nurse Aide (CNA) B said:
-The resident was an elopement risk;
-The orange dot on his/her name plate indicated the elopement risk.

Observations on 02/24/25 at 10:31 A.M., showed:
-Resident was sitting up in his/her wheelchair, self propelling chair;
-Alarm pad lying under incontinent padding on bed, attached to alarm box;
-Name plate at door has orange quarter size dot.

Observation on 02/25/25 at 11:10 A.M., showed:
-Resident was sitting up in his/her wheelchair, self propelling chair;
-Alarm pad lying under incontinent padding on bed, attached to alarm box.

During an interview on 02/27/25 at 9:37 A.M., Licensed Practical Nurse B said:
-Orange stickers on the door indicate elopement risk.
-The resident's care plan should say they are an elopement risk, have wounds, and anything pertinent in order to provide care to the resident.

2. Review of Resident #92 Admission MDS, dated 2/17/25, showed:

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F 656	Continued From page 15 -BIMS of 15 indicated no cognitive loss -Diagnoses of: fall with injury, osteoarthritis (a condition where the cushion at the ends of the bones (cartilage) breaks down, leading to pain/, stiffness and loss of movement), high blood pressure, atrial fibrillation (a irregular and rapid heart beat), urinary incontinence (involuntary loss of urine), heart failure (the heart cannot pump enough blood to meet the needs of the body), and pain. Review of the resident's baseline care plan, dated 2/5/25, showed: -Psychosocial needs will be addressed in a manner consistent with the resident's overall health and life goals. -No care plan for pressure ulcers or skin concerns. Review of the resident's Physician order sheet showed an order, dated 2/19/25, to apply zinc to open area twice a day until healed, obtained by the Director of Nursing. During an interview on 2/19/25 at 11:15 A.M., Resident #92 said he/she had sores on his/her bottom. Observation of Resident #92 on 2/19/25 at 11:40 A.M., showed he/she had a dime sized open area to the left buttock and a pencil eraser sized area to the right buttock, with red peeling skin surrounding the open wounds. During an interview on 2/19/25 at 11:40 A.M. Certified Nurse Aide (CNA) G said: -The resident had an open area for at least a week. -He/She had notified the nurse.	F 656		

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During an interview on 2/19/25 at 11:59 A.M. LPN C said he/she was not aware of resident #92 open area.

During an interview on 02/27/25 at 11:32 A.M. LPN B said care plans should be updated with changes as the change occurred.

3. Review of Resident #11's quarterly MDS, dated 12/13/24, showed:
- The resident had a BIMS score of 14, indicating little cognitive deficit;
- Diagnoses included: Diabetes Mellitus (DM) type II;
- He/She was completely dependent on staff for toileting needs, showers, and to get dressed:
- He/She was incontinent of bowel and bladder;
- He/She was a risk for the development of pressure ulcers (PU), but had none;
- He/She had skin break down on his/her buttocks.

Review of the Braden Scale (a form completed by the facility staff to determine the resident's risk for developing a wound), dated 1213/24, showed the resident at a high risk of developing a wound.

Review of the January 2025 progress notes showed the following:
- 1/5/25: LPN A documented on a skin assessment that the resident had an open area to his/her bottom;
- 1/9/25: LPN B documented on the monthly summary that the resident had fragile, warm, and dry skin. LPN B did not document any further details about the resident's skin breakdown;
-1/12/25: LPN B completed a skin assessment, the resident continued to receive a treatment for

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redness on the buttocks and a small open area, will fax the resident's physician for new orders.

Review of the resident's February 2025 skin assessments showed the following:
- 2/2/25: LPN A documented on a skin assessment the resident had an existing non-foot skin issue.
- 2/16/25: LPN A documented on a skin assessment the resident's bottom was red and had an open area.

Review of the resident's skin care plan, dated 8/26/22, showed:
- The resident had a chronic to his/her buttock that sometimes appeared to be open and sometimes appeared to be closed;
- The care plan did not include the resident's current PU.

Observation on 2/25/25 at 8:14 A.M. showed:
- The resident was lying in his/her bed;
- Licensed Practical Nurse (LPN) A entered the resident's room to complete wound care;
- The resident had a wound to his/her bottom that was 6 centimeters (CM) long by 0.3 CM wide;
- The center of the wound had a dark brown area that measured 2 CM long by 1.75 CM wide.

During an interview on 2/25/25 at 8:14 A.M., LPN A said:
- The wound appeared to be in worse condition than last week;
- Any of the nurses can update the resident's care plan.

During an interview on 2/27/25 at 11:39 A.M., The MDS Coordinator said:
- He/She helps with care planning, but most care

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plans and updates are completed by the nurses;
- The resident's care plan should have included his/her wound to his/her buttocks.

During an interview on 2/27/25 at 3:10 P.M. the Administrator said she would expect the resident's wound to be care planned with current interventions.

4. Review of Resident #15's quarterly MDS, dated 12/27/24, showed:
- He/She had a BIMS score of 15, indicating no cognitive deficit;
- Diagnoses included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture).
- He/She required assistance from staff to transfer, toileting needs and get dressed;
- He/She received a therapeutic diet and a mechanically altered diet;
- He/She had weight loss.

Review of the resident face sheet showed the resident had the following diagnoses: Dysphagia, oral phase (difficulty swallowing) and weakness

Review of the residents Physician Order Sheet (POS), dated February 2025, showed an order dated 9/5/24 for pureed food with honey thick liquids.

Review of the residents weights showed the following:
- 9/2/24- 248.4 pounds (lbs);
- 10/3/24- 242.6 lbs;
- 11/3/24- 234.4 lbs;
- 11/30/24- 232.4 lbs;
- 12/2/24- 224.2 lbs;
- 1/1/25- 224 lbs;

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- 2/1/25 222.2 lbs;
- Decreased 26.2 lbs and 10.5% of the resident's body weight over the past 6 months.

Review of the resident's nutrition status care plan, dated 2/25/20, showed:
-The resident was at risk for weight loss;
- The resident was on a pureed diet with honey thick liquids;
- The residents significant weight loss was not addressed in the resident's care plan.

During an interview on 2/27/25 at 3:10 P.M. the Administrator said the resident's significant weight loss should have been included in his/her care plan.

5. Review of Resident #36's quarterly MDS, dated 1/29/25, showed:
- The resident had a BIMS score of four, indicating severe cognitive deficit;
- The resident required assistance with eating, toileting and getting dressed;
- The resident was 72 inches tall and 148 pounds;
- The resident had a mechanically altered diet;
- The MDS did not indicated the resident had a significant weight loss.

Review of the resident's POS, dated February 2025, showed an order dated 12/2/24 for nectar thick liquids.

Review of the residents weight log showed the following:
-10/29/24 153.6 lbs;
11/3/24 152.6 lbs;
12/3/24 157 lbs;
1/1/25 156.4 lbs;
2/1/25 147.6 lbs;

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- The resident decreased 9.4 pounds and 5.98% in the past 2 months.

Review of the resident's undated comprehensive care plan showed the facility staff did not address the resident's weight loss.

6. During an interview on 02/27/25 at 11:39 A.M., the MDS Coordinator said:
-Most of the care plan is completed by the Charge Nurses;
-Resident specific care plans should include weight loss, the use of a nebulizer and oxygen, fall status and prevention interventions, psychosocial stuff, residents receiving hospice services, magic cup orders, contractures, wounds and skin issues;
-Primary care plans are related to the day to day care, behavioral issues;
-Communication was challenging; he/she was not always notified of changes; better communication between departments would ensure relevant information gets added to the resident care plans;
-He/She checks morning notes for changes.

During an interview on 02/27/25 12:28 P.M., the Quality Assurance Nurse said:
-She would expect Nebulizers, urinary tract infections, wounds and weight loss to be care planned for each individual resident;
-She expected every nurse to be able to access, update and utilize the care plan;
-The facility had a MDS coordinator that goes between other facilities;
-The charge nurses need more education to increase their comfort with care planning.

During an interview on 02/27/25 03:10 P.M.. the Administrator said:

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F 656	Continued From page 21 -She would expect any one can and would update a care plan, -The MDS Coordinator ensure the information is in the care plan; -She expected the CNA staff to report any changes to the Charge Nurse and the Charge Nurse to update the care plan; -She expected the care plan to be a snapshot of the specific resident and the care they require.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 12 sampled residents (Resident #15) received necessary assistance with activities of daily living (ADL). Resident #15 was dependent on a mechanical lift and two staff for transfers and required assistance with all his/her ADL's. Facility staff failed to reposition the resident every two hours and to provide timely perineal care. The facility census was 40. The facility did not provide a policy for timing and repositioning and perineal care for a resident's. 1. Review of Resident # 15's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/27/24, showed: - He/She had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit;	F 677		

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- Diagnoses included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture);
- He/She required assistance from staff to transfer, toileting needs, and get to dressed;
- He/She was incontinent of bowel and bladder.

Review of the resident's face sheet showed the following diagnoses: Dysphagia, oral phase (difficulty swallowing) and weakness.

Review of the resident's Activities of Daily Living (ADL) care plan, dated 11/26/19, showed:
- The resident was dependent on a mechanical lift and two staff for transfers;
- The resident's required assistance with all his/her ADL's.

Review of the residents skin care plan, dated 11/26/19, showed:
- The resident was incontinent of urine;
- The staff were supposed to assist the resident's with perineal care;
- The resident's had compromised skin integrity between his/her thighs.

During an interview on 2/23/25 at 10:32 A.M., the Resident said:
- He/She had a sore on his/her inner right thigh;
- It took a while for staff to change him/her;
- He/She he had been up since 7:00 A.M. this morning and has not been repositioned or changed since;
- He/She was wet.

Observation on 2/23/25 at 1:52 P.M., showed:
- The resident's was in his/her room in his/her wheel chair;
- Certified Nurse Aide (CNA) C and CNA I entered

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the resident's room with the mechanical lift;
- The CNA's assisted the resident in bed using the mechanical lift;
- The resident had a strong urine smell;
- CNA C provided perineal care;
- The resident had saturated through an incontinence brief, his/her pants, and the mechanical lift sling;
- The resident's bottom was red and appeared irritated.

During an interview on 2/23/25 at 1:52 P.M., CNA C said:
- He/She was trained to complete rounds every two hours;
- Rounds included repositioning residents, and cleaning residents if they are wet or soiled;
- Resident #15 was supposed to be repositioned every two hours;
- He/She came on duty at 7:00 A.M. and did not reposition or change the resident's before now;
- He/She should have ensured the resident's was dry and repositioned every two hours and as needed.

During an interview on 2/23/25 at 2:03 P.M., CNA I said:
- Cares were last provided for the resident at 7:30 A.M. for Resident #15;
- Cares included repositioning and ensuring the resident was clean and dry;
- The resident should have been changed earlier.

During an interview on 2/26/25 at 10:50 A.M., Licensed Practical Nurse (LPN) B said:
- Resident #15 was incontinent of bowel and bladder;
- The staff do not change the resident's like they are supposed to;

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F 677	Continued From page 24 - He/She expected the resident to be repositioned and perineal care provided every two hours and as needed; - The resident's really needed to be laid down every two hours because of his/her skin breakdown and incontinence. During an interview on 2/27/25 at 12:28 P.M., the Quality Assurance (QA) nurse said he/she expected the staff to provide repositioning and perineal care every two hours and as needed for resident's that need help. The staff should not have left Resident #15 sitting in his/her wheel chair from 7:30 A.M. to 1:52 P.M. with out repositioning and providing perineal care. During an interview on 2/27/25 at 3:10 P.M., the Administrator said staff should have repositioned Resident #15 and provided perineal care every two hours. It was not acceptable to let the resident's sit in his/her wheel chair for more that six hours without repositioning and cleaning the resident's.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		

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by:
Based on observation, interview, and record review, the facility failed to provide meaningful activities to meet the needs for three of 12 sampled residents (Resident #6, #28, and #92). The facility did not have an employee responsible for the activity program and did not have a system to inform all residents in advance of available activities, including location and time, which had the potential to impact all residents in the facility. The facility census was 40.

The facility did not provide a policy regarding Activities.

Review of the facility provided Resident Right policy, dated April 2006, showed:
-The resident has the right to a dignified existence and self determination. A Facility must protect and promote the rights of each resident.
--Right to participate in activities.
--Resident Rights are to be fully respected and adhered to.

The facility did not provide an activity calendar.

1. Review of Resident #6 Admission Activity Assessment, dated 3/14/20, showed:
- He/She liked 1:1 (1 staff to 1 resident) activities, independent leisure activities, and small group activities;
-Preferred activities included: cards/games, sports/exercise, music, spiritual/religious, walking/wheeling outdoors, and watching TV.

Review of the resident's Annual Activity Assessment, dated 5/3/24, showed:
-He/She liked 1:1 and large group activities;
-Preferred activities included: exercise/sports,

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music, and watching TV.

Review of the resident's Annual Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 8/6/24, showed Activity preferences:
-Very important for music
-Somewhat important to keep up with the news, do things with groups of people, do favorite activities, go outside and get fresh air and to participate in religious practices.

Review of Resident #6 Quarterly MDS, dated 2/8/25, showed:
-Brief Interview of Mental Status (BIMS) of 4, indicated significant cognitive deficit
-Dependence on staff for Activities of Daily Living (ADLs: tasks performed in a day to care for oneself)
-Diagnoses of Alzheimer's Disease (a progressive brain disorder that effects memory and thinking, leading to the inability to complete daily tasks), Hypertension, Cognitive Communication Deficit (difficulty communicating because of impaired brain function), Anxiety (constant feeling of nervousness, worry or fear), Depression (constant feeling of sadness, loss of interest and low energy) and Need for assistance with personal care.

Review of the resident's Comprehensive Care Plan, dated 2/18/25, showed:
-Problem: Resident involved in activities one third or less of the time related to he/she can not communicate very well due to his/her speech;
-Adjust the intensity, frequency, and/or duration of activities to accommodate his/her energy level and tolerance.
-Encourage him/her to become involved with

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activities that he/she enjoys; listening to the radio
-Involve him/her with those who have shared interests;
-Offer him/her opportunities to get to know others through activities such as shared dining, afternoon refreshments, monthly birthday parties, reminiscence groups, etc.

Review of the resident's Activity Attendance calendar showed:
-No activity attendance in January.
-No February Calendar provided.

Observations on 02/24/25 at 9:38 A.M., showed:
-Music played in his/her room, the resident was not in his/her room.
-The resident sat in his/her wheelchair, in the hallway,

2. Review of Resident #28 Quarterly MDS, dated 1/3/25, showed:
-Brief Interview of Mental Status (BIMS) of 0 indicated severe cognitive impairment;
-No behaviors;
-Moderate assistance for ADLs
-Diagnoses of: Memory Deficit after cerebral infarction (loss of memory after stroke: when blood flow to a part of the pain is blocked, causing loss of cells), Sick Sinus Syndrome (a condition where the heart's natural pacemaker does not function properly), need for assistance with personal care, history of falling, and delirium (a sudden change in mental state).

Review of the resident's Annual Activity Assessment, dated 10/1/24, showed his/her interests were crafts/arts, watching television, exercise/sports, music, talking/conversing, reading/writing and spiritual/religious activities.

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Review of the resident's Comprehensive Care Plan, dated 2/25/25, showed he/she needed one on one visits for socialization, and emotional support.

Review of the resident's Activity Attendance calendar showed:
-No activity attendance in January.
-No February calendar provided.

Observation on 02/24/25 at 10:31 A.M., showed:
- the television on in the resident's room,
-The resident sat in a wheelchair, in the hallway, with his/her head down and eyes closed.

Observation on 02/25/25 at 11:10 A.M., showed:
- The resident sat up in a wheelchair in the hallway. The resident looked around. No activities were being provided.

3. Review of Resident #92 Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 2/17/25, showed:
-Brief Interview of Mental Status (BIMS) of 15 indicated no cognitive loss
-Activity preference: Somewhat important to have books, newspapers, and magazines to read, listen to music,be around animals such as pets, keep up with the news, do things with groups of people,do favorite activities, go outside to get fresh air when the weather is good, and participate in religious services or practices.
-Diagnoses of: fall with injury, Osteoarthritis (a condition where the cushion at the ends of the bones (cartilage) breaks down, leading to pain, stiffness and loss of movement), Hypertension (high blood pressure), Atrial Fibrillation (a

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irregular and rapid heart beat), Urinary Incontinence (involuntary loss of urine), Heart Failure (the heart cannot pump enough blood to meet the needs of the body), and pain.

Review of the resident's baseline care plan, dated 2/5/25, showed psychosocial needs will be addressed in a manner consistent with the resident's overall health and life goals.

Review of the Resident's Activity Assessment, 2/5/25, showed:
-Preferred program of 1:1;
-Preferred music, reading/writing, watching TV, and talking/conversing.

During an interview on 2/19/25 at 11:15 A.M., the resident said:
-There is nothing to do at the facility.
-He/She just stays in his/her room and watches television.
-He/She gets lonely and bored.
-He/She has told staff he/she gets lonely and bored.

Observation on 2/19/25 at 11:15 A.M. showed the resident sat in his/her room, in the recliner, no music on, TV was not on, and one puzzle book lying on the table next to the resident.

4. Observation on 2/19/25 at 10:30 A.M., showed small group of three residents doing exercises in the lobby area, lead by a resident. No staff were involved. Resident #6, Resident #28 and #92 were not in attendance.

Observations on 2/19/25 from 12:00 P.M. to 2:50 P.M., showed no activity offered or provided for all residents.

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Observations on 2/23/24 from 9:44 A.M. to 1:39 P.M., showed no activity offered or provided for all residents

Observation on 02/23/25 at 10:32 A.M., showed no activity calendar in any of the resident's rooms.

Observation on 02/23/25 at 10:41 AM showed no activity calendar posted in the hallways or lobby area.

During an interview on 2/19/25 at 11:40 A.M., Certified Nurse Aide (CNA) D said:
-Resident volunteers provide Bingo or exercise group occasionally.
-There is no Activity personnel, as he/she was moved to the floor as an aide.

During an interview on 2/19/25 at 3:00 P.M., the Administrator said:
-There was no Activity Director.
-The plan was to move a CNA staff member to Activity Director the first of March.
-Volunteers provide bible study and BINGO.

During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said:
-She would expect someone to visit with resident's if he/she said he/she was lonely;
-She would expect activities to be done daily.

During an interview on 02/27/25 at 3:10 P.M., the Administrator said:
-All staff have stepped in to help with the activities, but no one was assigned.
-The previous Activity Director was moved to the floor as an aide;

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F 679	Continued From page 31 -A resident volunteer leads exercise. -One on one visits are completed with the Social Service visits. -She would expect visits to increase for someone who was lonely. -For residents who cannot leave their room she would expect daily visits. -There are books and magazines and a variety of things to be offered. -No one made me aware that a resident was sad because he/she could not see his/her friend during meals. -She expected staff to assist and activities to be done.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, or psychosocial well-being for one of three sampled residents (Resident #7) when staff failed to obtain a physician ordered blood transfusion in January 2025 for an anemic resident in a timely manner. The blood transfusion was not carried out until fourteen days after it was ordered. The facility census was 43.	F 684		

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Review of facility policy titled "Physician Orders," undated, showed physician's orders must be signed by the physician and dated when such order was signed.

Review of facility policy titled "Lab Reporting Guidelines," undated, showed:
-Guidelines will be followed to ensure that lab recommendations are completed timely;
-Nurse will received the lab for a lab draw; write a telephone order and document the order on the physician order sheet (POS) or note the order on the POS when written by the physician.
-The nurse will document on the lab report that the physician had been notified to include how they were notified, when (time and date) and the nurse's signature;
-The lab report will be placed in the medical record under the lab section;
-When any new orders were received, this will again be documented on the 24 hour report.

1. Review of Resident #7's Annual Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 11/22/24, showed:
-They had moderate cognitive impairment;
-They were dependent on a wheelchair;
-They took an antiplatelet medication (a medication that prevents blood platelets from sticking together and forming blood clots);
-Diagnoses included: Arthritis hypercalcemia (condition where there is high level of calcium in the blood), anemia, and high blood pressure.

Review of care plan, dated 12/7/24, showed the resident:
-had cognitive loss and their DPOA (Durable

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Power of Attorney) had been invoked by two physicians;
-their designated family member directed health care needs.

Review of physician's orders showed:
-Faxed order, dated 1/16/25, Type and cross 2 units PRBC (packed red blood cells) and transfuse, pre-treat with Tylenol 650 mg (milligram) by mouth and Benadryl 12.5 mg 30 minutes prior to start. Give Lasix (a water pill) 40 mg intravenous (IV) x 1 between units, for diagnosis anemia .

Review of the resident's medical record showed no documentation the physician orders were carried out.

Review of progress notes, dated 12/1/25-2/11/25, showed:
-On 1/17/25, physician ordered a blood transfusion due to low hemoglobin levels;
-On 1/27/25, resident returned to the facility from hospital appointment to have blood transfusion. Hospital did not have right blood type in stock so the resident did not receive transfusion.
-On 1/30/25, Resident received 1 unit of packed red blood cells (PRBC).

During an interview on 2/11/25 at 1:40 P.M., Family Representative A said:
-Resident had experienced some fatigue that physician had been concerned about;
-Resident did not receive a blood transfusion right away in January when it was ordered;
-They were unsure why a delay occurred in the resident receiving the blood transfusion.

During an interview on 2/11/25 at 11:48 A.M.,

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Licensed Practical Nurse (LPN) A said:
-Laboratory results went directly to the resident's physician;
-The facility staff did not receive the resident's lab results unless they specifically requested them;
-There should have been some documentation in the progress notes on the care resident received.

During an interview on 2/11/25 at 2:15 P.M., Physician's Registered Nurse (RN) A said:
- The resident had Complete Blood Count (CBC) (a medical test that measures the number and types of various cells in the blood) drawn on 1/16/25 and their hemoglobin was 7.5 g/dl;
-The physician sent an order for blood transfusion to occur and for facility to pre-treat resident with Tylenol and Benadryl;
-He/she called the facility to notify them of the orders and faxed the orders on 1/16/25 by 5:00 P.M.;
-The hospital outpatient said the facility dropped the resident off on 1/27/25 without an appointment and they did not have the resident's blood type on hand;
-The resident did not get the transfusion until 1/30/25;
-When the physician's office sends orders to the facility- the facility staff are able to call the hospital to schedule the transfusion;
-Without the blood transfusion the resident had a risk of having their hemoglobin levels drop further and experience additional fatigue.

During an interview on 2/11/25 at 2:20 P.M., LPN A said:
-He/she was unsure why resident's blood transfusion was delayed in January.
-BOM (Business office manager) was the person who scheduled appointments and arranged

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transportation to appointments for residents;
-When the BOM is out of facility the Human Resources (HR) staff person is supposed to cover for the BOM.

During an interview on 2/11/25 at 3:10 P.M., BOM said:
-Faxes were received on the fax machine located in the main business office of facility;
-She takes faxes to the west nurses station;
-The nurses were responsible for writing any orders and appointments that need made on the faxed orders received;
-Faxes were then brought back to him/her in the front office for scheduling of appointments;
-He/she was responsible for scheduling appointments for the residents;
-Paperwork and orders did sometimes get missed;
-Resident #1's paperwork said family was going to schedule resident's appointment;
-He/She contacted Resident #1's family member and they advised they were not taking care of appointment for transfusion;
-The facility driver took the resident to his/her transfusion appointment on 1/27/25 and all the pretransfusion mapping was completed at that time but transfusion did not occur because the hospital did not have the resident's blood type on hand;
-He/She took resident back to outpatient clinic on 1/30/25 for the transfusion;
-When he/she was not working in facility the HR staff was their back up regarding checking faxes and taking phone calls and writing down appointments.

During an interview on 2/11/25 at 3:30 P.M., Family Representative B said:

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F 684	Continued From page 36 -They did not agree or tell facility they would take resident to their second blood transfusion due to the extensive time commitment of 3-6 hours that the transfusions took to complete; -There was a communication break between administration and nurses at the facility. During an interview on 2/11/25 at 3:23 P.M., Physician said he/she expected their order for blood transfusion to be carried out within 5-7 days. During an interview on 2/11/25 at 3:50 P.M., Director of Nursing said he/she expected physicians orders to be carried out as soon as possible. During an interview on 2/11/24 at 4:11 P.M., Administrator said: -He/she expected facility staff to follow physicians orders; -Physician's orders were received in main office at fax machine and were taken to the west nurses station charger nurse; -The charge nurse took orders off fax and entered them into electronic medical record; -Physician then electronically signed the orders in electronic medical record; -Business Office Manager makes resident appointments; -When BOM was out of facility the Administrator or HR staff made appointments.	F 684		
	MO248336			
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		

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F 686	Continued From page 37 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate care and services were provided to residents to prevent the development and/or deterioration of pressure ulcers (PU) for four of 12 sampled residents (Resident #28, #92, #11, and #15). Facility staff failed to ensure the physician was notified of the PU and treatment obtained timely for one resident (Resident #92). The facility failed to ensure PU precautions were adhered to for one resident, resulting in the resident developing a PU (Resident #15), and failed to thoroughly assess and document assessments and measurements, and update the physician to obtain treatment orders for a new pressure ulcer for (Resident #92) and when a PU deteriorated for (Resident #11). Furthermore, the facility failed to follow their protocol assessment and documentation of skin issues when nurses did not consistently document and/or sign shower sheets at the time of a shower for two residents (Resident #28 and #92). The facility census was 40.	F 686		

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Review of the facility's undated policy Pressure Ulcer Care and Prevention showed:
-Purpose is to prevent and treat further breakdown of pressure sores.
-The nurse is responsible for implementing measures to prevent pressure ulcers;
-Change bed linen promptly whenever wet or soiled;
-Keep sheets dry, free of wrinkles and free of debris;
-Turn the resident every 2 hours and position with pads or pillows for protection;
-Assist the resident at mealtimes to assure adequate nutrition;
-Offer fluids frequently for adequate hydration.

Review of the facility's undated Wound Protocol document showed:
-Develop a turning and repositioning schedule, at least every two hours while in bed and at least hourly in a chair;
-Encourage Fluids;
-Thoroughly document all wound information such as type, location, stage, length, width, depth and drainage;
-Notify appropriate personnel of all new pressure ulcers.

Review of the facility's Skin Monitoring: Comprehensive CNA Shower Review showed:
-Perform a visual assessment of a resident's skin, report any abnormal looking skin to the charge nurse immediately. Forward any problems to the Director of Nursing for review. Use this form to show exact location and description of the abnormality.
-Signature areas for the Certified Nurse Aide completing the shower, the Charge Nurse, and the Director of Nursing;

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-Areas for documentation of Charge Nurse Assessment, and Intervention.

1. Review of Resident #28 Quarterly MDS, dated 1/3/25, showed:
-Brief Interview of Mental Status (BIMS) of 0 indicated severe cognitive impairment;
-Moderate assistance for Activities of Daily Living (ADL's: tasks completed in a day to care for oneself);
-Incontinent of urine and bowel;
-At risk for PU;
-No PU;
-Diagnoses of: Memory Deficit after cerebral infarction (loss of memory after stroke: when blood flow to a part of the pain is blocked, causing loss of cells), Need for assistance with personal care, history of falling, and delirium (a sudden change in mental state).

Review of the resident's Comprehensive Care Plan, dated 2/25/25, showed:
-He/She needs assistance with ADL's;
-No care plan for risk of PU or actual PU.

Review of the resident's bath sheets, dated January 2025, showed:
-1/1/25: no skin issues;
-1/7/25: Decubitus (damage to the skin and underlying tissues caused by prolonged pressure; a bedsore or pressure ulcer) to right and left buttocks. Signed by Charge Nurse: Licensed Practical Nurse (LPN) A on 1/8/25;
-1/10/25: Decubitus to right and left buttocks. No charge nurse assessment.; Signed by Charge Nurse: LPN A on 1/13/25; No DON signature;
-1/17/25: Decubitus to right and left buttocks. No charge nurse assessment; Signed by Charge Nurse: LPN A on 1/17/25; No DON signature;

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-1/21/25: Decubitus to right and left buttocks. No charge nurse assessment; Signed by Charge Nurse: LPN A on 1/22/25; No DON signature;
-1/24/25: Decubitus to right and left buttocks. No charge nurse assessment; No charge nurse signature; No DON signature;
-1/27/25: Decubitus to right and left buttocks. No charge nurse assessment; Signed by Charge Nurse: LPN A on 1/27/25; No DON signature;
-1/31/25: Decubitus to right and left buttocks. No charge nurse assessment; Signed by Charge Nurse: LPN A on 1/31/25; No DON signature.

Review of the Resident's progress notes showed:
-On 01/09/2025 at 10:11 A.M., Reported from Hospice Nurse the resident had two PU on his/her top right buttock and left inner buttock. Hospice gave order for areas to be cleansed with soap and water, pat dry, and apply zinc cream twice a day and as needed;
-On 01/09/2025 at 3:40 P.M., Nurse was informed that the resident had an open area to his/her bottom. He/She found an area at the top of the resident's inner left buttock that was covered with slough (a non-living, yellow or white material in wounds, made of dead cells and other debris), unstageable (the stage of a pressure ulcer is unknown because the wound bed is covered by dead tissue), measuring 0.8 centimeters (cm) in length x 0.9 cm width x 0.1 cm depth. Wound edges and surrounding skin appeared as dry skin. Physician was in the facility and gave an order to discontinue (DC) zinc and start cleansing the area with soap and water, pat dry, apply Santyl (prescription medicine that removes dead tissue from wounds so they can start to heal) applied nickel thick to wound bed, apply border gauze dressing, and change daily. An air cushion was added to his/her recliner. Staff will assist

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him/her turning side-to-side during the night to keep pressure off of the open area. He/She had a pressure reduction cushion to his/her wheelchair. An air mattress was requested from hospice.
-On 01/12/2025 at 2:33 P.M., The area on the resident's buttocks was cleansed and zinc was applied. Open area was barely visible and without drainage. The area appeared to be a stage 2 (a shallow open sore that has partially broken the skin's second layer);
-On 01/14/2025 at 10:37 A.M., Hospice nurse DC' d the Santyl order to stage 2 ulcer. New order received to cleanse the pressure ulcer with soap and water, apply thera honey (a medical product used in wound care to promote healing) gel nickel thick, apply breathable dressing, and change daily;
-No other progress notes in regards to wounds.

Review of the resident's bath sheets, dated February 2025, showed:
-2/3/25: Decubitus to right and left buttocks. No charge nurse assessment; No charge nurse signature; No DON signature;
-2/7/25: Decubitus to left buttock and discoloration to right buttock. No charge nurse assessment. Signed by LPN B on 2/9/25; No DON signature;
-2/7/25: Decubitus to left buttock and discoloration to right buttock. No charge nurse assessment. Signed by LPN B on 2/14/25; No DON signature;
-2/10/25: Decubitus to left buttock and discoloration to right buttock. No charge nurse assessment. Signed by LPN A on 2/10/25; No DON signature;
-2/19/25: Decubitus to left buttock and discoloration to right buttock. No charge nurse assessment. No charge nurse signature; No DON

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signature;
-2/24/25: Decubitus to left buttock and discoloration to right buttock. No charge nurse assessment. Signed by LPN A on 2/24/25; No DON signature.

Review of the resident's physician order sheets, dated February 2025, showed an order for Pressure Ulcer Care: Cleanse PU to left inner buttock with soap and water, apply thera honey gel nickel thick to wound bed, apply breathable border gauze dressing, change daily, ordered on 1/14/25.

Review of the resident's monthly summary, dated 2/15/25, showed no skin issues.

Review of the resident's medical record from January 2025-February 2025, showed no wound assessments documented.

Observations on 02/24/25 at 10:31 A.M.,to showed the resident in the hall sitting up in his/her wheelchair with a cushion in the wheelchair.

Observations on 02/24/25 at 12:00 P.M., showed
-Facility staff transported the resident in the wheelchair to the dining room. Staff did not assist the resident with incontinence care or reposition the resident.
-He/She was placed at the dining room table with his/her meal in front of him/her

Observations on 02/25/25 at 9:10 A.M. to 11:58 A.M., showed
-The resident sat up in his/her wheelchair in the hall.
-At 11:58 A.M. the resident was transported to the dining room and placed at the dining room table.

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Facility staff did not change or reposition the resident before transporting them to the dining room.

Observation on 02/25/25 at 12:17 P.M., showed:
-The resident sat in the dining room in his/her wheelchair;
-He/She was asleep at the table and had slid down toward the front of the wheelchair with his/her shoulders below the handle level of the wheelchair.

Observation and interview on 2/26/25 at 4:47 P.M., showed:
-The resident assisted to stand by staff and staff removed his/her slacks and incontinent brief;
-The resident had open wound to left upper buttock fold that was a half dollar in size with white/yellow slough, the skin at the edge of the wound was peeling and dry;
-The resident said the area hurts when he/she was cleansed and hurts at times when he/she was sitting.

During an interview on 2/26/25 at 4:47 P.M. CNA F said:
-The resident complains of pain to his/her bottom;
-The resident has had the open area for awhile, not sure exact date;
-He/She puts cream on the resident when he/she provided incontinent care.

During an interview on 2/27/25 11:32 AM LPN B said:
-The resident would take himself/herself to the bathroom and did not get himself/herself cleansed well;
-His/Her wound was difficult to heal because of his/her incontinence;

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-His/Her wound was closed last month and is now open again.

2. Review of Resident #92 Admission MDS, dated 2/17/25, showed:
-Admission date of 2/4/25;
-Brief Interview of Mental Status (BIMS) of 15 indicated no cognitive loss;
-Occasionally incontinent;
-No wounds;
-No risk for skin issues;
-Diagnoses of: fall with injury, osteoarthritis (a condition where the cushion at the ends of the bones (cartilage) breaks down, leading to pain, stiffness and loss of movement), urinary incontinence (involuntary loss of urine), heart failure (the heart cannot pump enough blood to meet the needs of the body), and pain.

Review of the resident's baseline care plan, dated 2/5/25, showed:
-Psychosocial needs will be addressed in a manner consistent with the resident's overall health and life goals;
-No care plan for skin issues.

Review of the resident's medical record for February 2025 showed no order for wound care.

Review of the resident's Comprehensive CNA Shower Review sheets showed:
-2/11/25 scattered bruising; signed by LPN A 2/11/25, no DON signature;
-2/14/25 open areas to right and left buttocks; signed by LPN B 2/14/25; no DON signature;

During an interview on 02/19/25 at 11:15 A.M., the resident said:
-He/She had sores on his/her bottom;

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-The sores were not there when he/she admitted to the facility;
-The sores burn and hurt badly;
-He/She had the sores because he/she wets his/her pants, because he/she is unable to get to the bathroom without staff assistance and has had to wait 30 minutes or more for his/her call light to be answered.

Observation on 2/19/25 at 11:40 A.M., showed:
-He/She was sitting in his/her recliner, no pressure relieving cushion in place;
-CNA D cleansed the resident's buttocks with cleansing wipes;
-He/She had a dime sized open area to left upper buttock;
-He/She had a pencil eraser size open area to right upper buttock;
-Surrounding skin red, inflamed and peeling;
-The resident complained of pain and burning with cleansing.

During an interview on 2/19/25 at 11:40 A.M., CNA G said:
-The resident had the open area for several days;
-He/She had told the nurse about the area the previous week.

During an interview on 02/19/25 at 11:59 A.M. LPN C said:
-He/She was not aware the resident had open areas;
-He/She was not told in report that the resident had open areas.

During an interview on 02/26/25 at 10:05 A.M. the resident primary care physician said:
-He/She had received a fax on 2/7/25 to approve admission medications;

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-He/She had received a fax on 2/13/25 in regards to pain and request for pain gel;
-He/She saw the resident on 2/23/25 at the hospital and noted the resident had open wounds;
-He/She was not notified by the facility of open wounds on the resident.

3. Review of Resident #11's quarterly MDS, dated 12/13/24, showed:
- The resident had a BIMS score of 14, indicating very little cognitive deficit;
- Diagnoses included: Diabetes Mellitus (DM) type II, multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves) and wound.
- He/She was completely dependant on staff for toileting needs, showers, and to get dressed;
- He/She was incontinent of bowel and bladder;
- He/She was a risk for the development of PU, but had none;
- He/She had skin break down on his/her buttocks.

Review of the resident's skin care plan, dated 8/26/22, showed the resident had a chronic wound to his/her buttock that sometimes appeared to be open and sometimes appeared to be closed.

Review of the Braden Scale (a tool completed by facility staff to determine the resident's risk for PU development), dated 12/13/24, with a score of 12, indicating the resident was a high risk for the devolvement of a PU.

Review of the resident's skin assessment, dated 1/5/25, showed LPN A documented on a skin assessment the resident had an open area to his/her bottom.

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Review of the resident's monthly summary, dated 1/9/25, LPN B documented the resident had fragile, warm, and dry skin. LPN B did not document any further details about the resident's skin breakdown.

Review of the residents skin assessment, dated 1/12/25, showed LPN B completed a skin assessment, the resident continued to receive a treatment for redness on the buttocks and a small open area, will fax the resident's physician for new orders, no new orders were obtained.

Review of the residents record showed the facility staff did not complete a skin assessment during the weeks of 1/19/25 and 1/26/25.

Review of the resident's skin assessment dated 2/2/25 showed LPN A documented on a skin assessment the resident had an existing non-foot skin issue.

Review of the resident's record showed the facility staff did not complete a skin assessment during the week of 2/9/25.

Review of the resident's skin assessment and monthly summary, dated 2/16/25, showed:
- LPN A documented on a skin assessment the resident's bottom was red and had an open area;
- LPN A documented on the monthly summary the residents skin condition was good, warm and dry;
- LPN A did not document any further details about the resident's skin breakdown.

Review of the resident's POS, dated February 2025, showed the following orders:
- 2/19/25: Barrier cream with collagen powder

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apply to buttocks' two times per day and as needed;
- 2/15/25: Wound care team consult for the wound on the resident's bottom.

Review of the medical record from January 2025 through February 2025, showed the facility staff did not document wound assessments and did not document the physician was notified of the resident's wound.

Observation on 2/25/25 at 8:14 A.M., showed:
- The resident lay in his/her bed;
- LPN A entered the resident's room to complete wound care;
- LPN A measured the resident's open wound to his/her bottom that was 6 CM long by 0.3 CM wide;
- The center of the wound had a dark brown area that measured 2 CM long by 1.75 CM wide, LPN A described as eschar (a dry crusted layer of dead tissue that forms over a wound);
- The wound had an area of dark pink moist skin that surrounded the wound from the gluteal cleft and both buttocks.

During an interview on 2/25/25 at 8:14 A.M., LPN A said:
- The wound appeared to be in worse condition than last week, because the wound looked larger than last week;
- The wound was a Stage II PU;
- There was an order for a wound care team to evaluate the resident's wound, but they have not been in yet;
- The facility nurses complete the resident's skin assessments weekly and provides the resident's wound care as the physician has ordered it.

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During an interview on 2/26/25 at 10:50 A.M., LPN B said:
- The resident's eschar was a new development;
- The resident's wound improved for a time and then has gotten worse;
- The facility staff have tried a lot of things for the resident's wound;
- The facility had experienced more wounds within the last couple of months.

4. Review of Resident # 15's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/27/24, showed:
- He/She had a BIMS score of 15, indicating no cognitive deficit;
- Diagnoses included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture).
- He/She required assistance from staff to transfer, toileting needs and get dressed;
- He/She was incontinent of bowel and bladder;
- He/She was at risk for the development of a PU but did not have a current PU.

Review of the resident's face sheet showed the following diagnoses: dysphagia, oral phase (difficulty swallowing) and weakness.

Review of the resident's Activities of Daily Living (ADL) care plan, dated 11/26/19, showed:
- The resident was dependent on a mechanical lift and two staff for transfers;
- The resident's required assistance with all his/her ADL's.

Review of the residents skin care plan, dated 11/26/19, showed:
- The resident was incontinent of urine;

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- The staff were supposed to assist the resident's with perineal care;
- The resident's had compromised skin integrity between his/her thighs.

Review of the resident's Braden Scale, dated 12/23/24, showed the facility staff assessed the resident had a score of 17, indicating the resident was at mild risk of the development of a PU.

Review of the resident's POS, dated February 2025, showed the following orders:
-11/26/24: Vitamin A&D ointment mixed with zinc, apply to the perineal area as needed to treat red skin;
-8/22/24: Cleanse the resident's right inner thigh area, pat dry, apply barrier cream and then abdominal (ABD) pad for comfort daily.

Review of the resident EMR showed the following:
- 2/2/25 Facility staff documented on a monthly summary, the resident's skin was in good condition, warm and dry;
- 2/4/25 Facility staff documented a skin assessment the resident's skin was intact.

During an interview on 2/23/25 at 10:32 A.M. the Resident said:
- He/She had a sore on his/her inner right thigh;
- It took a while for staff to change him/her;
- He/She had been up since 7:00 A.M. this morning and had not been repositioned or changed since;
- He/She was wet.

Observation on 2/23/25 at 1:52 P.M. showed:
- The resident's was in his/her room in his/her wheel chair;

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- CNA C and CNA I entered the resident's room with the mechanical lift;
- The CNA's assisted the resident in bed using the mechanical lift;
- The resident's had a strong urine smell;
- CNA C provided perineal care;
- The resident's has saturated trough an incontinence brief, his/her pants and the mechanical lift sling;
- The resident's bottom was red and appeared irritated;
- The resident had an open area to his/her back of upper right thigh;
- CNA C applied a large amount of a zinc based ointment to the open area.

During an interview on 2/23/25 at 1:52 P.M., CNA C said:
- He/She was trained to complete rounds every two hours;
- Rounds included repositioning residents and cleaning resident's if they are wet or soiled;
- Resident #15 was supposed to be repositioned every two hours;
- He/She came on duty at 7:00 A.M. and did not reposition or change the resident's before now;
- He/She should have ensured the resident's was dry and repositioned every two hours and as needed.

During an interview on 2/23/25 at 2:03 P.M., CNA I said:
- Cares were last provided for the resident at 7:30 A.M. for Resident #15;
- Cares included repositioning and ensuring the resident was clean and dry;
- The resident should have been changed earlier.

During an interview on 2/26/25 at 10:50 A.M.,

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LPN B said:
- The resident's wound to his/her upper right thigh was chronic;
- The resident was incontinent of bowel and bladder;
- He/She expected staff to reposition and clean the resident every two hours and as needed;
- He/She did not think the staff change and reposition the resident like they were supposed to;
- Staff should not have left the resident for more than six hours with out cleaning and repositioning him/her.

During an interview on 2/27/25 at 12:28 P.M., the Quality Assurance (QA) nurse said he/she expected the staff to provide repositioning and perineal care every two hours and as needed for resident's that need help. The staff should not have left Resident #15 sitting in his/her wheel chair from 7:30 A.M. to 1:52 P.M. with out repositioning and providing perineal care.

During an interview on 2/27/25 at 3:10 P.M., the Administrator said staff should have repositioned Resident #15 and provided perineal care every two hours. It was not acceptable to let the resident's sit in his/her wheel chair for more that six hours without repositioning and cleaning the resident's.

5. During an interview on 2/19/25 at 2:08 P.M., Certified Nurse Aide (CNA) F said:
-There are multiple residents with open areas. Resident#28, #92, #11, and #15 was among them;
-He/She told the nurse and Administration about the residents open areas.

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F 686	Continued From page 53 During an interview on 2/19/25 at 2:39 P.M., CNA C said: -Staff have to choose between baths and residents who need help being turned and repositioned every 2 hours; -He/She cannot get everything done with the staff available. During an interview on 2/19/25 at 3:10 P.M. CNA B said staff cannot get everything done and resident's have open areas, because there was not enough help. During an interview on 2/26/25 at 10:50 A.M., LPN B said: - There seem to be a lot more wounds in the past couple of months; - He/She did not think the aids were cleaning and repositioning resident like they were supposed to; - Several residents have open areas and redness on their bottoms; - He/She expected staff to clean and reposition residents that were not able to complete the task themselves every two hours and as needed; - Some of the aides left resident up in their wheel chairs from before breakfast until after lunch without cleaning the resident or repositioning the resident. During an interview on 2/27/25 at 3:10 P.M., the Administrator said she expected staff to reposition resident's every two hours and as needed.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		

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resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility staff failed to ensure a resident (Resident #15) with limited range of motion (ROM) to his/her left hand received treatment to prevent further ROM loss. The facility census was 40.

Review of the facility's undated policy titled, "Range of Motion," showed:
- ROM was suppose to be provided to prevent contractures from becoming worse; To maintain normal ROM;
- The facility staff can provide passive range of motion (PROM) for residents that cannot complete it themselves; To simulate circulation.

Review of Resident #15's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/27/24, showed:
- He/She had a Brief Interview for Mental Status

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(BIMS) score of 15, indicating no cognitive deficit;
- Diagnosis included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture);
- He/She required assistance from staff to transfer, with toileting needs, and to dress;
- He/She was incontinent of bowel and bladder.

Review of the resident's face sheet showed the following diagnoses: Dysphagia, oral phase (difficulty swallowing) and weakness.

Review of the resident's Activities of Daily Living (ADL) care plan, dated 11/26/19, showed:
- The resident was dependent on a mechanical lift and two staff for transfers;
- The resident's required assistance with all his/her ADLs;
- The resident's care plan did not address decreased ROM for the resident's left hand.

Review of the resident's Physician Order Sheet (POS) dated 2/25 showed the resident did not have an order for ROM services or a device to prevent decreased ROM.

Observation on 2/23/25 at 10:32 A.M., showed:
- The resident had a contracture to his/her left hand;
- The resident's fingers curled in and the resident was not able to straighten them;
- The resident did not have a device to prevent his/her fingers from curling in.

During an interview on 2/23/25 at 10:32 A.M., the resident said:
- He/She did not have any thing to help his/her fingers from curing in;
- The staff did not help him/her with ROM and did

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F 688	Continued From page 56 not provide PROM; - He/She would like to receive ROM so he/she does not lose more function of his/her hand. During an interview on 2/26/25 at 10:00 A.M., Certified Nurse Aide (CNA) C said: - The facility did not have staff to provide ROM for Resident #15; - He/She was not told to provide PROM for the resident with cares. During an interview on 2/26/25 at 10:50 A.M. Licensed Practical Nurse (LPN) B said: - There was no ROM program at the facility; - The CNAs were supposed to complete ROM with cares. During an interview on 2/27/25 at 3:10 P.M., the Administrator said: - The facility did not have a current ROM program; - The CNAs can complete PROM with cares; - The CNAs should be doing PROM and stretching with Resident #15 when they provide care.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to prevent a significant weight loss for one of 12 sampled resident's (Resident #15), when the facility did not provide the resident with his/her physician ordered Magic Cup (a nutritional supplement that contains additional calories and protein for persons experiencing involuntary weight loss) daily at lunch. The facility census was 40.

The facility did not provide a significant weight loss policy.

Review of Resident #15's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/27/24, showed:
- He/She had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit;
- Diagnoses included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture) and dysphagia (difficulty swallowing);
- He/She required assistance from staff to transfer, with toileting needs and to dress;
- He/She received a therapeutic diet and a mechanically altered diet;

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- He/She had weight loss.

Review of the resident's face sheet showed the following diagnoses: Dysphagia, oral phase and weakness.

Review of the resident's nutrition status care plan, dated 2/25/20, showed:
-The resident was at risk for weight loss;
-The resident was on a pureed diet with honey thick liquids.

Review of the resident's Physician Order Sheet (POS), dated February 2025, showed the following physician orders:
- 9/5/24: Pureed food with honey thick liquids due to dysphagia;
- 9/5/24: Magic Cup with lunch daily for weight loss.

Review of the resident's weights showed the following:
- 9/2/24: 248.4 pounds (lbs);
- 10/3/24: 242.6 lbs;
- 11/3/24: 234.4 lbs;
- 11/30/24: 232.4 lbs;
- 12/2/24: 224.2 lbs;
- 1/1/25: 224 lbs;
- 2/1/25: 222.2 lbs;
- Decreased 26.2 lbs and 10.5% of the resident's body weight over the past 6 months.

Review of progress notes in the electronic medical record (EMR) showed the following:
- 11/15/24: The Registered Dietician (RD) documented: The reason for consult was for the resident's weight change. The resident's current diet order was pureed with honey thickened liquids, Magic Cup with lunch daily. The resident's

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intake at meals was 51-75% of meals consumed. The resident's current weight was 234.4 pounds with a 3.4% in weight loss over the past 30 days;
- 12/11/24: The RD documented: The reason for the consult was for the resident's weight change. The resident's current diet order was pureed with honey thickened liquids. Magic Cup with lunch daily. The resident's meal intake was 51-75%. The resident's weight was 224.2 lbs;
- 1/8/25: The RD documented: The reason for the consult was for weight change. The resident's current weight was 224.0 lbs.
- 2/6/25 The RD documented the reason for the consult was for weight change. The resident's current was weight: 222.2 lbs. the resident's weight on 8/5/24 247.4 lbs indicating the resident lost 10.2% of his/her weight over the past six months. The resident's weight loss appears to have halted since last seen. The current interventions remain appropriate, and no changes warranted at this time.

Observation on 2/23/25 at 12:12 P.M., showed:
- The resident was at the dining table;
- The staff served the resident his/her lunch meal and did not give the resident a Magic Cup;
- The resident ate approximately 50% of his/her meal and left the dining room.

Observation on 2/24/25 at 12:08 P.M., showed:
- The resident was served his/her lunch meal;
- The resident was not served a Magic Cup;
- The resident consumed approximately 75% of his/her meal.

Observation on 2/25/25 at 12:26 P.M., showed:
- The staff served the resident his/her lunch meal;
- The staff did not provide a Magic Cup to the resident;

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F 692	Continued From page 60 - The resident consumed approximately 75% of his/her meal. During an interview on 2/26/25 at 3:48 P.M., the Dietary Manager (DM) said he/she expected the resident to receive his/her Magic Cup as it was ordered by the physician. During an interview on 2/26/25 at 10:50 A.M., Licensed Practical Nurse (LPN) B said: - He/She expected the staff to provide the resident a Magic Cup at lunch, because it was ordered; - He/She was not aware the resident was not receiving the Magic Cup; - He/She was not aware the resident had significant weight loss; - There was lack of communication between nursing and dietary. During an interview on 2/27/25 at 12:28 P.M., Quality Assurance (QA) Nurse A said -The facility had monthly risk meetings that include the RD; -The resident's weights are discussed during the meetings; - He/She expected staff to provide Resident #15 his/her Magic Cup as ordered. During an interview on 2/27/25 at 3:10 P.M. the Administrator said she expected staff to give Resident #15 his/her Magic Cup as ordered.	F 692		
F 695 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	F 695		

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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, interview, and record review, the facility staff failed to store nebulizer machine masks in a bag when not in use for two residents (Resident # 15 and #38) of 12 sampled residents. The facility census was 40.

The facility did not provide a policy for nebulizer masks.

1. Review of Resident #15's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/27/24, showed:
- He/She had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficit;
- Diagnosis included: Cerebral Palsy (is a disorder that affects movement, muscle tone and posture).

Review of the resident's face sheet showed the following diagnoses: Dysphagia, oral phase (difficulty swallowing), bronchitis, and weakness.

Review of the residents Physicians Order Sheet (POS), dated February 2025, showed an order dated 9/16/24 for Ipratropium-Albuterol (a liquid medication inhaled to treat breathing problems) 0.5 milligram (MG)- 3 MG per 3 milliliter (ML) nebulizer four times daily.

Observation on 2/23/25 at 10:32 A.M., in the

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resident's room showed a nebulizer machine sitting on the sink with the mask resting in the sink bowl, not covered.

Observation on 2/23/25 at 1:52 P.M., showed the resident's nebulizer machine was sitting on the sink with the mask lying on the sink bowl with no cover.

Observation on 2/23/25 at 2:40 P.M., showed the resident was using the nebulizer mask to receive a breathing treatment.

Observation on 2/25/25 at 9:20 A.M., showed the residents nebulizer mask was sitting directly on the sink.

During an interview on 2/26/25 at 10:50 A.M., Licensed Practical Nurse (LPN) B said:
- Nebulizer masks are supposed to be placed in a plastic bag when not in use;
- Nebulizer masks should not be placed directly on the sink or the sink bowl.

During an interview on 2/27/25 at 12:28 P.M., the Quality Assurance (QA) nurse said:
- He/She expected nebulizer masks to be in bags when not in use.

2. Review of Resident's #38's quarterly MDS, dated 1/17/25, showed:
- He/She had a BIMS score of 15, indicating no cognitive deficit;
- Diagnoses included: Heart failure and chronic obstructive pulmonary disease (COPD, a disease that affects how a person breaths).
- He/She required some assistance with activities of daily living (ADLs).

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F 695	Continued From page 63 Review of the resident's POS, dated February 2025, showed the following orders: - 11/13/24: albuterol sulfate 2.5mg/ 3 ml (0.83%) per nebulizer two times daily to treat COPD; - 11/13/24: change nebulizer tubing monthly. Observation on 2/23/25 at 11:44 A.M., showed: - The resident was sitting in his/her recliner; - The resident's nebulizer machine was sitting directly on a side table with no barrier and the nebulizer mask was sitting on a towel, not in a bag. Observation on 2/24/25 at 11:20 A.M., showed the resident's nebulizer was was sitting directly on a towel and not in a bag. During an interview on 2/27/25 at 12:28 P.M. the Quality Assurance (QA) nurse said: - He/She expected nebulizer masks to be in bags when not in use.	F 695		
F 700 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	F 700		

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F 700	Continued From page 64 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 observation, interview, and record review, the facility failed to document identification and use of possible alternatives prior to use of Halo side rails (a circular bed rail used for repositioning and bed mobility); failed to document assessing risk versus benefits of Halo side rail use; failed to obtain informed consent for the use of Halo side rails prior to installation; and failed to complete ongoing assessments to ensure the side rails were appropriate for use for one resident, and do not pose an entrapment risk (Resident #6), in a sample of 12 residents. The facility census was 40. Review of the facility provided, undated, Bed Rails policy showed: -Once a bed rail observation is completed the facility will review the associated risks and benefits with the resident and/or resident representative. After the review is complete, the resident and/or resident representative will sign the consent line and the nurse will sign as well. -Educate the resident/legal representative on the benefits and risks of bed rails; -Develop a care plan that outlines the medical factors necessitating bed rails and an explanation of how the use of bed rail is intended to treat a specific resident's condition; -Staff should follow manufacturer's	F 700		

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recommendations and specifications for applicable bed rails, mattresses, and bed frames;
-Staff will conduct regular inspections of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. When purchased separately the facility will select equipment that are compatible.

Review of Resident #6's Quarterly minimum data set (MDS), a federally mandated assessment completed by the facility staff, dated 2/8/25, showed:
-Brief Interview of Mental Status (BIMS) of 4, indicating significant cognitive deficit;
-Dependence on staff for Activities of Daily Living (ADLs: tasks performed in a day to care for oneself);
-Substantial assistance on staff to roll side to side;
-Diagnoses of Alzheimer's Disease (a progressive brain disorder that effects memory and thinking, leading to the inability to complete daily tasks), high blood pressure, cognitive communication deficit (difficulty communicating because of impaired brain function), anxiety (constant feeling of nervousness, worry or fear), depression (constant feeling of sadness, loss of interest and low energy), and need for assistance with personal care.

Review of the resident's Functional Abilities Assessment completed, 1/31/25, showed the resident required substantial/maximal assistance for rolling left and right.

Review of the resident's Comprehensive Care Plan, dated 2/20/25, showed:
-He/She had Halo rails (a circular, bed mobility device) times two for repositioning, with a start

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date of 11/3/22.

Review of the resident's medical record showed:
-No side rail assessment for use, entrapment, or to ensure the rails remain functional and safe;
-No consent for use of rails.

Observation on 02/24/25 at 9:34 A.M., showed:
-He/She was in bed on his/her back
-Quarter rails on his/her bed to both sides, in the up position.

During an interview on 02/27/25 at 11:32 A.M., Licensed Practical Nurse (LPN) B said:
-Therapy decided on use of rails for residents;
-He/She had never completed an assessment for bed rails or Halos;
-He/She was aware of an assessment tool for the use of rails, in the electronic health record system;
-The electronic health record system had a template consent and assessment tool for use of rails;
-He/She had no idea who completes the entrapment assessments;
-Resident #6 does have 2 Halos and an air mattress; he/she did not know if they were compatible.

During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said:
-Side rail application is done by maintenance;
-Nursing leadership or Administration would determine if the side rail is needed;
-Entrapment zones must be assessed, and informed consent must be obtained
-She would expect entrapment assessments to be completed at initiation of the rail, quarterly, and/or a change in the resident's function;

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F 700	Continued From page 67 -She would ask the medical equipment company for the compatibility of the air mattresses and the side rails. During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -Side rails have to be assessed, for resident specific use, by the charge nurse or possibly therapy to start the process; -Maintenance would get the Halo rails, measure for the entrapment spaces, and then install them; -She would expect the charge nurse or the Director of Nursing to complete the initial use assessment; then communicate that information on a maintenance request; -Entrapment measurements are done every 6 months by maintenance; -There was no maintenance staff and assessments have not been completed; -She would expect if a family or hospice brought in a bed with rails, for the same process to be completed; -She would expect rails to be checked at least monthly, or if the resident complains of them being loose, to ensure they are secured correctly.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		

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accordance with the facility assessment required at §483.71.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide adequate staffing to reposition and provide incontinence care for three residents who were at risk for pressure ulcers (Residents #28, #92, and #15), failed to answer the call light in a timely manner resulting in incontinence for one resident (Resident #92), and failed to provide two showers per week to one resident (Resident #28) as a standard of care. Additionally, the facility failed to ensure enough staff were in the dining room to assist residents who required assistance during meals, resulting in one staff member going between two tables to assist eight residents who needed nutritional assistance. The facility census was 40.

The facility did not supply a policy on staffing.

Review of staff schedules showed:

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-January 14th: day shift staff included 1 Licensed Practical Nurse (LPN), 1 Certified Medication Technician (CMT), and 4 Certified Nurse Aides (CNA); Night shift included: 1 Registered Nurse (RN), 2 CNAs and 1 Nurse Aide (NA);
-February 18th: day shift staff included 1 LPN, 1 CMT, and 3 CNAs; Night shift included: 2 CNAs and 1 NA;
-February 19th showed: day shift staff included the Director of Nursing (DON), 2 CMTs, and 3 CNAs; Night shift included: 2 CNAs and 1 NA
-February 23rd: Day shift staff included 1 Licensed Practical Nurse (LPN), 1 CMT and 4 CNAs; Night shift included: 1 RN and 2 CNAs;
-February 24th: Day shift staff included: 1 LPN, 1 CMT, and 4 CNAs, Night shift included: 1 RN, 2 CNAs and 1 NA;
-February 25th: Day shift staff included: 1 LPN, 1 CMT, and 5 CNAs, Night shift included:1 LPN and 2 CNAs;
-February 26th: Day shift staff included 1 LPN, 1 CMT, and 4 CNAs, Night shift included: 1 LPN and 2 CNAs.

1. Review of Resident #28 Quarterly minimum data set (MDS), a federally mandated assessment completed by the facility staff, dated 1/3/25, showed:
-Brief Interview of Mental Status (BIMS) of 0 indicating severe cognitive impairment;
-Moderate assistance for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);
-Incontinent of urine and bowel;
-At risk for pressure ulcers;
-No pressure ulcers;
-Diagnoses of Memory Deficit after cerebral infarction (loss of memory after stroke: when blood flow to a part of the pain is blocked,

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causing loss of cells), Sick Sinus Syndrome (a condition where the heart's natural pacemaker does not function properly), need for assistance with personal care, history of falling, and Delirium (a sudden change in mental state).

Review of the resident's Comprehensive Care Plan, dated 2/25/25, showed:
-He/She needs assistance with ADLs.

Review of the resident's bath sheet showed:
-He/She was scheduled for Tuesday/Friday baths;
-No bath on 1/3, 1/14, and 2/18.

Review of the resident's progress notes showed:
-On 01/09/2025 at 10:11 A.M., reported from Hospice Nurse the resident had two pressure ulcers on his/her top right buttock and left inner buttock. Hospice gave order for areas to be cleansed with soap and water, pat dry, and apply zinc cream twice a day and as needed.
-On 01/09/2025 at 3:40 P.M., nurse was informed the resident had an open area to his/her bottom. He/She found an area at the top of the resident's inner left buttock that was covered with slough (a non-living, yellow or white material in wounds, made of dead cells and other debris), unstageable (the stage of a pressure ulcer is unknown because the wound bed is covered by dead tissue), measuring 0.8 centimeters (cm) in length x 0.9 cm width x 0.1 cm depth. Wound edges and surrounding skin appeared as dry skin. Physician was in the facility and gave orders to discontinue (DC) zinc and start cleansing the area with soap and water, pat dry, apply Santyl (prescription medicine that removes dead tissue from wounds so they can start to heal) applied nickel thick to wound bed, apply border gauze

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dressing and change daily. An air cushion was added to his/her recliner. Staff will assist him/her turning side-to-side during the night to keep pressure off of the open area. He/She had a pressure reduction cushion to his/her wheelchair. An air mattress was requested from hospice.

Review of the resident's January monthly summary showed no skin issues.

Review of the resident's physician order sheets, dated February 2025, showed:
-Pressure Ulcer Care: Cleanse pressure ulcer to left inner buttock with soap and water, apply therahoney gel, nickel thick to wound bed, apply breathable border gauze dressing, change daily. Ordered on 1/14/25.

Observations on 02/24/25 at 10:31 A.M., showed:
-The resident was in the hall sitting up in his/her wheelchair;
-The resident had a cushion in his/her wheelchair.

Observation on 02/25/25 from 9:10 A.M. to 11:58 A.M., showed
-The resident was sitting up in his/her wheelchair in the hall;
-The resident had a cushion in his/her wheelchair.
-He/She was not repositioned, freshened up, or moved.

Observation on 02/25/25 from 12:17 P.M. to 1:30 P.M., showed
-The resident was sitting in the dining room in his/her wheelchair;
-He/She was asleep at the table;
-He/She was slid down toward the front of the wheelchair with his/her shoulders below the handle level of the wheelchair.

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-The resident had a cushion in his/her wheelchair.

Observation and interview on 2/26/25 at 4:47 P.M., showed:
-The resident was assisted to stand by staff; His/her slacks and saturated incontinent brief were removed;
-The resident had an open wound to the left upper buttock fold, half dollar in size with white/yellow slough, the skin at the edge of the wound was peeling and dry.
-The resident complained of pain to the area.

During an interview on 2/27/25 11:32 AM, LPN B said:
-The resident would take himself/herself to the bathroom and did not get himself/herself cleansed well;
-CNA staff do not have enough time to get everything done;
-Staff do the best they can to get all the residents cleaned up and taken care of;
-His/Her wound was difficult to heal, because of his/her incontinence;
-His/Her wound was closed last month and is now open again

2. Review of Resident #92 Admission MDS, dated 2/17/25, showed:
-Admission date of 2/4/25;
-BIMS of 15 indicating cognitively intact;
-Occasionally incontinent;
-No wounds;
-No risk for skin issues;
-Diagnoses of fall with injury, osteoarthritis (a condition where the cushion at the ends of the bones (cartilage) breaks down, leading to pain, stiffness and loss of movement), hypertension (high blood pressure), atrial fibrillation (a irregular

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and rapid heart beat), urinary incontinence (involuntary loss of urine), heart failure (the heart cannot pump enough blood to meet the needs of the body), and pain.

Review of the resident's baseline care plan dated 2/5/25 showed:
-Psychosocial needs will be addressed in a manner consistent with the resident's overall health and life goals.

During an interview on 02/19/25 at 11:15 A.M., the resident said:
-He/She had sores on his/her bottom;
-The sores were not there when he/she admitted to the facility;
-The sores burn and hurt badly;
-He/She had the sores because he/she wets his/her pants, because he/she was unable to get to the bathroom without staff assistance and has to wait 30 minutes or more, every evening, for his/her call light to be answered;
-He/She knows how long he/she waits, because he/she can see the clock.

Observation on 2/19/25 at 11:40 A.M., showed:
-The resident was sitting in his/her recliner,
-He/She had a dime sized open area to left upper buttock;
-He/She had a pencil eraser sized open area to right upper buttock;
-Surrounding skin red, inflamed, and peeling.
-The resident complained of pain and burning to the areas.

3. During an interview on 2/19/25 at 2:08 P.M., Certified Nurse Aide (CNA) F said:
-There are multiple residents with open areas;
-Most residents don't get two showers a week,

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because there was not enough staff to do everything that needed to be done, such as turning and repositioning residents, and the residents were getting wounds.

During an interview on 02/27/25 09:59 AM, CNA F said he/she was trying to get all the baths done during the shift, because later they would not have enough staff and the residents would not get a bath for a while, up to a week.

During an interview on 2/19/25 at 2:39 P.M., CNA C said:
-If he/she and his/her partner were able to get residents turned and repositioned every 2 hours on a shift, then the residents do not get baths;
-He/She had to choose between completing baths and residents who need help being turned and repositioned every 2 hours;
-He/She cannot get everything done with the staff available.

During an interview on 2/19/25 at 3:10 P.M., CNA B said:
-Staff cannot get everything done and multiple residents have open areas because there was not enough help.

4. Review of Resident #15's quarterly MDS dated 12/27/24, showed:
- He/She had a BIMS score of 15, indicating no cognitive deficit;
- Diagnosis included Cerebral Palsy (is a disorder that affects movement, muscle tone and posture);
- He/She required assistance from staff to transfer, toileting needs, and to dress;
- He/She was incontinent of bowel and bladder.

Review of the resident's face sheet showed the

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following diagnoses: Dysphagia, oral phase (difficulty swallowing), and weakness.

Review of the resident's Activities of Daily Living (ADL) care plan, dated 11/26/19, showed:
- The resident was dependent on a mechanical lift and two staff for transfers;
- The resident's required assistance with all his/her ADLs.

During an interview on 2/23/25 at 10:32 A.M., the resident said:
- He/She had a sore on his/her inner right thigh;
- The facility could use more staff because it took a while for staff to change him/her;
- He/She he had been up since 7:00 A.M. this morning and has not been repositioned or changed since;
- He/She was wet.

Observation on 2/23/25 at 1:52 P.M., showed:
- The resident was in his/her room in his/her wheelchair;
- Certified Nurse Aide (CNA) C and CNA I entered the resident's room with the mechanical lift;
- The CNAs assisted the resident in bed using the mechanical lift;
- The resident had a strong urine smell;
- CNA C provided perineal care;
- The resident had saturated through an incontinence brief, his/her pants, and the mechanical lift sling;
- The resident's bottom was red and appeared irritated.

During an interview on 2/23/25 at 1:52 P.M., CNA C said:
- He/She was trained to complete rounds every two hours;

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- Rounds included repositioning residents, and cleaning residents if they were wet or soiled;
- Resident #15 was supposed to be repositioned every two hours;
- He/She came on duty at 7:00 A.M. and did not reposition or change the resident's before now;
- He/She should have ensured the resident was dry and repositioned every two hours and as needed.

During an interview on 2/23/25 at 2:03 P.M., CNA I said:
- Cares were last provided for the resident at 7:30 A.M. for Resident #15;
- Cares included repositioning and ensuring the resident was clean and dry;
- There was not enough staff to keep up with the residents cares;
- The resident should have been changed earlier.

5. Observation on 2/23/25 at 12:02 P.M., showed:
- Two CNAs in the dining room passing trays to residents;
- There were eight residents at two assist dining tables;
- One CNA sat in a rolling chair at each table and rolled between the residents to assist them;
- No more staff came to the dining room to help.

Observation on 2/24/25 at 12:08 P.M., showed:
- There were eight residents at two assist dining tables;
- One CNA sat in a rolling chair at each table and rolled between the residents to assist them;
- No more staff came to the dining room to help.

6. During an interview on 2/25/25 at 8:38 A.M., CNA C said:
- The facility does not have enough staff working

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F 725	Continued From page 77 to complete his/her job; - The facility has had a lot of wounds lately because there is not enough staff to lay residents in bed, reposition them and clean them up every two hours; - The facility does not usually have a shower aide; - The CNAs on the floor are responsible for complete residents showers in addition to all their other tasks; - The facility does not have enough staff to serve the residents at meal time; - The facility does not have enough staff to assist the residents that need assistance during meals and typically have one CNA at each of the assist dining tables to go from resident to resident. During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -She believed there was plenty of staff to get all cares done with the residents; -New staff had been hired on in the past month; -She was not aware of multiple wounds in the building; -She was not aware residents were not receiving two baths weekly.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		

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§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day seven days a week. The census was 70.

The facility did not provide a policy on staffing.

Observation and interview on 02/23/25 at 9:44 A.M., showed:
-Licensed Practical Nurse (LPN) B was the Charge Nurse;
-He/She was the only nurse at the facility;
-He/She was the only nurse the previous day;
-There was no RN in the facility.

Review of the daily staffing sheets showed no RN on:
July 2024: 6th, 7th, 20th, and 21st;
August 2024: 3rd, 4th, 17th, and 18th;
September 2024: 1st, 14th, 15th, and 24th;
No staffing sheets provided for October;
November 2024: 16th, 17th, 23rd, 28th, 29th, and 30th;
December 2024: 1st, 6th, 7th, 8th, 14th, 15th, 21st, 22nd, 24th, 26th, 27th, 28th, 29th, 30th, and 31st;
January 2025: 4th, 5th, 11th, 12th, 15th, 18th, 19th, 25th, and 26th;
February 2025: 1st, 2nd, 22nd, 23rd, and 26th.

Observation of on-line staffing services showed an advertisement for a full time RN.

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F 727	Continued From page 79 During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said: -He/She was the Interim Director of Nursing (DON) from December 20, 2024 until February 3, 2025. -Another RN was hired for the DON position. During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -She was aware there were multiple days without a RN; -She had advertisements out for a DON for 3 years; She had advertisements out for charge nurses; -She added referral and sign on bonuses, and increased wages, but no applications were received; -She had not applied for a waiver. During an interview on 3/17/25 at 10:57 A.M., the Medical Director said: -He was not aware there were days without an RN in the facility; -Not having an RN in the facility could be detrimental to resident care in certain situations.	F 727		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 730		

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F 730	Continued From page 80 failed to ensure nurse aides had a yearly performance review, with resulting individually based education plans, for three nurse aides employed longer than 12 months. The facility census was 40. The facility did not provide a policy for education, and Nurse Assistant Training. Review of personnel records showed: -Certified Nurse Aide (CNA) D, Date of Hire 11/22/00, Annual Education Quiz completed 6/7/24. No competency assessment and training plan. -CNA E, Date of Hire 10/21/22, Annual Education Quiz completed 6/6/24. No competency assessment and training plan. -CNA F, Date of Hire DOH 9/17/01, Annual Education Quiz completed 6/6/24. No competency assessment and training plan. During an interview on 02/27/25 at 12:28 PM, the Quality Assurance Registered Nurse said trainings and tracking were completed by nurse leadership. During an interview on 02/27/25 at 3:10 P.M., the Administrator said: -The previous Director of Nursing (DON) completed the last competency. -He/She did not know the date of the last competency. -He/She expects the DON to complete yearly competency education. -He/She did not know where the tracking was kept	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:

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Based on observation, interview, and record review, facility staff failed to post required nurse staffing information, which included the resident census, and actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift on a daily basis. The facility census was 40.

Observations on 02/24/25 at 2:50 P.M., 02/25/25 at 9:51 A.M., and 02/26/25 at 1:31 P.M., showed posted staffing dated as February 10, 2025.

During an interview on 02/27/25 at 12:28 PM, Quality Assurance Registered Nurse (QA RN) said:
-He/She was the Interim Director of Nursing (DON) December 20, 2024 through February 3, 2025.
-Daily staffing numbers are posted by the night nurse, if it is not done, the DON should pick it up and try to catch it up to the correct day;
-He/She expected the DON ,or the person the DON assigned, to make sure it is done.

During an interview on 02/27/25 at 3:10 PM. the Administrator said:
-She was not aware the staffing information had not been updated and changed since February 10, 2025;
-The night charge nurse was supposed to complete and post the daily staffing;
-The DON should ensure it was completed;
-If the DON was not in the facility some one else should be responsible for checking it.

During an interview on 3/6/25 Registered Nurse A said:
-He/She worked night shift at the facility;
-He/She had not been instructed to fill out the

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F 732	Continued From page 83 posted staffing sheet; -He/She did not know who completed and/or posted the staffing sheet.	F 732		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801		

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or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for

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food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure the Dietary Manager (DM) had the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. The facility census was 40.

The facility did not provide the requested job description for the Dietary Manager.

Review of the DM's personnel file showed:
-Date of hire 10/04/2023;
-No certification for food service management or dietary manager was found.

During an interview on 02/24/25 at 11:32 A.M., the DM said:
-He had been the DM for six months;
-He has worked as a dietary aide, but does not have any managerial experience;
-The facility was getting ready to start on his DM training;
-He has not completed his/her DM's course.

During an interview on 02/27/25 at 03:10 P.M., the Administrator said:
-She would expect the DM to know all regulations related to the kitchen;
-The DM had not completed the dietary training yet;
-She would expect the DM to have the training

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F 801	Continued From page 86 completed. During an interview on 03/05/25 at 12:43 P.M., the Registered Dietitian (RD) said: -The facility is trying to work on training the DM; -He would expect the DM to have the required training to manage the kitchen.	F 801		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff prepared foods in a way to meet the needs of individual residents, when they did not ensure the puree (a texture-modified diet in which all foods have a soft, pudding-like consistency) food had a smooth and appropriate consistency and failed to ensure the mechanical soft diet contained meat that was ground and easy to chew. This affected two residents who had orders for a pureed diet (Residents #6, and #15) and one resident (Resident #3) who had an order for a mechanical soft diet. The facility census was 40. Review of the facility's policy titled, "Types of Diets," dated, May 2015, showed: -Mechanical soft diet is a regular diet modified using chopped or ground meat; -Puree diet foods are blended to mashed potato consistency or altered to meet the needs of the residents.	F 805		

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1. Review of Resident #6's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/08/25, showed:
-Severe cognitive impairment;
-Severe visual impairment;
-Dependent on staff for transfers, bathing, locomotion, toileting and eating;
-Diagnoses included dementia, heart failure, and high blood pressure.

A review of the resident's care plan, dated 02/20/25, showed:
-The resident was on a pureed diet.

A review of the resident's Physician Order Sheet (POS), dated February 2025, showed the resident had an order for a pureed diet.

2. A review of Resident #15's Quarterly MDS, dated 12/27/24, showed:
-No cognitive impairment;
-Substantial assistance of staff for transfers, bathing, locomotion, toileting and eating;
-Diagnoses included depression, stroke, and high blood pressure.

A review of the resident's care plan, dated 01/02/25, showed:
-The resident was on a pureed diet.

A review of the resident's POS, dated February 2025, showed the resident had an order for a pureed diet.

3. Review of Resident #3's Quarterly MDS, dated 02/07/25, showed:
- Severe cognitive impairment;

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- Dependent on staff for activities of daily living;
- Supervision with eating;
- Mechanical altered diet;
- Diagnoses included dementia, high blood pressure, and urinary tract infection.

Review of the resident's care plan dated, 02/20/25, showed:
-The resident has impaired decision making related to dementia;
-Mechanical soft diet.

Review of the resident's POS, dated, February 2025, showed:
-11/07/22, mechanical soft diet.

Observation of meal preparation for lunch on 02/25/25, at 11:31, A.M., showed:
- Cook A began preparing the pureed lunch meal;
- Cook A did not use a recipe to prepare the pureed lunch meal;
- He/She placed two cups of yellow rice into the food processor;
- He/She turned on the food processor and began adding butter and blended until it was the desired consistency;
- The mixture was thick with visible pea sized chunks in it;
- Cook A placed two cups of spinach into the food processor;
- He/She turned on the food processor and blended until it was the desired consistency;
- The mixture was watery and ran off the spoon;
- Cook A began preparing the mechanical soft lunch meal;
- Cook A placed a cooked tuna patty into the food processor;
- He/She turned on the food processor and blended until it was the desired consistency;

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- He/she added butter to the mixture;
- The mixture was dry, tough, and hard to chew.

Observation on 02/25/25, at 12:18 P.M. showed:
-Resident #6 and #15 were served pureed meals that were thick and had chunks in it;
-Resident #3 had difficulty chewing the mechanical soft meat.

Observation of the puree lunch meal test tray on 02/25/25, at 12:56 P.M., showed:
-The tuna patty melt was dry and hard to chew;
-The yellow rice was dry, hard and had no flavor;
-The pureed yellow rice was dry and had no flavor;
-The spinach was watery and ran off the spoon.

During an interview on 02/25/25 at 02:17 P.M., Cook A said:
- Pureed foods should have a pudding like consistency and not be hard to chew;
- Pureed foods should not be watery;
-Mechanical soft foods should not be dry and hard to chew.
- Food should have a good flavor and should not be dry.

During an interview on 02/25/25 at 02:30 P.M., the Dietary Manager (DM) said:
- Pureed foods should have a pudding like consistency and not be hard to chew;
- Pureed foods should not be watery;
-Mechanical soft foods should not be dry and hard to chew;
- Food should have a good flavor and should not be dry.

During an interview on 03/05/25, at 10:17 A.M., the Registered Dietitian (RD) said:

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F 805	Continued From page 90 - He/She expects pureed foods to have a pudding like consistency and not be hard to chew; -Mechanical soft foods should not be dry and hard to chew. - Food should have a good flavor and should not be dry; - He expects the dietary staff to ensure the food is palatable. During an interview on 03/05/25 at 01:38 P.M., the Administrator said: -She expects the food to be palatable and balanced; -She expects diet orders to be followed.	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		

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Based on observation, interview, and record review, the facility failed to ensure staff stored food in a sanitary manner and to maintain the kitchen in a sanitary manner. The food facility census was 40.

Review of the facility's policy, "General Dish Room Sanitation," dated, May 2015, showed:
-Dish rooms must be maintained in a clean and sanitary condition;
-Items must be stored inverted (upside down) to prevent contamination.

Review of the facility's policy, "Cleaning Floors," dated, May 2015, showed:
-Floors will be cleaned after every meal;
-The dietary department must keep the floors of the kitchen free from soil and clutter.

Review of the facility's policy, "Refrigerators and Freezers," dated, May 2015, showed:
-The floors of walk in refrigerators and freezers should be swept and mopped weekly;
-Food should be stored at least 6 inches above the floor.

Review of the facility's policy, "Dishwashing," dated, May 2015, showed:
-Check chemical dispensers for proper operation and an adequate supply of chemical.

Review of the facility's policy, "Wet Mopping," dated, May 2015, showed:
-Dietary floors should be kept in good repair;
-Cracked tiles should be repaired and replaced.

Observation of the kitchen on 02/23/25 at 09:50 A.M., showed:
-The hand washing sink in the kitchen was dirty

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with dirt and grime in the basin;
-The handles on the hand washing sink were covered with dirt and debris;
-A white bucket of dirty water containing debris was sitting under the hand washing sink;
-The dish room floor was covered in dirt and debris;
-There was a black substance on the outside of the dishwasher and under the dishwasher on the floor;
-The paint was peeling off the ceiling in the dish room.

Observation on 02/23/25 at 09:50 A.M., showed Dietary Aide (DA) A put a water pitcher, three glasses, and a coffee cup on to a dish rack and put the rack in the dishwasher;
-The dishes ran through a wash and rinse cycle;
-DA A removed the dish rack with the washed dishes from the dishwasher;
-DA A did not check the sanitizer in the dishwasher before or after using the dishwasher.

Review of the dishwasher sanitation and temperature log dated, February 2025, showed:
-No entry indicating staff checked the sanitizer level on 02/01/25 at lunch;
-No entry indicating staff checked the sanitizer level on 02/02/25 at lunch;
-No entry indicating staff checked the sanitizer level on 02/05/25 at lunch;
-No entry indicating staff checked the sanitizer level on 02/06/25 at lunch;
-No entry indicating staff checked the sanitizer level on 02/07/25 at lunch.

During an interview 02/23/25 at 10:01 A.M., DA A said:
-The sanitizer should be checked before running

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the dishwasher at every meal;
-The sanitizer level should be recorded on the sanitation and temperature log before running the dishwasher;
-He/She did not know why entries were missing on the temperature and sanitation log.

Observation of the serving area in the dining room on 02/23/25 at 10:12 A.M., showed:
-The outside of the refrigerator was covered in dirt and debris;
-The handle was covered in a brown sticky substance;
-The inside and bottom of the refrigerator was covered with food debris and a brown sticky substance;
-A table behind the steam table with multiple glass cups and bowls, setting face up with dirt and debris in them;
-Plastic bowls setting on the table behind the steam table setting face up with dirt and debris in them;
-The glass on the steam table covered in splattered food debris and smudges;
-The inside left corner of the steam table with a puddle of black sticky liquid in the corner;
-The steam table was on and steam was coming from under the lids on the steam table;
-The lids had food debris on them;
-The control knobs of the steam table were covered in sticky, brown grime with food debris stuck to them;
-Dirty masking tape was hanging down from each of the control knobs on the stream table;
-There were multiple tiles missing from the floor next to the steam table;
-The trash can next to the hand washing sink in the serving area with no lid.

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F 812	Continued From page 94 Observation of the kitchen on 02/23/25 at 10:52 A.M., showed: -The walk in cooler had a wet substance the size of a basketball on the floor; -Undated zip lock bag of hamburger patties; -Undated zip lock bag of hotdogs; -A box of health shakes setting on the floor; -A package of opened and undated Brussels sprouts; -The floor of the cooler was sticky and covered with food debris; -Multiple black spots on the ceiling outside of the walk in cooler the size of nickels; -Dry storage showed a clear plastic container of thickener with the dates 09/25/24 - 10/25/24 written on the lid; -16 ounce clear plastic container of flour with the dates 08/16/24 to 10/24/24 written on the lid; -An open package of sugar with no date; -The inside of the microwave covered in dirt and debris; -Floors of the kitchen were covered in dirt and debris. Observation of the kitchen on 02/25/25 at 08:25 A.M., showed: -A rack of pots and pans stored face up; -A plastic container of whisks and spoons with dirt and debris in the bottom; -The ceiling of the kitchen with dust on it; -A black piece of plastic hanging from the sky light over the dish drying rack. During an interview on 02/25/25 at 1:25 P.M., the Dietary Manager (DM) said: -The kitchen should be clean and sanitary; -There should be no food stored on the floor in the cooler; -Food should have a date it was put into storage;	F 812		

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-All food should be stored in a closed container;
-The thickener and flour in the dry storage should have been discarded according the the dates on the containers;
-The kitchen staff clean the kitchen, including the floors;
-The floors in the kitchen should be swept and mopped daily;
-The dietary staff tries to work on it together, but sometimes there is not enough time;
-The kitchen staff is responsible for keeping the service area and the steam table clean in the dining room;
-The dishwasher sanitizer should be checked three times a day and recorded on the log in the dish room;
-Maintenance is in charge of repairs in the kitchen and the dining room;
-The facility does not have a full time maintenance man at this time.

During an interview on 02/27/25 at 03:10 P.M., the Administrator said:
-She expects the kitchen to be clean and in good repair;
-She expects foods to be stored appropriately;
-There should not be food on the floor;
-The dietary staff is in responsible for cleaning the kitchen;
-Maintenance is responsible for the repairs in the kitchen;
-The facility does not have a full time maintenance man right now.

During an interview on 03/05/25 at 12:43 P.M., the Registered Dietitian (RD) said:
-He expects the kitchen to be clean and sanitary;
-He expects the kitchen to in good repair;
-He expects the sanitizer in the dishwasher to be

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F 812	Continued From page 96 checked three times a day and recorded on the log in the dish room; -He expects dishes to be stored in a manner to prevent contamination; -He expects food to be stored in a safe manner.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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(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, interview, and record review, the facility failed to develop and implement water management policy and procedures to reduce the risk of growth and

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spread of Legionella (bacteria that causes Legionnaires' disease, a serious type of pneumonia) which had the potential to affect all residents who resided at the facility. Furthermore, the facility failed to follow infection control guidelines when one staff administered eye drops for one resident (Resident #23) without the use of gloves. The facility census was 40.

The facility did not provide a Legionella policy.

1. Review of the facility's records showed they did not have an implemented water management plan.

During an interview on 2/25/25 at 3:50 P.M. the Administrator said:
- The facility had not had a maintenance employee for over a month;
- The maintenance employee would assess the building water systems;
- The maintenance employee would document water testing and monitoring;
- She was not able to find the facility water management plan.

2. Review of the facility provided, undated policy Gloves showed:
-Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes (moist, inner linings of body cavities such as the nose, eyes, throat, etc), non-intact skin, any moist body substances (blood, sweat, tears, urine, etc) or surfaces soiled with these substances;
-Use examination gloves for procedures involving contact with mucous membranes, for other resident care or diagnostic procedures that do not require sterile gloves.

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F 880	Continued From page 99 Review of Resident #23 Quarterly Minimum Data Set (MDS: A federally mandated assessment tool completed by facility staff) showed: -Brief Interview of Mental Status of 13, indicated very little cognitive deficit; -Partial to moderate assistance of staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself); -Diagnosis of Dementia (a decline in mental ability severe enough to interfere with daily life), Anxiety (excessive worry, fear and nervousness that interferes with daily life), hypertension (high blood pressure), and dry eye. Review of the resident's physician orders for February 2025 showed, Artificial tears 1 drop each eye for dry eye. Observation on 02/26/25 at 12:43 P.M. showed: -Certified Medication Technician (CMT) B did not apply gloves. -CMT B administered one drop of Artificial Tears into the resident's right eye, held pressure to the inner corner of the eye with a tissue for one minute, then applied one drop into the resident's left eye. During an interview on 02/26/25 at 12:43 P.M., CMT B said -He/She should have worn gloves to administer eye drops; -He/She just did not think and gave the eye drops after administering oral medications. During an interview on 02/27/25 at 12:28 P.M., the Quality Assurance Nurse said she would expect gloves to be worn when administering eye drops.	F 880		

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F 880	Continued From page 100 During an interview on 02/27/25 03:10 P.M.. the Administrator said she would expect staff to follow infection control guidelines.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an infection prevention and control program that included an antibiotic stewardship program (a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) that included antibiotic use protocols and a system to monitor antibiotic use. The facility census was 40. The facility did not provide an Antibiotic Stewardship policy. The facility did not provide Antibiotic Stewardship Program documentation that should include: - Protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic are prescribed the appropriate antibiotic; - Procedures to reduce the risk of adverse	F 881		

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F 881	Continued From page 101	F 881		

events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use;
- Procedures to promote and implement a facility-wide system to monitor the use of antibiotics including a system of reports related to monitoring antibiotic usage and resistance data;
- Designated appropriate facility staff accountable for promoting and overseeing antibiotic stewardship;
- Accessing pharmacists and others with experience or training in antibiotic stewardship;
- Implementation of a policy or practice to improve antibiotic use;
- Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff;
- Educate staff and residents about antibiotic stewardship.

Review of the Infection Control binder showed the following:
- January 2025 showed 10 infections, six urinary tract infection (UTI), one eye infection, one tooth infection, and two sialoadentis (infection of the salivary glands);
- February 2025 showed 11 infections, eight UTIs, two respiratory infections, and one skin infection.
- The infections were tracked on a color coded facility map, but no evidence was presented to show the facility staff determined the root cause analysis for the infections;
- There was no evidence the facility provided the staff with infection control education.

During an interview on 2/25/25 at 3:00 P.M., the Administrator said he/she did not have a current Infection Preventionist.

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F 882	Continued From page 102	F 882		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to hire an Infection Preventionist (IP). The facility census was 40. The facility did not provide and Infection Preventionist policy. Review of the Infection Control binder showed it did not include an IP training or certification. During an interview on 2/25/25 at 3:00 P.M. the Administrator said; - The Director of Nursing (DON) said he/she completed the IP course, but had not produced certification indicating the DON had completed the task;	F 882		

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F 882	Continued From page 103 - The facility did not have a current IP; - She knew the facility was suppose to have an IP.	F 882		
F 947 SS=F	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 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 interview and record review, the facility failed to ensure three Certified Nursing Assistants (CNAs), of 7 sampled staff had a minimum of 12 hours of documented yearly in-service education (which should have included abuse, neglect, and dementia cares). This had the potential to affect all of the residents. The facility census was 40 residents. The facility did not provide a policy for education	F 947		

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or and Nurse Assistant Training.

Review of personnel records showed:
-Certified Nurse Aide D, Date of Hire 11/22/00, Annual Education Quiz completed 6/7/24. No other education/in-service records;
-CNA E, Date of Hire 10/21/22, Annual Education Quiz completed 6/6/24. No other education/in-service records;
-CNA F, Date of Hire 9/17/01, Annual Education Quiz completed 6/6/24. No other education/in-service records;
-Nurse Aide A, Date of Hire 10/3/24, no education/in-service records.

During an interview on 02/27/25 at 12:28 PM the Quality Assurance Registered Nurse said:
-Training, documentation of training, and tracking are completed by nurse leadership;
-Yearly trainings for CNAs are based on a calendar year, set up by nursing Leadership;
-Outside vendors, such as hospice, will also provide education for staff at times;
-Ultimately the documentation, tracking and training schedule were the responsibility of the Director of Nursing (DON).

During an interview on 02/27/25 at 3:10 P.M. the Administrator said:
-The previous DON completed the last competency;
-Education is completed by combination of the DON and the Leadership Team;
-He/She expects tracking of all trainings, such as a checklist of all of the employees with their individual components;
-She would expect the DON to document and track all training.
-He/She did not know where the tracking and

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F 947	Continued From page 105 attendance records are.	F 947		

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A4026	19 CSR 30-85.042(22) In-service Training-Nursing Personnel The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/III This regulation is not met as evidenced by: Class III Please refer to F947.	A4026		
A4040	19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights Licensed Nursing Requirements; Skilled Nursing Facility. (B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II This regulation is not met as evidenced by: Refer to F727.	A4040		
A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is	A4046		

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	01936A	A. BUILDING: _____ B. WING _____	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW HOME	1313 SOUTH 25TH ST BETHANY, MO 64424

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A4046	Continued From page 1 responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725, F727, F730, and F947.	A4046		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F684, F692, F695, F656, F677, F686, and F688. MO248336	A4075		
A4076	19 CSR 30-85.042(67) Clean, Dry, Odor Free Each resident shall be clean, dry, and free of body and mouth odor that is offensive to others. I/II This regulation is not met as evidenced by: Class II Refer to F677.	A4076		
A4080	19 CSR 30-85.042(71) Mealtime Assistance/Supervision	A4080		

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A4080	Continued From page 2 All residents who require assistance at mealtimes, whether it be preparation of the food items or actual feeding, shall be provided the assistance upon delivery of the tray. Facilities shall provide dining room supervision during meals. II/III This regulation is not met as evidenced by: Class III Please refer to F688.	A4080		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II Refer to F686.	A4083		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II	A4086		

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A4086	Continued From page 3 This regulation is not met as evidenced by: Class II Refer to F695, F880, F881, and F882.	A4086		
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to his/her needs and interests. II/III This regulation is not met as evidenced by: Class II* Please refer to F679. *The higher classification merited due to the extent of the violation.	A4101		
A4103	19 CSR 30-85.042(94) Activities-Advance Notification The facility shall establish and maintain a program for informing all residents in advance of available activities, activity location and time. III This regulation is not met as evidenced by: Refer to F679.	A4103		

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A5004	19 CSR 30-85.052(4) Food Texture-Chewing Difficulty Special attention shall be given to the texture of food given to residents who have chewing difficulty. II/III This regulation is not met as evidenced by: Class III Please refer to F805.	A5004		
A5012	19 CSR 30-85.052(12) Diet as Ordered, Identification System An identification system shall be established to assure that each resident receives the diet as ordered. II/III This regulation is not met as evidenced by: Class II* Please refer to F805. * Higher classification merited due to the extent of the violation.	A5012		
A5014	19 CSR 30-85.052(14) Personnel Sufficient, Trained There shall be sufficient personnel properly trained in their duties to assure adequate preparation and serving of food. II This regulation is not met as evidenced by: Refer to F801 and F882.	A5014		
A6015	19 CSR 30-87.020(15) Walls/Ceilings/Doors/Windows Clean	A6015		

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A6015	Continued From page 5 Walls and ceilings, including doors, windows and skylights, shall be clean and maintained in good repair. III This regulation is not met as evidenced by: Refer to F812 and F584.	A6015		
A7083	19 CSR 30-87.030(81) Machine Chemical Sanitization, PPM Measured Machines (single-tank, stationary-rack, door-type machines and spray-type glass washes) using chemicals for sanitization may be used provided that-the temperature of the wash water is not less than one hundred twenty degrees Fahrenheit (120°F), the wash water is kept clean, chemicals added for sanitization purposes are automatically dispensed; utensils and equipment are exposed to the final chemical sanitizing rinse in accordance with manufacturers ' specifications for time and concentration, the chemical sanitizing rinse water temperature is not less than seventy-five degrees Fahrenheit (75°F) nor less than the temperature specified by the machine ' s manufacturer; chemical sanitizers used shall meet the requirements of 21 CFR 178.1010 (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services and a test kit or other device that accurately measures the parts per million concentration of the solution is available and is used. II/III This regulation is not met as evidenced by: Class II* Refer to F812.	A7083		

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A7083	Continued From page 6 *The higher classification merited due to the extent of the violation.	A7083		
A7089	19 CSR 30-87.030(87) Glasses/Cups/Utensils Storage Glasses and cups shall be stored inverted. Other stored utensils shall be covered or inverted, wherever practical. Facilities for the storage of knives, forks and spoons shall be designed and used to present the handle to the employee or consumer. Unless tableware is prewrapped, holders for knives, forks and spoons at self-service locations shall protect these articles from contamination and present the handle of the utensil to the consumer. III This regulation is not met as evidenced by: Refer to F812.	A7089		
A8010	19 CSR 30-88.010(10) Advance Directive Requirements Prior to or upon admission and at least annually after that, each resident or his or her next of kin, legally authorized representatives or designees shall be informed of facility policies regarding provision of emergency and life-sustaining care, of an individual's right to make treatment decisions for himself or herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Residents' next of kin, legally authorized representatives or designees shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining	A8010		

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A8010	Continued From page 7 medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he or she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' next of kin, legally authorized representatives or designees shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III This regulation is not met as evidenced by: Class II* Refer to F578. *The higher classification merited due to the extent of the violation.	A8010		

AMENDED PLAN OF CORRECTION

Provider/Supplier Name:	Crestview Home
Street Address, City, Zip:	1313 S. 25th Street, Bethany, Missouri 64424
Date of Survey:	March 4, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265807

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. This submission of the POC does not constitute an admission on the part of Crestview Home ("the facility") as to the accuracy of the surveyor findings, nor the conclusions drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction.	
F578 **SS=E** **A8010**	**Request/ Refuse/ Discontinue Treatment; Formulate Advance Directives** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • Residents #3 and #19, had their advance directive documentation reviewed and corrected. • Resident # 32 expired on March 6, 2025 • Out-of-Hospital DNR (OHDNR) forms signed prior to official incapacitation declarations were invalidated and reissued only after legal confirmation of incapacitation in accordance with state law. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** *All residents are at potential risk.*	**04/17/25**

	• A comprehensive facility-wide audit was completed on all residents with active DPOAs or DNRs to ensure documentation includes required incapacity verification prior to surrogate decision-making. • Special attention was paid to the number of physician signatures required per individual DPOA documents and compliance with applicable state laws. **3. What Measures Will Be Put In to Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Education & Training:** Social Services, Nursing, and administrative staff were re-educated on legal requirements for DPOA activation and execution of OHDNRs. • **Review of DPOA Documents:** All newly received DPOA forms are reviewed by the Social Services Director or designee to determine the conditions under which the DPOA may act, including the number of physician assessments and signatures needed. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Monthly Audit:** The Social Services Director or designee will conduct monthly audits of new and existing Advance Directives, OHDNRs, and DPOA activations to ensure compliance with policy and legal standards. • **Quarterly QAPI Review:** All findings related to advance directive documentation will be reported to and reviewed in monthly QAPI meetings to ensure compliance and identify trends. • **Ongoing Staff Training:** Annual in-services and onboarding orientation for nursing and social services staff will include Advance Directive policy training. • **Documentation Review During Care Plan Meetings:** Advance directive documentation will be reviewed quarterly and as needed with significant changes during resident care plan meetings to ensure it reflects the resident's current legal and medical status. **Date of Compliance:** April 17, 2025	
F584 **SS=E** **A6015**	**Safe/Clean/Comfortable/Homelike Environment**	**04/17/2025**

	1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice: • Repaired or replaced the HVAC system in the main dining room to ensure temperatures are maintained between 71–81°F. • Ensured all dining room doors are operational and remain closed as needed to maintain temperature control. • Removed white rolled blankets used to block drafts at door thresholds and replaced them with proper insulation methods. • Cleaned and opened window blinds in the dining room and hallways to allow natural light and improve resident comfort. • Repaired cracked and missing floor tiles in the dining room; secured any loose tiles and eliminated jagged edges. • Cleaned dead bugs, dust, and debris from all light fixtures, including in the dining room, hallways, and common areas. • Cleaned PTAC unit in the courtyard hall; removed dust and debris and replaced broken or missing plastic vent covers. • Chipped covering on fire doors - new Acrovyn has been ordered and is scheduled to be repaired by May 16, 2025 • Formica on service hall doors – new Acrovyn has been ordered and is scheduled to be repaired by May 16, 2025 • Repaired slash and gouges in the corner sheetrock of the service hall; patched and repainted peeling paint. • Repaired gouges and scratches in the lower third of the sheetrock in the television room on the 400 hall. • Cleaned dust and debris from the surface of the glass table lamp in the television room. • Patched and repainted multiple gouges and scratches along the 400 hallway walls. • Replaced missing handrail end cap at room 421 to eliminate sharp edge hazard. • Secured loose handrail end cap at room 419 and replaced the missing opposite end cap. • Replaced missing handrail end cap at room 416. • Replaced missing handrail end cap at room 414. • Secured loose handrail end cap at room 412. • Tightened and secured small handrail at the corner of the dining hall and 400 hall. • Tightened loose handrail between rooms 408–410. • Replaced missing handrail end cap at room 503 to eliminate sharp edge hazard. • Replaced missing handrail end cap at room 504 to eliminate sharp edge hazard. • Reattached the loose handrail end cap at room 517.	

	• Removed sharp U-shaped metal piece and 2-inch exposed screw from the handrail at the end of the 500 hall. • Patched and repainted drywall and paint damage in the nurse station TV area. • Cleaned dead bugs, dust, and debris from lobby light fixtures. • Cleaned PTAC unit in the lobby; removed dust and debris from vent and unit surface. • Removed cobwebs from ceiling can lights throughout the building. • Replaced second PTAC unit's broken grate and cleaned dust and debris from the vent. • Cleaned dried white drips from the glass billboard. • Replaced long fluorescent light bulbs with covered or shielded fixtures. • Repainted nurse station walls to correct scuffed and chipped paint. • Vacuumed and shampooed carpet in the nurse station and lobby area to remove multiple stains and discoloration. • Removed accumulated dust and debris in the carpet seams. • Removed mold-like substance covering ¼ of the lower shower wall and grout in the 500 hall shower room. • Treated affected shower areas with an anti-microbial cleaner. • Repaired exposed electrical wires in the outlet cutout by the tub to meet safety standards. • Replaced ceiling tiles in the shower room with brown water stains. • Cleaned light fixtures in the 500 hall shower room of dead bugs, dust, and debris. • Removed rhinestone gems and sticky/gummy adhesive residue from the back of the treatment cart; cleaned all surfaces. • Removed glitter letters and cleaned the uncleanable surface on the treatment cart. • Removed black scuff marks from the lower third of the hallway wall from the lobby to the dining room. • Cleaned cobwebs, dust, and debris from windows in the hallway to the dining room. • Cleaned PTAC unit in the hallway from lobby to dining room; replaced cracked plastic vent cover. • Repaired broken wooden trim above the PTAC unit; removed sharp edges and patched peeling sheetrock and chipped paint. • Cleaned dining room windows of dirt, dust, debris, and cobwebs. • Repainted or touched up lower third of dining room walls where nicks and scratches were present. • Replaced rolling stools with cracked vinyl covering and exposed padding in the dining room.	

	• Repaired or replaced crooked cabinet doors in the dining room. • Deep cleaned tile grout in the dining room to remove blackened buildup and crusty substances. • Removed and sanitized small serving bowls/dishes on the prep cart; cleaned dust and debris from storage tray. • Cleaned and sanitized the steam table, including removal of white crusty/dusty substances from the bottom shelf. • Cleaned and sanitized the storage chart legs and bottom shelf to remove white crusty/dusty residue. • Cleaned cobwebs, dirt, and debris from the white prep table and from hanging areas under the legs and corners. • Created and implemented a deep cleaning checklist for all common areas of the facility, including high dusting tasks. • Assigned specific staff to perform and document completion of high dusting and fixture cleaning. • Added dining room and hallways to the facility's deep cleaning rotation. • Retrained housekeeping staff on frequency, standards, and responsibilities for vacuuming, shampooing, and surface cleaning. • Hired a full-time Maintenance Director to ensure timely completion of all work orders and building repairs. • Reinstated a formal work order tracking system and prioritized repairs based on resident safety and comfort. • Assigned administrator and QAPI team to conduct regular walkthroughs to verify maintenance and housekeeping task completion. • Established cross-training and back-up procedures to ensure maintenance and cleaning tasks are completed during staffing shortages. **2.How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** *All residents are potentially at risk.* • A full environmental walkthrough was conducted to assess physical plant safety, cleanliness, and comfort in all areas used by residents. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Reinstatement of Maintenance Department:** A full-time Maintenance Director has been hired and upon orientation will be oriented to the building layout, systems, and immediate repair needs. • **Environmental Services Rounds:** Housekeeping and maintenance supervisors will complete structured	

	weekly environmental rounds, using a standardized checklist that includes flooring, lighting, furnishings, and dusting. • **Preventative Maintenance Program:** A preventative maintenance schedule will be re-implemented, covering HVAC systems, floor and wall inspections, and furniture condition assessments. • **Training and Responsibilities Clarified:** Housekeeping and maintenance staff were/will be retrained on high dusting expectations, daily and deep cleaning tasks, and use of the carpet cleaner. Maintenance staff will be oriented on interior repair protocols, shared duties, and communication expectations. • **Dining Room Climate Control Plan:** The facility maintenance staff performs preventative maintenance on HVAC systems, or utilizes an outside vendor for inspections and or repairs needed. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Weekly Administrator Walkthroughs:** The Administrator or designee will conduct weekly environmental rounds to observe dining areas, common spaces, and resident rooms. Findings will be recorded and follow-ups documented. • **QAPI Review:** All monitored findings will be reviewed monthly at the Quality Assurance Performance Improvement Committee meetings to ensure ongoing compliance or for further review. • **Temperature Logs:** Dining room temperature will be logged three times daily by dietary staff/designee and reviewed by the Maintenance Director and/or Administrator for compliance with comfort standards (71–81°F). **Date of Compliance:** April 17, 2025	
F656 **SS=E** **A4075**	**Develop/Implement Comprehensive Care Plan** **1.Corrective Actions for Residents Affected by the Deficient Practice:** **Resident #28:** • Care plan was updated to include interventions for elopement risk, based on an elevated elopement	**04/17/2025**

	assessment score and observable facility cues (orange door dot). • Interventions for pressure ulcer prevention and treatment were added to reflect the documented wound. **Resident #92:** • Care plan was revised to include skin integrity issues and treatment for existing open areas. • Interventions for pressure injury prevention and monitoring were incorporated. • Staff re-education provided on documenting and reporting new wounds. **Resident #11:** • Wound care plan was updated to include current condition and interventions for the open area on the buttocks. • Ongoing wound status tracking and physician communication were ensured. **Resident #15:** • Care plan was updated to address significant weight loss. • Nutritional interventions and monitoring strategies were added. • Diet order and changes in weight were reviewed and incorporated into the plan to ensure timely dietary adjustments and follow-up. **Resident #36:** • Care plan was revised to reflect recent weight loss trends. • Nutritional interventions, including dietary modification and weight monitoring, were added. **2. Identification of Other Residents Who Could Be Affected:** All residents are at risk of being affected by this deficient practice. A comprehensive audit of all resident care plans is underway to ensure they are individualized, complete, and reflective of current conditions and interventions. **3. Systemic Changes to Ensure the Deficient Practice Does Not Recur:**	

	• Facility policies on care planning were reviewed to strengthen expectations for timely updates and interdisciplinary communication. • All licensed nursing staff and interdisciplinary team members received training on individualized care planning, with emphasis on identifying, documenting, and updating care plans based on changes in condition. • Daily shift communication and end-of-shift reports are reviewed for changes in condition and potential care plan concerns **4. Monitoring of Performance to Ensure Sustainability:** • Auditing of three charts will occur 2x weekly x 4 weeks, then weekly x 4 weeks, then as needed on an ongoing basis by the MDS Coordinator or designee to ensure care plan documentation accuracy and completeness. • Interdisciplinary care plan reviews are conducted during routine care plan meetings to ensure they reflect the most current assessments and interventions. • Audit findings are reviewed during Quality Assurance and Performance Improvement (QAPI) meetings monthly and as needed to identify trends and ensure sustained compliance. **Date of Compliance:** April 17, 2025	
F677 **SS=D** **A4075** **A4076**	**ADL Care Provided for Dependent Residents** **1.Corrective Actions for Residents Affected by the Deficient Practice:** **Resident #15:** • The resident was assessed for any signs of skin breakdown or worsening of the affected area. • Perineal care was provided, and the resident was cleansed, dried, and repositioned. • A full skin inspection was conducted by the licensed nurse, and appropriate wound care interventions were initiated as needed. • Outside wound vendor consulted to evaluate and treat resident • The resident's care plan was reviewed and updated to reinforce specific needs related to incontinence care,	**04/17/2025**

skin integrity, and frequent repositioning, i.e. every 2 hours while in bed, every 1 hour while in chair.

- Staff assigned to the resident received direct re-education on individualized ADL assistance, incontinence care, and frequent repositioning.

1.Identification of Other Residents Who Could Be Affected by the Same Deficient Practice:

All residents who require assistance with ADLs, repositioning, and incontinence care are at risk of being affected by this deficient practice.

2. Measures and Systemic Changes to Ensure the Deficient Practice Does Not Recur:

- **Staff Education:** All direct care staff, including CNAs and nurses, received training on the ADL care policy, expectations for timely repositioning, every 2 hours while in bed, every 1 hour while in chair, and the importance of timely perineal care, every 2 hours or as needed.
- **ADL Rounds Implementation:** The facility implemented frequent ADL rounds each shift, every 2 hours, with care responsibilities documented in real-time using electronic health record entries.
- **Nursing Oversight:** Charge nurses are required to verify ADL care and repositioning compliance during their shift rounds by performing random spot checks to ensure that turning, repositioning and incontinence care are occurring per recommended scheduled and are expected to intervene immediately if deficiencies are observed.

3. Monitoring of Performance to Ensure Solutions Are Sustained:

- **Daily Rounding Audits:** The Director of Nursing or designee will conduct rounds 3x week x 4 weeks, then weekly x 4 weeks, then as needed on dependent residents to monitor compliance with repositioning and perineal care schedules.
- **QA/QAPI Oversight:** All findings from audits and care observations are reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing compliance and develop additional corrective actions if trends are noted.

	• **Ongoing Education:** Refresher training on ADL care and resident dignity is provided annually or as needed based on audit outcomes or staff performance concerns. **Date of Compliance:** April 17, 2025	
F679 **SS=E** **A4101** **A4103**	**Activities Meet Interest/Needs Each Resident** **1. Corrective Actions for Residents Affected by the Deficient Practice:** **Resident #6:** • Resident's comprehensive care plan and activity preferences were reviewed and updated to reflect current needs. • One-on-one and small group activities tailored to the resident's interests (music, spiritual programs, TV, and social interaction) were initiated; Resident was invited to attend and attendance or refusal documented. **Resident #28:** • Individualized activity interventions were initiated, including music, spiritual support, trivia and exercise and brief social interactions to meet emotional needs. • Care plan was revised to emphasize one-on-one social visits and staff-facilitated participation in simple group or hallway activities. • The resident's activity attendance is now being closely monitored and documented. **Resident #92:** • The resident was assessed and care plan updated to reflect personal preferences including reading, music, fresh air, and spiritual activities. • Access to books, puzzles, and music was ensured in the resident's room, and meaningful engagement was initiated.	**04/17/2024**
	3. Identification of Other Residents Who Could Be Affected by the Same Deficient Practice: All residents are at risk of being affected by the absence of a structured, responsive, and consistent activity program. A facility-wide audit of all residents' activity assessments and participation records was initiated to identify unmet activity needs and ensure that individual preferences are honored.	

	3. Measures and Systemic Changes to Ensure the Deficient Practice Does Not Recur: • **Activity Director:** A dedicated Activity Director has been appointed to oversee the development and execution of the activity program, ensuring it is resident-centered and consistent with regulatory requirements. • **Activity Calendar Implementation:** A monthly activity calendar has been developed and distributed to each resident room, and posted in common area, listing daily group and individual activities with activity times and locations. • **Assessment and Documentation:** Activity preferences are reviewed during admission, quarterly assessments, and upon any changes in condition. Resident participation is documented, and non-participation is followed up with individualized alternatives. • **Staff Training:** All staff were re-educated on the importance of activities for resident well-being and trained to identify signs of social withdrawal or boredom, and to refer residents to the activity program or report concerns to nursing or social services.	
	4. Monitoring of Performance to Ensure Solutions Are Sustained: • **Weekly Activity Audits:** The facility Administrator or designee conducts weekly reviews of activity participation logs, calendar postings. Activity program resident satisfaction will continue to be reviewed monthly during resident council meetings x 8 weeks, then as needed to ensure ongoing compliance. • **Resident Interviews:** Monthly resident council meetings and individual interviews are conducted, if necessary, to gather feedback on activity satisfaction and suggestions. • **Quality Assurance Review:** The QA Committee reviews activity engagement data monthly and as needed with focus on participation trends, preference alignment, and individual needs of residents with limited interaction. • **Documentation Review:** Care plans are reviewed quarterly and as needed to ensure activity preferences are reflected and individualized strategies are documented and implemented. **Date of Compliance:** April 17, 2025	

F684 **SS=D** **A4075**	**Quality of Care** **1. Corrective Actions for Residents Affected by the Deficient Practice:** **Resident #7:** • The resident received the physician-ordered blood transfusion. • The care plan was updated to reflect the need for timely follow-through on lab results and physician-ordered treatments. • Staff responsible for the delayed follow-through, including the Business Office Manager and nursing team, were re-educated on their respective roles in processing and executing physician orders. **2. Identification of Other Residents Who Could Be Affected by the Same Deficient Practice:** All residents are at risk of being affected by this deficient practice. **3.Measures and Systemic Changes to Ensure the Deficient Practice Does Not Recur:** • **Designated Order Review:** The Director of Nursing or designee reviews physician orders that have been entered into the medical record, and that corresponding actions (appointments, medications, lab draws, etc.) have been scheduled. • **Backup Staffing Protocol:** A formal back-up procedure was established for the Business Office Manager (BOM). In the BOM's absence, the HR Director/AP specialist or Administrator will ensure all incoming physician communications are processed without delay. • **Staff Education:** All nursing staff, the BOM, HR staff, and administrative personnel were re-educated on the importance of timely execution of physician orders, interdepartmental communication, and professional standards of care. Training emphasized risk factors associated with delays in critical treatments like blood transfusions. **4. Monitoring of Performance to Ensure Solutions Are Sustained:**	**04/17/2025**

	• **Daily Review:** The Director of Nursing or designee reviews physician orders and new order entries daily to ensure no delays occur in implementation. • **Weekly Audits:** A random sample of 10 physician orders is reviewed weekly x 8 weeks, then as needed for timely follow-up and documentation, including lab work, referrals, and treatments by the Director of Nursing or designee. Any non-compliance is addressed as it is identified. • **QAPI Oversight:** Monthly Quality Assurance and Performance Improvement (QAPI) meetings include a standing agenda item on order processing efficiency and delays. Results of audits are reviewed and additional training or system improvements are implemented as needed. **Date of Compliance:** April 17, 2025	
F686 **SS=E** **A4075** **A4083**	**Treatment/Services to Prevent/Heal Pressure Ulcer** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** **Resident #28:** • A full wound assessment was completed by the licensed nurse/outside wound care vendor and/or hospice. • Physician notified and orders obtained for wound care. • Care plan updated to reflect PU risk, current treatment, and prevention strategies. • Resident placed on a frequent turning and repositioning schedule, every 2 hours while in bed, every 1 hour while in chair. **Resident #92:** • Wounds/skin concerns assessed; treatment orders obtained from physician. • Resident provided with pressure-relieving cushion and frequent incontinence care. • Resident declined the implementation of a low air loss mattress due to personal preference • Call light response times are now being closely monitored for this resident. **Resident #11:**	**04/17/2025**

	• Wound assessment completed; outside wound team continue to follow resident weekly. • Physician notified and updated treatment orders obtained. • Gaps in previous documentation were addressed with staff re-education. • Care plan revised to reflect current wound status and interventions. • Resident on frequent repositioning schedule, every 2 hours while in bed, every 1 hour while in chair **Resident #15:** • Skin area of concern was assessed with outside wound care team and treatment initiated per physician orders. • Resident placed on frequent repositioning schedule, every 2 hours while in bed, every 1 hour while in chair/recliner. • Care plan updated to reflect skin/wound status, repositioning needs, and incontinence management. • Involved CNAs were re-educated on ADL support and repositioning frequency.	
	2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice: All residents are at risk. A facility-wide audit was initiated for: • All residents with current wounds or at mild-moderate risk or higher per Braden Scale. • Presence and accuracy of care plans related to skin integrity. • Timely communication with providers for new or worsening wounds.	
	3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Wound Care Protocols Reinforced:** Facility wound policy was reviewed. All licensed staff re-educated on identification, assessment, staging, and documentation of pressure ulcers, timely notification of provider and	

	implementation of orders and reduction strategies, and turning/repositioning schedule. • **Braden Scale Accuracy:** Braden assessments are now reviewed by the DON/designee to ensure accuracy and proper care planning. • **Repositioning Schedule Implementation:** All elevated risk residents are placed on a frequent turning and repositioning schedule, every 2 hours while in bed, every 1 hour while in chair. • **Wound Documentation Tools:** Standardized wound tracking documentation method was re-introduced. These include size, depth, drainage, location, staging, and dressing status, reviewed weekly; utilizing 'Wound Management' module in EMR. • **Shower Sheet Compliance:** CNAs, nurses, and DON are re-educated on completing and signing CNA Shower Review forms. Supervisory spot checks will be conducted as needed by the Director of Nursing or designee. • **Staffing and Workload Review:** Staffing patterns were evaluated to ensure adequate CNA coverage to allow for turning, repositioning, and skin care per resident's needs. Adjustments will be made based on resident acuity and needs. • **Chain of Communication:** New communication expectations were established: o CNAs must report all observed skin concerns immediately to the nurse. o Nurses must notify the physician and document interventions. o DON/designee to ensure follow-up and order implementation. • **Education:** Facility-wide training was conducted on PU prevention and care, including: o Early identification and proper notification of provider of skin issues. o Documentation responsibilities. o Repositioning and incontinence care protocols.	

	○ Communication procedures for new or worsening wounds. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Skin Rounds:** The DON or designee conducts weekly and as needed skin integrity rounds for high-risk residents, reviewing wound care, positioning, and documentation to ensure completion of weekly skin assessments by licensed nurses. • **Weekly Wound Audits:** All weekly wound documentation will be audited weekly x 8 weeks, then as needed on an ongoing basis by the facility Director of Nursing or Designee for completeness, accuracy, and timely physician and resident responsible party notifications. • **Shower Sheet Audits:** The DON/Designee reviews CNA Shower Review forms to ensure all skin changes are properly reported and addressed. • **QAPI Oversight:** All findings and trends related to skin integrity are reviewed during monthly and as needed QAPI meetings. Root cause analysis will be conducted for any new facility-acquired wounds. • **Re-education as Needed:** Any lapse identified in compliance will result in immediate re-education and potential disciplinary action based on severity. **Date of Compliance:** April 17, 2024	
F688 **SS=D** **A4075** **A4080**	**Increase/Prevent Decrease in ROM/Mobility** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** **Resident #15:** • A physician order was obtained for an Occupational Therapy evaluation for contracture management to include passive range of motion (PROM) exercises for the left hand. • Occupational Therapy scheduled to evaluate resident's left-hand contracture and establish treatment/splinting/ROM plan. • Nursing and CNA staff were instructed on the resident's individualized ROM needs, including PROM during daily care.	**04/17/2025**

	• The resident's care plan was updated to reflect ROM deficits and interventions, including devices and PROM needs.	
	2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice: All residents are at risk. A facility-wide audit was initiated to: • Identify all residents with known or suspected ROM deficits. • Review care plans for inclusion of ROM interventions and assistive devices.	
	3. What Measures Will Be Put Into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Therapy Screening and Oversight:** The therapy department will perform ROM screens on residents as needed. Referrals will be made for therapy services as appropriate. • **Care Plan Updates:** All identified contracture management/prevention needs will be documented in the comprehensive care plan, including any PROM needs, positioning needs, use of therapy services, and the use of assistive devices (e.g., splints, braces). • **CNA and Nursing Education:** Staff were re-educated on: o Identifying contractures and the risks of immobility. o Performing PROM during ADL care. o Proper use and documentation of assistive devices. o Reporting changes in ROM to licensed nurses.	
	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained: • **Weekly ROM Compliance Audits:** The DON or designee will conduct weekly audits x 8 weeks, then as needed on an ongoing basis to ensure residents with ROM deficits are receiving contracture management	

	services as ordered such as therapy, splinting, PROM, and that resident care plans reflect current needs. • **QAPI Oversight:** Audit results, and staff compliance will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to drive ongoing improvement. • **Continued Staff Education:** ROM care will be included in annual in-service training for all direct care staff, with additional education provided if compliance issues arise. **Date of Compliance:** April 17, 2025	
F692 **SS=D** **A4075**	**Nutrition/Hydration Status Maintenance** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** The facility will ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight ranges, electrolyte balance, unless the residents clinical condition demonstrates that it is not possible or the resident preferences indicate otherwise; (2) Is offered sufficient fluid intake to maintain proper hydration and health; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet R# 15 will receive supplementation as recommended by the Registered Dietician (RD) and as ordered by the physician, and be weighed monthly and/or weekly as needed **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. **3. What Measures Will Be Put Into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** All Dietary and Nursing staff will be in-serviced by the Facility Administrator, Director of Nursing or Designee(s) regarding the following: (1) Providing ordered supplementation at and between meals The Dietary Manager or Designee(s) will complete an audit to ensure ordered supplements are in place by monitoring meals to ensure supplements are being provided 3-4 x per week x 8	**04/17/2025**

	weeks, then as needed on an ongoing basis to ensure continued compliance. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** The Dietary Manager or Designee(s) will report all monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for further review and to ensure continued compliance. **Date of Compliance:** April 17, 2025	
F695 **SS=D** **A4086**	**Respiratory Care Including Tracheostomy Care and Suctioning** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** **Resident #15 and Resident #38:** • Both residents' nebulizer masks were removed, cleaned, and stored properly in clean, labeled plastic bags. • Replacement nebulizer kits were provided if contamination was suspected. • Their treatment areas were cleaned and disinfected. • Both residents' care plans were updated to include specific instructions for nebulizer mask storage. • Staff responsible were re-educated on proper storage procedures for nebulizer equipment. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents who use nebulizer treatments are at risk. A full audit of all residents with physician orders for nebulizer use was conducted to: • Verify that masks and tubing are stored appropriately per infection control standards. • Ensure all equipment is clean, dry, and stored in labeled, sealed bags when not in use. • Identify and replace any improperly stored or potentially contaminated equipment. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:**	**04/17/2025**

	• **Staff Training:** All nursing staff were re-educated on:
	  ○ Infection control standards related to nebulizer use
	  ○ Appropriate cleaning and storage procedures
	  ○ The importance of adhering to physician orders and equipment care guidelines
	• **Labeling and Supplies:** Labeling pens and plastic storage bags are now stocked and available on all carts and units to ensure proper storage of respiratory devices.
	• **Resident-Specific Instructions:** All residents with nebulizer treatments now have care plan interventions specifying proper storage and equipment handling.	

	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained: • **Daily Respiratory Equipment Checks:** The assigned nurse on duty or designee complete visual checks of nebulizer storage during their daily rounds. Non-compliance is corrected as it is identified. • **Weekly Audits:** The Director of Nursing or designee will conduct weekly audits x 8 weeks, then as needed of respiratory equipment storage for all residents using nebulizers. • **Monthly QAPI Review:** Results of respiratory equipment audits are reviewed during the monthly and as needed Infection Control and QAPI meetings. • **Ongoing Staff Education:** Refresher training on nebulizer storage and infection prevention practices will be conducted annually and as needed. **Date of Correction:** April 17, 2025	
F700 **SS=D**	**Bed Rails** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** **Resident #6:** • A comprehensive bed rail assessment was completed, including evaluation of risks and benefits.	**04/17/2025**

	• The compatibility between the Halo rails, the resident's bed frame, and mattress was reviewed to ensure safety and reduce the risk of entrapment. • Entrapment zone measurements were conducted and documented. • The resident's representative was provided with education regarding the bed rail use and informed consent was obtained and placed in the resident's medical record. • The care plan was revised to include the rationale for bed rail use, monitoring instructions, and documentation requirements. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents are at risk. A facility-wide review was completed to: • Identify residents currently using any form of bed rails. • Confirm the presence of required documentation, including risk/benefit assessments, informed consents, entrapment zone evaluations, and equipment compatibility checks. **3. What Measures Will Be Put Into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Policy Review and Revision:** The Bed Rail policy was reviewed including detailed procedures for: o Completion of resident-specific assessments prior to installation. o Documentation of risk/benefit evaluations and informed consent. o Entrapment zone testing and ongoing re-evaluation schedules. o Verification of equipment compatibility. • **Staff Training:** Nursing and maintenance staff received training on: o Regulatory requirements for bed rail use. o How to complete bed rail assessments, informed consent documentation, and care planning.	

	○ Responsibilities for proper rail installation and testing procedures. • **Clarified Roles:** ○ Nursing is assigned responsibility for conducting assessments and obtaining consent. ○ Maintenance/designee is assigned responsibility for installation, entrapment testing, and ensuring equipment compatibility. ○ Oversight is provided by the Director of Nursing/designee to confirm interdisciplinary coordination. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Monitoring:** The Director of Nursing or designee will review bed rail use weekly x 8 weeks, then as needed for all applicable residents to verify presence of current assessments, consents, compatibility documentation and care planning. • **Entrapment Testing Schedule:** Maintenance will perform entrapment zone evaluations for each bed rail system every six months, and whenever bed or mattress changes occur. • **Quality Assurance Reviews:** Bed rail safety practices and audit findings will be reviewed quarterly during QAPI meetings, with action plans developed for any identified issues. • **Incident-Based Reassessment:** Any concerns, complaints, or incidents related to bed rails will trigger a reassessment of the resident's rail use and review of compliance with policy. • **Ongoing Training:** Bed rail regulations and safety practices will be integrated into annual training for clinical and maintenance staff to maintain awareness and consistency. **Date of Correction:** April 17, 2025	
F725 **SS=E** **A4046**	**Sufficient Nursing Staff** **1.How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:**	**04/17/2025**

	Residents #15, #28, and #92: • Reassessments were completed to evaluate each resident's skin integrity, ADL needs, and incontinence management. • Missed or delayed care services, including repositioning and bathing, were addressed and care plan interventions updated to reflect current needs. • Skin care treatments were reviewed and adjusted as needed in consultation with the physician and outside wound care vendor. • Call light response times will be randomly monitored for Resident #92 and care adjusted based on feedback and needs. • Each resident was reassessed for dining assistance needs and assistance scheduled accordingly to ensure appropriate support provided during meals.	
	2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice: All residents are at risk. A facility-wide review was conducted to: • Assess staffing levels in relation to resident acuity and ADL support requirements. • Identify gaps in the delivery of repositioning, incontinence care, showering schedules, and meal assistance. • Verify that all residents are receiving the care outlined in their individualized care plans.	
	3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Staffing Pattern Review:** The facility reviewed its staffing model considering resident acuity, care complexity, and peak care hours (e.g., mornings and meal times). Adjustments were made accordingly, if warranted. • **Reinforced Shower Schedule:** A master shower schedule continues to be used in the CNA assignment book.	

	• Charge nurse or designee will verify shower/bathing completion per schedule/needs.
	• **Meal Assistance Staffing:** Staffing assignments were adjusted to provide additional support in the dining room. A minimum of two CNAs per assistive dining area are scheduled during meals, with backup staff available.
	• **Education and Expectations:** All nursing staff were re-educated on:
	  o The importance of timely incontinence care, repositioning, and bathing. Repositioning while in bed every 2 hours, every 1 hour while in chair/recliner, incontinence care every 2 hours and as needed.
	  o Monitoring and supporting residents during meals.
	  o Prompt call light response expectations.
	  o The relationship between staffing adequacy and quality care outcomes, including pressure ulcer prevention.
	
	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:
	• **Compliance Audits:** The Director of Nursing or designee will review turning/repositioning and incontinence care through random audits, will review shower logs, call light response times and assess for adequate dining room assistance coverage 3x week x 4 weeks, weekly x 4 weeks, then as needed on an ongoing basis to ensure continued compliance.
	• **QAPI Review:** All monitored findings will be reviewed monthly and as needed. Trends are analyzed and addressed through action plans or staff reallocation.
	• **Resident/Family Feedback:** Comments related to care timeliness, cleanliness, and meal support from grievance forms are reviewed and factored into staffing evaluations.
	
	Date of Correction: April 17, 2025	

F727 **SS=E** **A4040**	**RN 8 hours a day / 7 days a week, Full Time DON**	**04/17/2025**

A4046	**1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • RN coverage is now maintained according to federal requirements to ensure timely assessment, supervision, and clinical decision-making for all residents. • The facility ensured nursing care services provided during RN absences were reviewed to identify any care concerns; none were substantiated. • **Waiver Process Awareness:** The Administrator and DON were educated on CMS waiver requirements for RN coverage and procedures to apply, should recruitment challenges continue to persist in the future.	
	2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice: All residents are at risk when there is insufficient RN coverage.	
	3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Staffing Plan Revision:** The facility's staffing schedule has been revised to ensure RN coverage is maintained for at least eight consecutive hours daily, seven days per week. • **Back-Up Coverage Protocol:** A contingency plan was implemented for RN coverage during absences, utilizing PRN RN staff, regional RN support, or temporary staffing agencies. • **Recruitment and Retention Strategy:** o A competitive wage review was conducted and adjustments made. o Sign-on and referral bonuses were enhanced. o Partnerships were established with nursing schools and local agencies to improve recruitment pipelines. • **DON Role Clarification:** The DON position is now fully staffed and designated exclusively for administrative and leadership functions, without routine charge nurse duties, in compliance with regulation.	

	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained: • **Weekly Review:** The Administrator and DON/designee will conduct an audit 2x week x 4 weeks, weekly x 4 weeks, then as needed of staffing schedules to ensure the RN presence meets regulatory expectations. • **Monthly QAPI Monitoring:** RN staffing compliance is reviewed as a standing agenda item during QAPI meetings. • **Communication with Medical Director:** The Medical Director is included in quarterly and as needed reviews of staffing adequacy and will be notified of any prolonged or unexpected gaps in RN coverage. • **Staffing Benchmark Reports:** Reports are generated monthly to track staffing trends, RN turnover, and recruitment efforts, which are analyzed for opportunities for improvement. **Date of Compliance:** April 17, 2025	
F730 **SS=E** **A4046**	**Nurse Aide Performance Review – 12 Hr/Year In-Service** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • A performance review was completed for CNAs D, E, and F. • Based on their evaluations, individualized in-service education plans were developed and implemented, tailored to each CNA's identified learning needs and job responsibilities. • All three CNAs received in-service hours to ensure compliance with the minimum 12-hour annual requirement. • Education records were updated and placed in each employee's personnel file. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents are at risk when nurse aides do not receive annual performance reviews and competency-based education.	**04/17/2025**

	• A facility-wide audit of all nurse aide personnel files was conducted to identify any missing performance reviews, training records, or incomplete in-service hours. • All identified gaps were addressed with completion of reviews and provision of required training.	
	3. What Measures Will Be Put Into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Centralized Tracking System:** A tracking system was established to monitor due dates for each CNA's annual review, competency assessment, and in-service hours. The HR Director or designee maintains and reviews the system monthly. • **Standardized Competency Checklist:** A comprehensive checklist was developed to ensure consistency in skill assessment across all CNAs. It includes core competencies (e.g., infection control, communication, ADL care) and specialty topics relevant to facility needs. • **Individual Learning Plans:** Each CNA now has an individualized in-service education plan based on their performance evaluation results and facility trends (e.g., pressure ulcer prevention, dementia care). • **Ongoing Training Schedule:** A calendar of monthly CNA in-services was developed to ensure consistent delivery of relevant education topics throughout the year.	
	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained: • **Monthly Compliance Reviews:** The HR Director or Designee will review the CNA education tracker monthly to ensure timely completion of performance reviews and in-services. • **Quarterly Audit Reports:** Compliance with CNA annual reviews and in-service hour requirements will be presented at monthly Quality Assurance and Performance Improvement (QAPI) meetings. • **Leadership Oversight:** The Administrator and DON/designee will jointly review education records monthly during QAPI meeting to confirm regulatory compliance and address any deficiencies proactively.	

	Date of Compliance: April 17, 2025	
F732 **SS=C**	**Posted Nurse Staffing Information** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • The facility updated and posted the nurse staffing information in a clear and readable format, including all required elements (facility name, current date, total number of staff, actual hours worked by RNs, LPNs, CNAs per shift, and the resident census). • Staff responsible for posting this information were educated on the regulatory requirements and proper procedures. • The posting area was checked to ensure visibility and accessibility to residents and visitors. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents and visitors are at risk when staffing information is not updated and accurately displayed. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Staffing Posting Procedure:** A standardized daily staffing log and posting form was updated. The form includes fields for all required data and prompts the staff member to complete each section. • **Designated Responsibility:** The night shift charge nurse was designated to complete and post the staffing information. • **DON Oversight:** The Director of Nursing (DON) or designee will verify the staffing board has been updated as part of his/her daily rounds. • **Education and Accountability:** All licensed nursing staff received education on the requirement to post nurse staffing data daily. Staff were made aware of the importance of this regulation and the consequences of non-compliance. • **Permanent Posting Location:** The staffing data board is permanently located in a prominent area near the	**04/17/2025**

	West Nurse's Station entrance door for clear visibility to residents, families, and visitors. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Daily Review:** The DON or designee will review the staffing board daily to ensure that the data has been updated correctly. • **Monthly QAPI Oversight:** Compliance with nurse staffing postings will be reviewed monthly in QAPI meetings. Any lapses will trigger corrective action, retraining, or procedural changes. • **18-Month Retention Monitoring:** All posted staffing data will be retained in a secure, organized format for at least 18 months, as required by federal and state regulations. **Date of Compliance:** April 17, 2025	
F801 **SS=F** **A5014**	**Qualified Dietary Staff** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** The facility will employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services, taking into consideration resident assessments, individualized plans of care and the number, acuity and diagnosis of the facility's resident population in accordance with the facility assessment required. This includes; (1) A Qualified Registered Dietitian on a consultant basis (2) A Designated Director of Food and Nutrition Services whom: a. Is a Certified Dietary Manager b. Is a Certified Food Service Manager c. Has a similar National Certification for Food Service Management d. Has an Associates or higher level of Education in Food Service or Hospitality Management. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents are potentially at risk if the dietary personnel do not receive the required education. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:**	**04/17/2025**

	1. The Dietary Manager has completed an approved Certified Food Service Manager program on March 25, 2025. 2. The Dietary Manager will continue to have regular consultation from the Registered Dietitian Consultant as well as daily oversight from the facility Administrator. The Registered Dietitian will continue to provide "Consultant" services as agreed upon between the "Facility" and "Consultant. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** The Dietary Manager's completed certification was reported to the QA&A Committee in March 2025. **Date of Compliance:** April 17, 2025	
F805 **SS=E** **A5004** **A5012**	**Food in Form to Meet Individual Needs** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** The facility will ensure each resident receives and the facility provides; (1) Food prepared in a form designed to meet individual needs. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents were potentially affected by the alleged deficient practice, specifically resident's #6, #15, and #3. **3. What Measures Will Be Put Into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** All recipes, inclusive of Soft and Bite Size, Minced and Moist, and Pureed; will be followed to ensure desired, appropriate consistencies are achieved and food is palatable. Dietary staff will be monitored by the Dietary Manager or designee(s) on following all recipes to achieve desired textures and palatability of food items served. The Administrator, Dietary Manager or designee will monitor meal service 3-4 times weekly for compliance and to ensure food consistencies and palatability are appropriate. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:**	**04/17/2025**

	All monitored findings will be reported monthly to the Quality Assurance Performance Improvement committee and monitored 90 days thereafter. **Date of Compliance**: April 17, 2025	
F812 **SS=F** **A6015** **A7083** **A7089**	**Food Procurement, Store/Prepare/Serve-Sanitary** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** Facility will ensure: (1) Food is procured from sources approved by or considered satisfactory by Federal, State or Local authorities; • May include food items obtained directly from local producers, subject to state and local laws or regulations. • Does not prohibit or prevent facility from using produce grown in facility gardens. • Does not preclude residents from consuming foods not procured by the facility. (2) Food is stored, prepared, distributed and served in accordance with professional standards for food service safety **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents were potentially affected by the alleged deficient practice. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** The facility will ensure; 1. Handwashing sink and handles will be cleaned and free of debris. White bucket collecting water will be removed. 2. Dish room area and floor will be cleaned and free of debris. 3. Ceiling in the dish room will be repaired and free of chipping paint. 4. Dish Machine temperatures and sanitizing solution will be checked and documented prior to each use every day. 5. Refrigeration units will be cleaned and free of food debris and/or food splatters inside and outside of unit. 6. Table behind the steam table will be cleaned and free of debris. 7. Steam table, steam table glass, and knobs will be cleaned and free of build-up and food debris. Black tape will be removed from knobs.	**04/17/2025**

	8. Cups, bowls and dinnerware will be clean and free of debris, and stored inverted down to prevent contamination. 9. Dinnerware (domes) will be free of dried food build up. 10. Tiles will be replaced on the floor next to the steam table. 11. All trash can lids will be intact when the can is not in use. 12. Walk-in cooler floor will be cleaned, free of food debris, and free of pooling water. 13. Microwave will be cleaned and free of food debris 14. All cookware and service ware will be stored inverted down, service utensils will be stored in a clean and secure location. 15. Skylight will be repaired. 16. All food not labeled, dated or stored appropriately will be discarded. Food will be stored appropriately, labeled, dated and stored in a secure location. All dietary staff will be in-serviced by the Dietary Manager/designee on the following areas: 1. Food storage, labeling and dating. 2. Dishwashing process and documentation 3. Cleaning of large and small equipment 4. Storage of cookware and service ware 5. Trashcan maintenance 6. Maintenance repair reporting. The Administrator, Dietary Service Manager or designee will monitor the above areas 3-4 times weekly for compliant practice. The Registered Dietitian will monitor during regular scheduled visits. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** All results will be reported to Quality Assurance Performance Improvement Committee monthly and monitored for 90 days thereafter. **Date of Compliance**: April 17, 2025	
F880 **SS=F** **A4086**	**Infection Prevention and Control** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** The facility does and will continue to ensure that it maintains a water management program to include weekly, monthly and annual water surveillance checks for temperature management and the presence of biofilm to minimize the risk of Legionella in the facility's water supply.	**04/17/2025**

	A new maintenance staff member was hired to oversee building systems and ensure completion of water system monitoring per the water management plan. Outside vendor has been scheduled to complete water system monitoring per the water management plan until the newly hired maintenance staff member can be trained on the water management protocol and testing. R#23 was reassessed by nursing to ensure no adverse effects occurred from the eye drop administration performed without gloves. No signs of infection or harm were noted. All CMT's, including CMT B was re-educated on proper infection control practices, specifically related to glove use when administering eye drops and other procedures involving mucous membranes. **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 cited deficiency. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** The facility Administrator and Maintenance Supervisor/designee were provided education regarding the requirement to complete the Water Management Program to include "Monthly Water Management Checklist" and "Annual Water Checklist" by the Independent Environmental Consultant. The facility Administrator and Maintenance Supervisor/designee will ensure that monthly water checks are completed per facility guidelines using the "Monthly Water Management Checklist". The facility Director of Nursing or designee will perform random infection control audits to include proper glove use, 2x week x 4 weeks, then weekly x 4 weeks, then as needed to ensure ongoing compliance. Any negative findings will be addressed immediately. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** The Maintenance Supervisor or designee will report monitored water management findings to the QAPI committee for review and further action monthly and 90 days thereafter. The Director of Nursing or designee will report infection control/gloving audit findings to the QAPI committee for review and further action monthly and 90 days thereafter.	

	Date of Compliance: April 17, 2025	
F881 **SS=F** **A4086**	**Antibiotic Stewardship Program** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • All residents who were prescribed antibiotics in the last 3 months had their antibiotic usage reviewed by the Infection Preventionist to ensure appropriateness of the antibiotic, dosage, duration, and diagnosis. • Any concerns identified during review were discussed with the prescriber and corrected accordingly. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents are at risk for adverse outcomes from inappropriate or unmonitored antibiotic use. • A facility-wide review of antibiotic orders from the past 3 months was completed to identify prescribing trends, appropriateness, and documentation of infection diagnosis. • All current residents receiving antibiotics were reviewed to ensure orders are consistent with best practices and that there is documentation supporting clinical necessity. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Antibiotic Stewardship Policy:** A review of the antibiotic stewardship policy occurred that included protocols for appropriate prescribing, documentation, duration, and diagnosis. • **Designated Stewardship Leader:** The facility part-time MDS Coordinator is serving at the Infection Preventionist (IP) and was assigned as the facility's Antibiotic Stewardship Coordinator. • **Pharmacist Collaboration:** The consulting pharmacist now reviews all antibiotic prescriptions monthly and provides feedback to the Interim IP and/or Director of Nursing on any inappropriate or high-risk usage. • **Infection Tracking:** The facility will continue to monitor infections to identify any trends	**04/17/2025**

	• **Staff Education:** All licensed staff were educated on the purpose and procedures of the Antibiotic Stewardship Program. Topics included appropriate use, resistance prevention, and documentation practices. • **Antibiotic Review Tool:** An antibiotic review tracking form is utilized to capture indication, agent, dose, route, duration, and culture results for all new antibiotic orders.	
	4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained: • **Monthly Antibiotic Review Reports:** The IP and pharmacist will review all antibiotic use monthly and compile a report of trends, appropriateness, and opportunities for intervention. These reports will be shared with the medical director and reviewed at QAPI. • **QAPI Oversight:** Antibiotic stewardship findings, trends, and action plans will be reviewed monthly in the QAPI committee meeting to identify ongoing improvement opportunities. • **Infection Education and Surveillance:** Staff will receive annual and as needed infection control education, including updated stewardship goals. Surveillance logs will include not just infection data, but antibiotic review and interventions. • **Annual Program Review:** The Antibiotic Stewardship Program will be reviewed annually by the Infection Preventionist, Medical Director, and QAPI committee and updated as needed based on national guidance and facility data. **Date of Compliance:** April 17, 2025	
F882 **SS=F** **A4086** **A5014**	**Infection Preventionist Qualifications/Role** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:** • A qualified individual with nursing and infection control experience, the facility part-time MDS Coordinator RN with ICP certification, was assigned to oversee the Infection Prevention and Control Program (IPCP) while the permanent IP role is fulfilled. • The Director of Nursing (DON) was enrolled in a CMS-approved Infection Preventionist training program the	**04/17/2025**

	MDS Coordinator will serve as the designated Infection Preventionist until completed. **2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:** All residents are at risk of being affected due to the absence of a designated and qualified IP. **3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur:** • **Designation of Qualified IP:** A Registered Nurse with infection control experience was designated as the facility IP, and proof of completion of the CMS-approved Infection Preventionist training will be placed in the Infection Preventionist Manual and retained on file. • **IPCP Reinforcement:** The Infection Control Program was reviewed and revised to ensure ongoing surveillance, prevention, and reporting functions are maintained by qualified staff. • **Ongoing Training:** The DON, IP, and/or designee(s) will attend infection prevention webinars and training sessions through CMS or other approved bodies to maintain up-to-date knowledge and competencies as available. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Monthly QAPI Review:** The IP will provide monthly reports to the QAPI committee on infection rates, interventions, training completed, and program updates. • **Certification Monitoring:** The Administrator, Director of Nursing or designee will verify annually that the IP has completed required education. • **Annual Program Review:** The Infection Prevention and Control Program will be reviewed annually by the QAPI team and revised as needed to ensure alignment with CDC and CMS guidelines. **Date of Compliance:** April 17, 2025	
F947 **SS=F** **A4026** **A4046**	**Required In-Service Training for Nurse Aides** **1. How Corrective Action Will Be Accomplished for Those Residents Found to Have Been Affected by the Deficient Practice:**	**04/17/2025**

	• Certified Nurse Aides (CNAs) D, E, and F were re-assessed for compliance with the annual 12-hour in-service requirement. • Each CNA was promptly scheduled for supplemental in-service education sessions covering the minimum 12-hour requirement. • Topics included resident abuse prevention, dementia care, infection control, care of the cognitively impaired, and other facility-relevant competencies. • In-service training logs were updated, and completion was documented in their personnel files.	
	2. How the Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice: All residents are potentially at risk if CNAs do not receive required education to ensure ongoing competency. • A facility-wide audit of all CNA personnel files was conducted to identify any additional staff members who had not met the 12-hour annual training requirement or lacked appropriate documentation. • Any deficiencies identified during the audit were corrected through scheduled make-up in-service sessions and updated documentation.	
	3. What Measures Will Be Put into Place or Systemic Changes Made to Ensure That the Deficient Practice Will Not Recur: • **Centralized Tracking System:** A tracking system was implemented to monitor annual education hours for all CNAs. This log includes training dates, topics, durations, and attendance. • **In-Service Calendar:** A rolling annual in-service calendar was created to ensure routine delivery of required topics, including abuse prevention, dementia care, infection control, and cognitive impairment care. • **Quarterly Reviews:** The Director of Nursing (DON) or designee will review staff training records monthly to ensure compliance with annual requirements. • **DON Accountability:** The DON was educated on regulatory expectations for CNA in-service training, tracking responsibilities, and documentation requirements.	

	• **Use of Outside Vendors:** The facility re-established partnerships with hospice providers and education vendors to supplement internal education efforts on specialized topics such as end-of-life care and dementia. **4. How the Facility Plans to Monitor Its Performance to Make Sure That Solutions Are Sustained:** • **Monthly Compliance Audits:** The DON or designee will conduct monthly audits of the CNA training records to ensure that in-service hours are up to date and properly documented. • **QAPI Oversight:** Training compliance data will be reviewed monthly during QAPI meetings to identify trends and ensure sustained performance. **Date of Compliance: April 17, 2025**	
K222 **A2041**	**Egress Doors** The facility has taken additional measures to ensure delayed egress doors are maintained according to code.	**04/17/2025**

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.