STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	5/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Pinnacle Care of Battle Creek was surveyed for a Recertification survey on 5/12/25. Census: 61	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required	F0550	F550 – Resident Rights/Exercise of Rights Element #1: Resident #38 and #35 were assessed by the Director of Nursing and/or designee to ensure satisfaction with the room change conducted and psychosocial support provided. Element #2: A facility-wide audit will be completed to identify any additional residents reporting verbal conflicts or roommate issues. All care plans will be updated accordingly. Element #3: The Resident Rights policy was reviewed and updated as necessary by the Administrator. Community staff were re-educated on the Resident Rights policy and the Grievance process. Element #4: The Social Services Director or designee will conduct random audits of 5 resident pairs weekly for 12 weeks to assess interpersonal compatibility and care plan interventions related to dignity and resident rights. Audit findings will be reported monthly to the QAPI Committee for review and corrective follow-up. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	6/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2025

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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	under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one resident (R38) was treated with dignity and respect out of one reviewed. Findings include: Review of the medical record revealed R38 was admitted to the facility on 10/3/24 with diagnoses that included: legal blindness, muscle weakness, need for assistance with personal care, anxiety disorder, and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/25 revealed R38 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 5/5/25 at 12:34 PM, R38 was observed lying on his back in his bed, speaking with a soft/quiet voice with his eyes closed during most of the interview. R38 reported that his roommate R35 calls him names ("dumb son of a b*tch") and "is not friendly at all". R38 reported that the facility is aware and that staff have been in the room and witnessed R35 calling him names. On 5/7/25 at 10:32 AM, R35 was asked what he could tell me about his interactions with			

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	his roommate R38. R35 reported that R38 is loud and has alarms that are bothersome. When asked if the two have ever exchanged words R35 replied "oh yeah, he is a dumb*ss and I tell him too", "he treats me like sh*t but wants me to pamper him". When asked if staff had asked him not to call R38 names, R35 smiled and said that he would prefer not to answer that question. On 5/8/25 at 12:48 PM, during an interview with CNA "II", she reported that she had observed R25 being inappropriate to staff in the past. On 5/12/25 at 10:15 AM, during an interview with certified nursing assistant CNA "HH", when asked what she could tell me about R38 and his roommate R35, stated that R38 had reported that his roommate called him a "dumb*ss" and a "f*cking idiot" and that he (R38) was afraid of him (R35). She further reported that R35 can have a "strong demeanor" when he is mad, he gets mad easily and that he had an issue with his previous roommate. CNA "HH" reported that she had heard R35 "get loud" and "say things" to R38 in the past but never to the extent R38 described. Review of R35's care plan revealed no interventions for inappropriate behavior until 5/12/25, despite staff and residents reports that R35 had a history of this behavior. Review of the facilities policy titled "Resident			

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	Rights", documented in part "The resident has a right to be treated with respect and dignity, including ...The resident has the right to a safe, clean, comfortable and homelike environment, including, but not limited to receiving treatment and supports for daily living safely ..."			
F0552 SS= D	Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain and document required informed consent from the resident's guardian prior to administering a psychotropic medication for two (Resident #33, #41) of five reviewed for unnecessary medications. Findings include:	F0552	F552 – Right to be Informed/Make Treatment Decisions Element #1: For Residents #33 and #41, physician orders for psychotropic medications were reviewed, and informed consent forms were obtained as necessary. The guardians were notified and documentation updated in the medical record. Element #2: A comprehensive audit of all residents on psychotropic medications was completed by the Director of Nursing to verify that current signed informed consents are present in the medical record. Any missing documentation will be obtained and filed. Element #3: The Administrator and Director of Nursing implemented a new Psychotropic Medication Informed Consent to ensure residents/responsible parties are made aware of the medication, benefits, potential adverse reactions, and alternate interventions. Licensed Nurses were re-educated on this document and the requirement for a signed consent prior to the distribution of the medication. Element #4: The Director of Nursing or designee will audit all new psychotropic medication orders weekly for 12 weeks to verify compliance with informed consent requirements. Results of the audits will be submitted to the QAPI	6/20/2025

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	Resident #33 (R33) A review of the medical record indicated that Resident #33 was admitted to the facility on 12/6/21 with diagnoses including major depressive disorder and early-onset Alzheimer's disease. According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/25, R33 scored 0 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. During an interview conducted on 5/05/25 at 11:14 AM, family member (FM) "FF" reported concerns regarding the recent administration of the anti-anxiety medication Ativan (Lorazepam) to R33. The family member stated that she had questioned why he was receiving the medication and how long it had been prescribed, noting that the family, specifically FM "FF" guardian, had not been informed of the new medication order. A review of the medical record confirmed an active physician's order dated 3/6/25 for Lorazepam (Ativan) 0.5 mg, to be given by mouth every 4 hours as needed for anxiety. Although documentation reflected that a request for consent for the use of this psychotropic medication was initiated, a signed consent was not obtained and was not available for review by the time of survey exit.		Committee monthly for review. The QAPI Committee will be responsible for changes to the auditing process. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	Resident #41(R41) Review of the medical record reflected R41 was admitted to the facility on 7/6/22 and readmitted on 12/3/22, with diagnoses that included dementia. R41 was not interviewable. Review of the Physician order revealed an order for Zyprexa (an antipsychotic) oral tab 2.5 milligrams initiated on 8/28/24. A signed consent was not obtained and was not available for review by the time of survey exit.			
F0558 SS= E	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure six out of 15 residents (Resident # 4, 7, 23, 26, 46 & 134) had call lights that were accessible. Findings Included: Resident #4 (R4): During an interview on 5/05/2025 at 10:42 AM, Resident #4 (R4) was observed in bed. The call	F0558	F558 – Reasonable Accommodations of Needs/Preferences Element #1: The Maintenance Director and designee conducted rounds to ensure that call lights were accessible for all cited residents (R4, R7, R23, R26, R46, R134). Faulty equipment was replaced or repaired, cords were secured properly, and staff were directed to check accessibility at each point of care. Element #2: A facility-wide sweep was conducted by the Maintenance Director and designee to assess call light accessibility for all residents. Maintenance documented and addressed any additional concerns observed. Element #3: The Administrator reviewed the Call Light Accessibility policy and updated as necessary. Community staff were re-educated regarding call light accessibility, function and response. Element #4:	6/20/2025

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	light was observed to be hanging out of reach of R4. R4 was alert and able to answer questions. R4 stated that he does not have a call light, but there was one hanging on the wall. It was then observed that a call light was wrapped around the call light outlet box that was on the wall. The call light was not within reach of R4, and R4 stated he was not able to reach the call light, and also stated he never used that call light. During the same interview it was observed that a bell was on R4's over the bed table, and upon asking R4 the reason for the bell, R4 stated it was so he could ding it to get someone to come in his room when he needed assistance. R4 said, "but said they (staff) never hear it", so he gets himself up to his wheelchair and takes himself to the BR, but sometimes he falls on the floor so he yells out really loud for help. In another interview on 5/05/2025 at 4:33 PM, R4's room call light button was pushed and it was revealed that the call light did not turn on, did not light up in the room, nor outside the room. Also, no audible sounds was heard from the call light. R4 was asked how long he had the ding bell, in which he stated about one year. Immediately after the interview with R4 on 5/5/2025 at 4:33 PM, Certified Nurse Aid (CNA) "N" confirmed R4 had the ding bell for about one year ever since the call light system was new from one year ago. On 5/06/2025 at 12:13 PM, R4 call light situation had not changed. However, R4 resided in bed one, and for bed two there was no bed in that space, so the call light for bed two was pushed which revealed that call light was functional. The call light for bed two reached over far enough to be fully accessible to R4 in his bed; bed one however, that call light had not been given to R4.		The Director of Nursing and/or designee will conduct random weekly audits of 10 residents for 12 weeks to ensure call lights are within reach and functioning appropriately. Any concerns will be immediately corrected. Results of the audits will be brought to the QAPI Committee monthly for review. The QAPI Committee will be responsible to determine changes to the auditing process. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	In an interview and observation on 5/06/2025 at 12:16 PM, CNA "CC" was asked to ring R4's bell for an audible test at the nurses station. Upon CNA "CC" ringing the bell the ding was only vaguely heard, and was washed out due to other noise. R4's room was room 138 which was four rooms down form the nurse's station. Resident #7 (R7): On 5/5/2025 at 11:45 AM, R7 was observed in his room in bed awake, and was also observed to not have a call light within reach. The only call light that was observed on the wall was at the head of R7's bed which was the emergency red string light, but the string was behind R7's headboard and out of reach for R7. R7 was asked where his call light was located, and he said "right here", and pointed to the side of his bed. Upon telling R7 there was no call light there, R7 was asked what color was the call light in which R7 stated it was red, a red string. No other call light system was observed on the wall. The cord was observed to have no support mechanism to prevent it from falling back behind the headboard. Resident #23 (R23): On 5/08/2025 at 9:25 AM, R23 was observed in bed with legs hanging off the side of the bed, stated she was not trying to get out of bed, but wanted to get out of bed. R26's call light was observed to be out of reach, and located behind the head of the bed between the headboard and the wall. Resident #26 (R26): In an observation and interview on 5/5/2025 at 1:34 PM, R26 was yelling out for the nurse from his bed in his room. R26 asked if he had his call			

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	light, in which R26 very angrily stated "no", and threw his arm roughly over his head which suggested his call light was behind him. Upon entering R26's room the call light was found to be on the floor underneath R26's bed. R26 stated that when his call light falls on the floor it makes him very angry. In an observation on 5/5/2025 at 4:00 PM, R26 began yelling out for nurse. R26's call light was observed to be wrapped around the call light outlet box on the wall and was out of R26's reach. Resident #46 (R46): In an observation and interview on 5/05/2025 at 11:58 AM, R46 was observed to be in bed eating his lunch. R46 asked how he would call for a Certified Nurse Aid or nurse in the even he needed assistance. R46 was observed to reach for his bed remote and said that was his call light. R46 was made aware that was not his call light. The R46 reached for his TV remote and said that was the call light. R46 was told that was the TV remote, then R46 stated "Hell I don't know then." A red string emergency call light was observed behind R46's headboard on the wall, which was out of R46's reach. R46 stated that the red cord was the cord he pulled when he needed the nurse. The cord was observed to have no support mechanism to prevent it from falling back behind the headboard and out of reach. Review of the facility's policy and procedure, not dated, titled "Call lights: Accessibility and Timely Response" revealed, "Policy Explanation and Compliance Guidelines: 5. Staff will ensure the call light is within reach of resident and secured as needed."			
F0578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request,	F0578	F578 – Right to Refuse/Discontinue Treatment and Advance Directives	6/20/2025

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SS= D	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 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based interview and record review, the facility		Element #1: Resident #36's EMR was updated to reflect their current wishes for Advanced Directives. A reconciliation process was conducted between the documented code status and the banner in the EMR. Element #2: The Social Worker audited all residents to confirm accuracy in code status documentation. Any discrepancies were corrected and documented. Element #3: The policy Residents' Rights Regarding Treatment and Advanced Directives was reviewed and updated as necessary by the Administrator. Social Services and Licensed Nurses were educated on the policy and procedure. Element #4: The Social Worker or designee will review new physician orders weekly, Monday through Friday, for 12 weeks to ensure documentation is correctly reflected in all relevant systems. Any discrepancies will be reported in the audits and corrected immediately. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	failed to ensure the accuracy of code status information for one (R36) of one reviewed for advance directives. Findings include: Review of the medical record reflected R36 admitted to the facility on 12/11/24, with diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, vascular dementia and chronic kidney disease. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/18/25, reflected R36's cognitive status was not assessed. According to the medical record, R36 was their own responsible party. Review of the medical record reflected R36's Physician's Order, dated 2/5/25, reflected they were a full code (full resuscitation/Cardiopulmonary Resuscitation-CPR). Further review of the medical record reflected R36 and two witnesses signed a Do Not Resuscitate (DNR/no CPR) form on 4/23/25. The Physician signed the DNR form on 4/25/25. The document was scanned into the Miscellaneous section of the Electronic Medical Record (EMR). In an interview on 05/07/25 at 9:43 AM, Licensed Practical Nurse (LPN) "X" reported			

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	that in the event of an emergency, they would refer to the banner (section of main page) of the EMR to verify code status and hope it was correct. In an interview on 05/07/25 at 11:06 AM, Registered Nurse (RN) "Q" reported that in the event of an emergency, they would look at the EMR banner for code status but would also verify the documents in the Miscellaneous section of the EMR to ensure the information matched. Upon review of R36's medical record, RN "Q" agreed the banner, which reflected full code, and the Code Status form in the Miscellaneous tab, which reflected DNR, did not match. In an interview on 05/07/25 at 11:21 AM, Social Worker (SW) "C" reported being responsible for code status/advance directives. SW "C" reported R36's code status form was updated 4/23/25, but they remained full code status until the Physician signed the form. SW "C" reported she may not have communicated the need to change R36's code status to DNR after receiving the signed DNR form back from the Physician.			
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §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	F0584	F584 – Safe/Clean/Comfortable/Homelike Environment Element #1: R38's missing DVD set was replaced and an inventory checklist was reissued to the resident and updated. Element #2: The Social Service Director conducted an audit of all resident grievances and personal	6/20/2025

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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	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. §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, interview and record review the facility failed to ensure personal belongings were available for use for one (Resident #38) of one reviewed for personal belongings, resulting in misplaced personal items. Findings include: Review of the medical record revealed R38 was admitted to the facility on 10/3/24 with diagnoses that included: legal blindness, muscle weakness, need for assistance with personal care, anxiety disorder, and		belongings reports to ensure appropriate follow-up. Any open items were addressed and resolved. Element #3: The policy on Resident and Family Grievances was reviewed by the Administrator and updated as necessary. Community staff were re-educated on the grievance process, along with resident inventories. Element #4: The Administrator or designee will audit the concern log weekly for 12 weeks to confirm timely follow-up on any resident property issues. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/25 revealed R38 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 5/5/25 at 12:52 PM, R38 reported that a DVD (digital optical disc) set (of episodes of Law and Order) had been purchased by his daughter and was stolen the same day that it was brought into the facility, the facility is aware and his daughter had completed a form to request the facility remedy the situation about 5 months ago. R38 reported being upset about the missing DVD set because his plan was to play them on a portable DVD player, using headphones, because his roommate will turn his television up so loud that R38 can't hear his own TV that is mounted on the wall. During a phone interview on 5/12/25 at 8:19 AM, with R38's family member (FM "KK"), she reported that the missing DVD set was given to the resident for his birthday in January 2025 and when the resident switched rooms the family could not find the DVD set. Additionally, FM "KK" reported that this was reported to the facility and a concern form was handed into the receptionist in the main lobby and that she had not heard anything about it since filing the concern form. FM "KK" reported the DVD set was of R38's favorite Law and Order show.			

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	During an interview with Receptionist "LL" on 5/12/25 at 9:48 AM, she reported that she recalled R38's family filling out a concern form related to missing DVD's and that she would have turned it into the administrator at that time. On 5/8/25 at 1:28 PM, an email was sent to the facility administrator requesting any grievance/concern forms for R38. One was provided by the facility; however, it was unrelated to the missing DVD set. On 5/12/25 at 10:33 AM, during an interview with assistant director of nursing (ADON), when asked about a concern form filed by R38's family related to a missing DVD set she reported that after the previous administrator left there were papers that should have been in his office that could not be located.			
F0605 SS= D	Right to be Free from Chemical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .	F0605	F605 – Right to be Free from Chemical Restraints Element #1: The PRN order for Lorazepam for Resident #33 was discontinued after review and discussion with the physician. Element #2: The Director of Nursing initiated a full audit of all psychotropic medications with PRN orders on to ensure compliance with PRN orders. Any noncompliant orders were corrected immediately. Element #3: The Psychotropic Medication Policy was reviewed by the Administrator and revised as necessary. Licensed Nurses and Providers were re-educated on the regulation F605 and	6/20/2025

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	§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to		its guidelines. Element #4: The Director of Nursing and/or designee will review all new psychotropic PRN orders weekly for 12 weeks to verify duration limits and appropriate physician documentation. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to limit the duration of a PRN (as needed) psychotropic medication to 14 days and/or ensure the physician documented rationale to extend the duration of use for one (Resident #33) out of five reviewed for unnecessary medications. Findings include: Resident #33 (R33) Review of the medical record reflected R33 was admitted to the facility on 12/6/21, with diagnoses that included major depressive disorder and Alzheimer's with early onset. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R33 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).			

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	Review of the Medical Record revealed an active Physician order initiated on 3/6/25 for "Lorazepam (Ativan-an antianxiety medication) Tablet 0.5 milligrams. Give 1 tablet by mouth every 4 hours as needed for Anxiety. " On 05/08/25 at 11:27 AM, Director of Nursing (DON) "B" reviewed the as needed Ativan order for R33 and stated that the order should have been discontinued after 14 days and a reevaluation for continued use should have occurred.			
F0628 SS= D	Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or	F0628	F628 – Discharge Process Element #1: R#67 no longer resides in the community. Element #2: A full audit of discharges within the past 90 days was initiated by the Social Worker on to ensure notification letters and documentation were completed. Any missing notifications were sent. Element #3: The Administrator reviewed the regulation F628 and updated the Discharge Checklist to include evidence of the mailed or emailed communication. Licensed Nurses and Social Work were educated on the guidelines for F628. Element #4: The Social Worker and/or designee will audit all discharges weekly for 12 weeks to confirm notice was provided to both the resident/representative and monthly to the Ombudsman. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee.	6/20/2025

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	discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,		The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			

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	§483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).			

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the resident/representative with a written notice of transfer/discharge and send a copy to the ombudsman for one (R67) of one reviewed. Findings include: Review of the medical record revealed R67 was admitted to the facility on 4/2/25 with diagnoses that included diabetes, quadriplegia, anxiety, and atrial fibrillation. The Discharge Minimum Data Set (MDS) with an Assessment Reference Date of 4/6/25 revealed R67 was independent with cognitive skills for daily decision making and had an unplanned discharge to the hospital with a return not anticipated. Review of the Health Status Note dated 4/6/2025 revealed R67 was transferred to the hospital. R67 did not return to the facility. There was no documentation that a written notice of transfer/discharge was provided. In an interview on 05/08/25 at 12:45 PM, Director of Nursing (DON) "B" reported a transfer/discharge notice would not have been sent to the ombudsman because they were unaware that was a requirement. On 05/08/25 at 1:03 PM, Assistant Director of Nursing (ADON) "J" joined the interview.			

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	Both DON "B" and ADON "J" reported they were not aware a written notice of transfer/discharge to the resident/representative and the ombudsman were required; therefore, they did not have documentation that this was done.			
F0636 SS= D	Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F0636	F636 – Comprehensive Assessments & Timing Element #1: R20's comprehensive assessment and care plan were updated and completed. R20 was assessed by the Director of Nursing and/or designee to ensure no lasting effects related to the inaccurate assessment. Element #2: An audit of all residents admitted in the past 6 months was conducted by the MDS Coordinator and/or designee to ensure that comprehensive assessments were completed on time and accurately. Element #3: The Administrator reviewed the regulation F636, and education was provided to Licensed Nurses and Department Managers on the regulation and guidelines. Element #4: The MDS Coordinator and/or designee will review the assessment tracker weekly for 12 weeks to verify timely completion and accuracy of comprehensive assessments. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	6/20/2025

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	nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to accurately complete a comprehensive assessment for one (Resident #20) of 15 residents reviewed. Findings include: Review of the medical record reflected that Resident #20 was admitted to the facility on 10/07/22 and readmitted on 02/07/25, with diagnoses that included muscle weakness, contractures of both right and left legs, pressure-induced deep tissue damage of the left heel, dementia, and acute and chronic respiratory failure with hypoxia. The Minimum Data Set (MDS), with an Assessment Reference Date of 02/10/25,			

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

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	reflected that Resident #20 scored 3 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Resident #20 was not interviewable. On 05/05/25 at 10:07 AM, Resident #20 was observed seated in the dining room wearing pressure-relieving ankle-foot orthosis (PRAFO) boots on both feet. However, the right boot was nearly detached from Resident #20's foot. During an interview conducted on 05/05/25 at 10:43 AM, Family Member "O" reported that Resident #20 had developed a sore on his heel. Family Member "O" stated that Resident #20 was unable to move his legs due to muscle atrophy and contractures. A skin assessment dated 02/05/24, completed upon readmission, described an unstageable pressure ulcer on the left heel with a length of 5 centimeters and a width of 7 centimeters. An outside wound care service note dated 04/21/25 described the left heel wound as an unstageable, pressure-induced tissue injury measuring 7.2 centimeters in length by 5.6 centimeters in width, with an undetermined depth. The wound bed was described as 10 percent granulation tissue, 20 percent slough, and 70 percent eschar. Treatment instructions included " Clean with Dakin ' s solution, apply Santyl and alginate. "			

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	An outside wound care service note dated 04/28/25 described the left heel wound as an unstageable, pressure-induced tissue injury measuring 7.0 centimeters by 4.7 centimeters, with an undetermined depth. The wound was noted to have 20 percent granulation tissue, 20 percent slough, and 60 percent eschar. Treatment instructions included " Clean with normal saline and apply Santyl and alginate daily. Cover with an abdominal pad and wrap with Kerlix. " Review of the Qaurterly MDS assessment dated 3/28/25 revealed the section under Skin Conditions reflected R33 was marked "0" for unstageable pressure ulcers, despite the wound documentation reporting differently.			
F0637 SS= D	Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F0637	F637 – Comprehensive Assessment After Significant Change Element #1: The MDS Coordinator completed the significant change assessment for R11. The resident's care plan was reviewed and revised based on updated assessment data. R11 was assessed by the Director of Nursing and/or designee to ensure no lasting effects related to the incomplete significant change assessment. Element #2: The MDS Coordinator and/or designee initiated a review of current residents with recent hospitalizations, new diagnoses, or care plan changes in the last 30 days to identify if additional significant change assessments were warranted. Assessments will be initiated based on results of the 100% audit. Element #3:	6/20/2025

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	review, the facility failed to perform a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) for one (R11) of 15 reviewed. Findings include: R11: Review of the medical record reflected R11 admitted to the facility 7/3/14 and readmitted 11/13/24, with diagnoses that included vascular dementia, dependence on wheelchair and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R11's cognition and mood were not assessed. The same MDS reflected R11 did not walk, was dependent for transfers and required substantial/maximal assistance with personal hygiene and partial/moderate assistance with rolling left and right. On 05/06/25 at 9:21 AM, R11 was observed seated in a wheelchair, in the hallway, without a seating cushion in the wheelchair. On 05/07/25 at 8:12 AM, R11 was observed seated in a wheelchair, in the hallway, without a seating cushion in the wheelchair. On 05/07/25 at 2:52 PM, R11 was observed lying in bed, on a standard mattress, positioned towards their right side. An additional mattress was on the floor at the right bedside.		The Administrator reviewed the regulation F637. Licensed Nurses and Department Managers were provided education on significant change assessments, and the guidelines for F637. Element #4: The MDS Coordinator and/or designee will review weekly nursing reports and change-of-condition documentation to identify any missed significant change triggers for 12 weeks. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance Compliance Date: 6/20/2025	

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	R11's medical record reflected the development of two facility-acquired stage II (two) pressure ulcers (partial thickness loss of dermis/middle layer of skin, presenting as a shallow open ulcer with a red/pink wound bed; may also present as an intact or open/ruptured blister) on 4/18/25. The pressure ulcers were documented to be in left intergluteal (between the buttocks) region and posterior (back) scrotum. During a phone interview on 05/08/25 at 1:11 PM, Nurse Practitioner (NP) "AA" reported R11's stage II pressure ulcers to the scrotum and left intergluteal region were unchanged (still present/not healed) upon their assessment on 5/5/25. In a phone interview on 05/08/25 at 1:38 PM, MDS Registered Nurse (RN) "BB" reported a SCSA MDS could be prompted by things such as significant weight loss, large changes in activities of daily living and hospice admission and/or discharge. RN "BB" reported they had never conducted a SCSA MDS for pressure ulcers. RN "BB" reported their understanding was that a SCSA MDS was required for hospice admission and discharge, but it was up to the discretion of the facility to conduct a SCSA MDS for other changes. RN "BB" was unaware that R11 had developed pressure ulcers. RN "BB" acknowledged that the development of two stage II pressure ulcers could have warranted a SCSA MDS, which would have guided the			

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	development of a pressure ulcer Care Plan. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, dated October 2024, reflected, "...The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [Interdisciplinary Team] has determined that a resident meets the significant change guidelines for either major improvement or decline...A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan...When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met...Decline in two or more of the following: ...Emergence of a new pressure ulcer at Stage 2 or higher..."			
F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse	F0641	F641 – Accuracy of Assessments Element #1: The MDS Coordinator reviewed and corrected inaccuracies in the submitted MDS for R9, R11, and R40. Corrections were submitted to CMS as needed. R9, 11, and 40 were assessed by the Director of Nursing and/or designee to ensure no lasting effects related	6/20/2025

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	must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete accurate Minimum Data Set (MDS) assessments for three Residents (#9, #11, #40) of 15 residents reviewed for MDS accuracy. Findings Included: Resident #40 (R40) Review of the medical record demonstrated R40 had been admitted to the facility 01/31/2025 with diagnoses chronic obstructive pulmonary disease (COPD), asthma, type 2 diabetes, stage 4 pressure ulcer of sacral region, stage 3 pressure ulcer of right buttock, muscle weakness, bone		to inaccurate assessment. Element #2: A 100% audit of MDS assessments completed in the last 30 days was initiated by the MDS Coordinator and designee team to identify and correct any additional inaccuracies. Element #3: The Administrator reviewed the policy on Conducting an Accurate Resident Assessment and revised as necessary. Education was provided to the Licensed Nurses and Department Managers on the policy and procedure for completion of accurate assessments. Element #4: The MDS Coordinator and/or designee will randomly review 3 assessments per week for 12 weeks for accuracy and documentation verification. All discrepancies will be logged and assessments modified to ensure accuracy. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	density disorder, hyperlipidemia (high fat content in flood), urinary retention, gastro-esophageal reflux, anemia, and left below knee amputation. Review of R40's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/2025, revealed R40 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. Review of R40's medical record demonstrated that she had been prescribed Lexapro (antidepressant) 10 mg (milligrams), which was written 03/11/2025. The prescription stated "Give 10mg by mouth one time per day for severe depression. Review of R40's medical diagnoses list, did not include the diagnoses of depression. Review of R40's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/2025, revealed section I-Active Diagnoses, Sub section I5800-Depression was documented as "No". In a telephone interview on 05/08/2025 at 01:38 p.m. Minimum Data Set (MDS) Coordinator "BB" explained that she is responsible for completing section I-Active Diagnoses of the MDS. MDS Coordinator "BB" explained that she reviews the medical record and talks with clinical staff when completing the MDS. MDS Coordinator "BB" also explained that she would place diagnoses of resident's illness in the medical record based on information provided by the physician. MDS Coordinator "BB" explained			

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	that if a physician medication order included the medical diagnoses that would be enough justification to enter the medical diagnoses. MDS Coordinator "BB" reviewed R40's physician orders and explained that R40 had a diagnosis of depression as revealed in the physician order for Lexapro. MDS Coordinator "BB" confirmed that she was the person that had completed the MDS, with an Assessment Reference Date (ARD) of 03/24/2025, section I-Active Diagnoses, Sub section I5800-Depression and confirmed that she had documented "No". MDS Coordinator "BB" explained that she should have documented "Yes" as R40 had the diagnoses of depression during the MDS assessment period. During observation and interview on 05/08/2025 at 02:06 p.m. R40 was observed lying in bed. R40 explained that she had been diagnosed with depression in the past but could not recall if she was currently taking any medication for depression. Resident #9 (R9): Review of the medical record reflected R9 admitted to the facility on 1/25/23 and readmitted 11/14/24, with diagnoses that included dementia, major depressive disorder, insomnia, Alzheimer's and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R9's cognition and mood were not			

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	assessed. On 05/06/25 at 1:12 PM, R9 was observed seated in a wheelchair, in their room, watching TV. Section C (Cognitive Patterns) of the Quarterly MDS, with an ARD of 3/31/25, reflected questions C0100 through C1000 were marked with responses of dashes and "Not assessed". Section D (Mood) of the same MDS was marked with responses that included "Not assessed" and "Not assessed/no information". In an interview on 05/07/25 at 11:21 AM, Social Worker (SW) "C" reported R9 could be "cranky" and unwilling to do things, and their behaviors included refusal of care and lashing out at others. In an interview on 05/08/25 at 10:49 AM, Certified Nurse Aide (CNA) "N" reported R9 had behaviors of screaming, yelling and refusing care. Resident #11 (R11): Review of the medical record reflected R11 admitted to the facility 7/3/14 and readmitted 11/13/24, with diagnoses that included vascular dementia, dependence on wheelchair and diabetes. The Quarterly MDS, with an ARD of 3/31/25, reflected R11's cognition and mood were not assessed. The same MDS reflected R11 did not walk, was			

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	dependent for transfers and required substantial/maximal assistance with personal hygiene and partial/moderate assistance with rolling left and right. On 05/06/25 at 9:21 AM, R11 was observed seated in a wheelchair, in the hallway, without a seating cushion in the wheelchair. On 05/07/25 at 8:12 AM, R11 was observed seated in a wheelchair, in the hallway, without a seating cushion in the wheelchair. Section C (Cognitive Patterns) of the Quarterly MDS, with an ARD of 3/31/25, reflected questions C0100 through C1000 were marked with responses of dashes and "Not assessed". Section D (Mood) of the same MDS was marked with responses that included "Not assessed" and "Not assessed/no information". R11's MDS history reflected a Discharge Return Anticipated MDS, with an ARD of 10/25/24, which reflected R11 had not had any falls since admission/entry or reentry or the prior assessment (OBRA [Omnibus Budget Reconciliation Act] or scheduled PPS [Prospective Payment System]), whichever was more recent. Review of R11's Incident Reports reflected they had fallen, without injury, on 10/21/24 and 10/24/24. Review of R11's MDS history reflected a Quarterly MDS, with an ARD of 12/31/24, which reflected R11 had not had any falls			

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	since admission/entry or reentry or the prior assessment (OBRA or scheduled PPS), whichever was more recent. R11's prior MDS was an End of PPS (Medicare) Part A Stay, with an ARD of 11/18/24. Review of R11's Incident reports reflected they had a fall, without injury, on 11/29/24, which had not been coded on an MDS assessment. During a phone interview on 05/08/25 at 1:38 PM, MDS Registered Nurse (RN) "BB" reported they were conducting MDS assessments from outside of the facility. RN "BB" relied on documentation of the Unit Managers, Social Worker and Director of Nursing for personal interviews or questions that she would not be able to do (from offsite). RN "BB" reported R9 and R11's mood and behavior sections of the Quarterly MDS, with an ARD of 3/31/25, were not assessed due to there being a short period of time without a Social Worker in the facility to conduct the assessments. RN "BB" reported interview information collected after the ARD could not be used on the assessment, therefore the responses to those items had to be dashed.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §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	F0656	F656 – Develop/Implement Comprehensive Care Plan Element #1: The facility updated the care plan for R11 to reflect current clinical status and interventions. Element #2: A review was initiated by the Director of Nursing and/or designee of all new admissions in the past 30 days to ensure	6/20/2025

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (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 develop and		comprehensive care plans were developed and implemented within the required timeframe, and are an accurate reflection of the resident's status. Element #3: The Administrator reviewed the policy on Comprehensive Care Plans and revised as necessary. Education on the policy was provided to Licensed Nurses and Department Managers to ensure Care Plans are up to date and accurate to reflect the resident's status. Element #4: The Director of Nursing and/or designee will review 5 residents weekly for 12 weeks to confirm accuracy and timeliness of care plans and interventions. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	implement a comprehensive Care Plan for one (R11) of 15 reviewed. Findings include: Review of the medical record reflected R11 admitted to the facility 7/3/14 and readmitted 11/13/24, with diagnoses that included vascular dementia, dependence on wheelchair and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R11's cognition and mood were not assessed. The same MDS reflected R11 did not walk, was dependent for transfers and required substantial/maximal assistance with personal hygiene and partial/moderate assistance with rolling left and right. On 05/06/25 at 9:21 AM, R11 was observed seated in a wheelchair, in the hallway. Gripper socks were observed on both feet. Rear anti-tip bars and anti-rollback brakes were observed on the wheelchair. A seating cushion was not observed in the wheelchair. Upon entering R11's room, a standard mattress was noted on their bed, without linens in place. On 05/06/25 at 3:42 PM, 4:05 PM and 4:52 PM, R11 was observed seated in a wheelchair, without a seating cushion in place. On 05/06/25 at 4:52 PM, R11's bed was observed without linens in place on the mattress. R11's risk for falls Care Plan reflected an			

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	intervention, dated 4/25/25, to apply new bedding immediately following removal of old bedding. R11's medical record reflected the development of two facility-acquired stage II (two) pressure ulcers (partial thickness loss of dermis/middle layer of skin, presenting as a shallow open ulcer with a red/pink wound bed; may also present as an intact or open/ruptured blister) on 4/18/25. The pressure ulcers were documented to be in left intergluteal (between the buttocks) region and posterior (back) scrotum. During a phone interview on 05/08/25 at 1:11 PM, Nurse Practitioner (NP) "AA" reported visiting the facility weekly for wounds. NP "AA" reported they had seen R11 two to three times, and R11's stage II pressure ulcers had remained stable. NP "AA" stated they had recommended a low air loss mattress (specialty mattress) and a cushion for R11's wheelchair. Regarding the type of wheelchair cushion recommended, NP "AA" reported they usually recommended Roho cushions (specialty cushion for pressure relief). According to NP "AA", their recommendations had been conveyed to the facility. NP "AA"'s visit notes for 4/21/25 and 4/28/25 reflected, "...The patient is noncompliant with repositioning...Change positions often to keep pressure off the wound, and spread body weight evenly with cushions,			

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	mattresses, pillows, foam wedges, or other pressure-relieving devices..." In a phone interview on 05/08/25 at 1:38 PM MDS Registered Nurse (RN) "BB" was unaware that R11 had developed pressure ulcers. RN "BB" acknowledged that the development of two stage II pressure ulcers could have warranted a Significant Change in Status MDS, which would have guided the development of a pressure ulcer Care Plan. A risk for skin breakdown Care Plan reflected it was created on 7/9/2014 and was initiated 3/5/25. An additional Care Plan, initiated on 5/5/25, reflected R11 had impaired skin integrity on the scrotum and intragluteal region. R11's Care Plan did not reflect the presence of pressure ulcers, nor interventions for pressure relief.			
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F0657	F657 – Care Plan Timing and Revision Element #1: Social worker held a quarterly care conference for R33 on 05.12.2025. Element #2: The Social Service Director conducted a 100% audit of residents to ensure care conferences are held timely and per policy. Element #3: The Administrator reviewed the regulation F657. Licensed Nurses and Department Managers were provided education on the regulation and its guidelines. Element #4: The Social Service Director will conduct weekly audits of 5 residents to ensure their care conferences have been scheduled and	6/20/2025

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	not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct a quarterly care conference for one (resident 33) of three residents reviewed for careplanning. Findings include: Review of the medical record reflected R33 was admitted to the facility on 12/6/21, with diagnoses that included major depressive disorder and Alzheimer's with early onset. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R33 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). During an interview conducted on 5/5/25, at 11:14 AM, Family Member "FF" reported recent inconsistencies regarding the care conferences, which are typically scheduled on a quarterly basis. A review of R33's care conference records showed that the last quarterly care conference was held on 12/9/24. The subsequent conference was due in March		held per regulatory guidelines. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	2025, however, documentation confirmed that it was not conducted. In an interview on 5/8/25 at 10:56 AM, Social Services (SS) staff member "C" explained that the facility had recently lost their social worker. As a result, she had only recently taken over the role and was working to get care conferences scheduled and back on track. After reviewing the care conference documentation, SS "C" acknowledged that R33 should have had a quarterly care conference in March 2025.			
F0679 SS= D	Activities Meet Interest/Needs Each Resident §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 by: Based on observation, interview, and record review the facility failed to provide consistent and meaningful activities, ensure adequate staffing and staff engagement, and maintain accountability for the implementation of scheduled activities for one (Resident #33) out of one reviewed for activities. Findings include:	F0679	F679 – Activities Meet Needs/Interests of Each Resident Element #1 The Activity Director met with Resident #33 to assess personal preferences, interests, and participation barriers. The resident's care plan was updated to include individualized activity interventions aligned with their preferences. The resident was also reintroduced to one-on-one and small group programming, and staff were assigned to ensure engagement during scheduled activities. Element #2 The Activity Director conducted an audit of all residents' activity care plans and participation records to identify residents who have had limited engagement or inconsistencies in scheduled activities. Residents with low participation or dissatisfaction with current offerings were flagged for follow-up by the Activities Department. Element #3 The Administrator reviewed the policy on Activities and revised as necessary. Community staff were re-educated on the policy for Activities to include the importance	6/20/2025

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	Resident #33 (R33) **Review of the medical record reflected R33 was admitted to the facility on 12/6/21, with diagnoses that included major depressive disorder and Alzheimer's with early onset. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R33 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).** **During an interview on 5/05/25 at 11:14 AM, Family Member (FM) "FF" reported that resident R33 was previously a "very active person." The FM expressed concern regarding the current level of activity and engagement available to R33, stating that they were concerned about the activities. FM "FF" stated that it's hard to engage someone when there doesn't seem to be any life enrichment happening. FM "FF" shared that R33 spent a lot of time siting in his chair without anything engaging occurring.** **On 5/06/25 at 12:55 PM, R33 was observed sitting in a chair at a table. Rubber duck and Yoshi toy placed in front of him along with water. R33 was not paying attention to items in front of him.** **On 5/07/25 at 9:27 AM, an activity staff member was observed at the dining room table seated next to a female resident. The activities staff member was scrolling through her phone, not interacting with any of the residents in the dining room. One resident was seated at a nearby table, repeatedly hitting his fist on the table. No meaningful engagement occurred with the residents in the dining room, including R33 who was**		of person-centered programming and timely execution of the daily activity schedule. Element #4 The Activity Director and/or designee will conduct weekly audits of scheduled activity implementation, participation logs, and resident feedback for 12 weeks. At least 5 residents will be randomly selected weekly to verify engagement and satisfaction. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	seated at an adjacent table staring off. On 9:42 AM, a continuation of the previous observation continued. R33 was observed in his Broda chair with no staff interaction. Another resident was observed nearby still repeatedly hitting his fist on the table. The activities staff member was seated next to a female resident. The activity staff member was completing a craft alone without interacting with any of the residents in the dining room. The Activity whiteboard listed the following schedule of activities for the day: o 9:00 AM - Chronicle Reading o 10:45 AM - Balloon Toss o 1:30 PM - Music Exercise o 2:30 PM - Balloon Toss o 3:30 PM - Movie In an interview on 5/7/25 at 10:17 AM, Certified Nursing Assistant (CNA) "S" stated she has observed times challenges with activity staff implementing consistent activities and continuity of care. As a result, the staff in the memory care unit have had increased responsibility attempting to not only provide care for the residents, but, provide some sort of interaction and engagement. Without the interaction and engagement, behaviors and accidents seem to increase. On 5/7/25 at 11:12 AM CNA "R" reported that the 10:30 AM balloon toss activity did not			

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	occur. **On 5/7/25 at 11:17 AM, Licensed Practical Nurse (LPN) "GG" denied the balloon toss activity occurring, stating she had been present in the room during the time frame.** **On 5/08/25 at 10:59 AM Activities Director (AD) "C" stated that efforts need to be made to implement structured and sensory-based activities in the memory care unit. AD "C" reported challenges with consistent staffing and needing more presence on the memory care unit. AD "C" indicated that staff departures and training of new hires have impacted activity delivery consistency, nonetheless, staff should not be on their personal phones and the expectation would be to carry out the scheduled activity and engage with all residents in the dining room during an activity.**			
F0684 SS= E	Quality of Care § 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 observation, interview and record review the facility failed to 1) follow physician orders (Resident #20) 2) assess and monitor edema (Resident #11) 3) secure and monitor a urinary catheter (Resident #38) and 4)	F0684	F684 – Quality of Care Element #1 R20: Physician orders were reviewed and reconciled. Orders were implemented as appropriate. R11: A head-to-toe assessment was completed, and the resident's edema was evaluated and documented. The care plan was updated, and physician notification occurred as necessary. R38: The urinary catheter was properly secured. R67: Wound care orders were implemented, and a complete skin assessment was completed. Element #2 The Director of Nursing and/or designee conducted an audit of residents newly admitted within the last 30 days, residents	6/20/2025

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	implement wound care orders upon admission from the hospital (Resident #67) for 4 out of 15 reviewed for quality of care. Findings include: Resident #20 (R20) A review of the medical record revealed that Resident #20 was admitted to the facility on 10/07/22 and readmitted on 02/07/25, with diagnoses including heart failure and both acute and chronic respiratory failure with hypoxia. On 05/07/25 at 9:24 AM, Resident #20 was observed lying flat in bed while wearing a nasal cannula. At 9:47 AM that same day, the resident was again observed lying flat in bed with the nasal cannula in place. A nurse's note dated 05/07/25 at 5:21 AM indicated that Resident #20 had returned from an Emergency Department visit with a diagnosis of "possible pneumonia." The After Visit Summary from the Emergency Department revealed that Resident #20 presented with shortness of breath. Emergency medical services reported that the resident had a "low pulse ox" of 91% on room air. The resident was placed on 2 liters of oxygen via nasal cannula, which improved the oxygen saturation to 93%. A review of a physician's order initiated on 02/06/25 stated: "The resident cannot lie with head of bed flat due to shortness of breath while lying flat and diagnosis of chronic respiratory failure." Another physician's order, initiated on		with physician orders involving wound care, indwelling catheters, or fluid retention diagnoses. Each resident was reviewed for missed orders, unaddressed edema, improper catheter care, and delayed implementation of hospital orders. Element #3 The policies on Admission Orders and Catheter Care were reviewed by the Administrator and revised as necessary. Licensed Nurses and Department Managers were provided education on the aforementioned policies to ensure compliance with orders. Element #4 The Director of Nursing or designee will conduct weekly audits of 10 randomly selected charts for 12 weeks to ensure appropriate orders are in place and being followed per resident record. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	03/12/25, stated: "Oxygen at 2 liters via nasal cannula PRN (as needed) for SpO2 below 90%." In an interview conducted on 05/08/25 at 12:06 PM, Registered Nurse (RN) "J" stated that she also observed Resident #20 lying flat in bed. She acknowledged that, based on the physician's order, the expectation was that the resident should not have been lying flat. Resident #11 (R11): Review of the medical record reflected R11 admitted to the facility 7/3/14 and readmitted 11/13/24, with diagnoses that included vascular dementia, dependence on wheelchair and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R11's cognition and mood were not assessed. The same MDS reflected R11 did not walk, was dependent for transfers and required substantial/maximal assistance with personal hygiene and partial/moderate assistance with rolling left and right. On 05/06/25 at 9:21 AM, R11 was observed seated in a wheelchair, in the hallway. Gripper socks were observed on both feet. Rear anti-tip bars and anti-rollback brakes were observed on the wheelchair. A seating cushion was not observed in the wheelchair. Upon entering R11's room, a standard mattress was noted on their bed, without linens in place.			

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	R11's medical record reflected weights that included 210.5 pounds on 4/24/25, 275.5 pounds on 5/1/25 and 237 pounds on 5/8/25. An eINTERACT SBAR (Situation Background Assessment Recommendation) Summary for Providers Progress Note for 4/30/25 reflected R11 had new or worsening edema (swelling), with edema around both eyes, to the right side of the abdomen, to the scrotum and both legs. The edema on R11's legs was documented as +2 pitting edema (measurement of swelling with indentations that remain after pressing on the skin). A hospital After Visit Summary, dated 4/30/25, reflected R11 was seen due to edema and was to receive 40 milligrams of Lasix (diuretic medication) daily for seven days. Review of R11's medical record, including Progress Notes, the Assessments section and Physician's Orders did not reflect assessment and monitoring of R11's edema. In an interview on 05/08/25 at 2:48 PM, Director of Nursing (DON) "B" agreed that there had not been assessment and monitoring of R11's edema since their return from the hospital. Regarding assessments for edema, DON "B" reported R11 would be placed on daily weights, as well as monitoring of lung sounds, vital signs and assessment of edema and circulation.			

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	Resident #R38 (R38) Review of the medical record revealed R38 was admitted to the facility on 10/3/24 with diagnoses that included: retention of urine, legal blindness, muscle weakness, need for assistance with personal care, anxiety disorder, and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/25 revealed R38 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 5/5/25 at 12:45 PM, resident was observed laying on his back in bed, reported that his penis is "splitting in half" and that he is going to have a suprapubic catheter placed. On 5/7/25 at 3:04 PM, during an interview with RN "Q", she reported completing R38's catheter care that morning. When asked about the condition of his penis, she reported that it didn't look pink or rashy but was "split down" the length of the head of his penis. On 5/7/25 at 3:39 PM, observed R38's penis with RN "Q", there was a split where the urethral opening should be that extended the length of the penis head (approximately 1 inch long and ¼ inch wide). R38 had been observed wearing a brief and sweat pants and no catheter securing device was in place at that time. The tubing for his catheter had			

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	been fed through the left leg of his sweat pants. R38 reported at that time he didn't have any feeling in his penis which was new and prior to that he had significant pain with any slight movement, R38 rated it 8/10 on the pain scale. When asked what he could tell me about the history of his penile injury, R38 reported that it was "due to them placing the catheter", that it had slowly gotten worse and that he didn't have any "slack" with the tubing which caused it to pull and tear. R38 reports that there was a time where the staff were placing a catheter securing device and he believed that had made an improvement. He further reported that it (the catheter securing device) would come off at night due to sweat. When asked about documentation that resident had refused to see urology in the past, R38 reported that was a misunderstanding and that he had wanted to be seen by the provider in the facility and did not want to have to be sent out to see the provider if possible. On 5/8/25 at 2:28 PM, during an interview with ADON, when asked what she could tell me about R38's penis injury, stated that it started as deterioration from the tip of his penis. When asked what led to the injury ADON reported she believed it was from his refusal to use a cath secure (device used to secure catheter in place) which caused tugging and wear and tear from the catheter. She further stated that when R38 would experience hallucinations he would tug at it. It should be noted that progress notes or			

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	care plan do not reflect resident tugging on his catheter or any interventions to help prevent this from occurring. On 5/8/25 at 2:45 PM, during an interview with Doctor "MM", when asked what he could tell me about R38's split penis, reported that he knows there was a delay in getting his suprapubic catheter placement scheduled. When asked what caused the split/injury to the head of R38's penis, Doctor "MM" reported that all long term, male catheters will cause a split in the penis. During a phone interview on 5/12/25 at 8:19 AM, with R38's family member (FM "KK"), when asked about the injury to her father's penis, stated that he doesn't know when he is peeing so he required a catheter. She further stated that the facility waited too long to change it and "ripped his penis hole". FM "KK" reported that she was previously the caregiver for R38 and that he had normal penile anatomy prior to this injury. On 5/12/25 at 12:44 PM, during an interview with DON, when asked what she could tell me about the injury to R38's penis, reported that Doctor "MM" said it was "chronic" and that resident was supposed to have a suprapubic catheter placed. DON reported that with a leg strap and proper catheter care an injury to the penis is avoidable for male catheter patients. A review of R38's physicians orders revealed,			

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	1/20/24 "A and D ointment (skin protectant) to excoriated underside of penis, twice a day for damage to penis from Foley catheter". A review of R38's progress notes revealed: 1/8/2025 11:38 Nurses Note Late Entry: "Received from night nurse that resident was c/o (complaint of) pain at the site of insertion of foley catheter. It was reported that resident's catheter was changed by night nurse and resident tolerated well. This nurse answered the resident's call light at approximately 11am to the resident stating that he needed his emesis emptied and the basin returned to him quickly due to nausea and vomiting. Resident stated that he was in a lot of pain in his abd (abdomen)/bladder. This nurse assessed his foley, emptied the balloon and tried to advance the foley further to see if this would relieve the resident's pain. The resident stated that his pain was relieved with the balloon being deflated, however upon advancing the catheter, this nurse noted frank red blood into the foley bag. The resident continued to have decreased pain as this nurse advanced the catheter into the bladder and refilled the balloon with 10cc of NS. This nurse flushed the resident's catheter and noted more blood in the foley bag. At this point, the resident asked that the catheter be removed stating that he no longer wanted it because it hurt him. The catheter was removed by this nurse's hall partner. The resident was presenting with confusion, vomiting, copious amounts of			

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	frank red blood with clots to his brief. At this point, this nurse spoke with the resident about going to the ED (emergency department) for evaluation r/t (related to) bleeding from his urethra. The resident agreed. (EMS company name redacted) EMS was called to transport. (Name redacted), resident's daughter was called to notify. Report called to (name redacted) at (Hospital name redacted) ... On 1/8/25 at 3:38 PM Nurses note "Resident c/o (complained of) discomfort at Foley catheter insertion site. Foley changed per sterile procedure; resident tolerated well." On 1/27/25 at 3:36 PM Nurses note " ...Foley cath (catheter) patent with clean tallow urine in bag ..." On 2/25/25 at 1:23 PM Nurses note "(Doctor "MM") in to see resident, (Doctor "MM") suggested that he see a urologist for suprapubic cath placement as soon as possible. Per resident he stated that the did not want to go out to the urologist or to the hospital, refused urology consult." On 2/26/26 at 2 PM Admission Note: Late Entry: Resident arrived via stretcher accompanied by 2 EMTs (Emergency Medical Technician) at 12:28 pm today, Wed Feb 26 2025 ...Resident returns to (name of facility redacted) after about one week in (hospital name redacted), where he was treated for a urinary tract infection and resulting			

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	encephalopathy ...Wound on undersurface of tip of penis continues. Treatment with A&D ointment continues. Resident still has his Foley catheter." On 3/6/25 at 4:35 PM Nurses Note: "(Doctor "MM") notified of resident change in condition including increased confusion, hallunications, and picking at skin. Doc recommended transfer to (hospital name redacted) due to recurrent UTI's ..." On 3/13/25 at 2 PM Admission Note, Late Entry: "Resident arrived at (facility name redacted) at 12:39 PM via stretcher in the company of two EMTs ..." On 3/17/25 at 3:39 PM Nurses Note "Spoke to Dr regarding delusions and hallucinations vivid to resident causing distress, and recurrent UTI with sepsis. New orders for Seroquel and prophylactics added to orders ..." Review of urology consult revealed, 3/18/15 "Ventral erosion of penis, UTI (urinary tract infection) symptoms, Recommend suprapubic catheter, surgery scheduled will contact, change foley today and collect sample to send out for culture, will call with results and prescribe antibiotic once culture is back." Review of office visit notes from R38's primary care provider revealed 4/4/25 "(age redacted)-year old male has a indwelling			

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	Foley catheter that is literally splitting his penis in half. Patient was scheduled to get a suprapubic catheter placed but this apparently is still trying to be scheduled. Patient gets frequent urinary tract infections secondary to the eroding of the catheter, he had significant metabolic encephalopathy ...Patient will benefit from avoiding metabolic encephalopathy which comes with his urosepsis which comes from his catheter eroding through his penis while waiting for urology to place a suprapubic catheter ..." Review of R38's care plan revealed no interventions related to foley catheter care or securement. Review of Kardex revealed the following: CATHETER: I have a catheter, please position my catheter bag and tubing below the level of my bladder and away from the entrance room door. Provide me with a leg strap and use a dignity bag to cover my catheter bag. It should be noted that staff reported that resident would refuse to use a leg strap however no progress notes were found indicating refusal, education or re-education on the importance of securing the catheter. Requested incident/accident reports related to injury, none provided prior to survey end. Review of facilities policy titled "Catheter Care", documented in part "It is the policy of			

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	this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...Leg bags will be attached to the residents thigh or calf making sure to have slack on the tubing to minimize pressure and tension. Ensure straps are snug but not tight." It should be noted that the facilities policy does not address securing a catheter except for when a leg bag is used. Resident #67 (R67) Review of the medical record revealed R67 was admitted to the facility on 4/2/25 with diagnoses that included diabetes, quadriplegia, anxiety, and atrial fibrillation. The Discharge Minimum Data Set (MDS) with an Assessment Reference Date of 4/6/25 revealed R67 was independent with cognitive skills for daily decision making and had an unplanned discharge to the hospital with a return not anticipated. Review of hospital records from prior to admission revealed a wound assessment dated 3/24/25 which revealed an abdominal wound to the left lower quadrant. The wound measured 3.5 centimeters (cm) long x 15 cm wide x 1 cm deep. The wound had moderate serous: thin, water, clear drainage. Wound management was listed as Negative Pressure Wound Therapy (NPWT/wound vacuum assisted closure [vac]).			

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	Another assessment dated 3/24/25 revealed a second wound on the midline abdomen measuring 12 cm long. The wound was approximated with sutures and moderate amount of serosanguineous: thin watery, pale red/pink drainage. The wound management was listed as alginate; transparent film. Review of the Hospital After Visit Summary dated 4/2/25 revealed wound care instructions were as follows: 1) Left lower quadrant abdominal wound: NPWT wound management with continuous pressure set at -125 mmHg (millimeters of Mercury) with black foam and drape; change Monday, Wednesday, Friday, and as needed if dressing is no longer intact. These instructions were circled with two stars drawn on the left side and "wound vac?" written above the circled area. 2) Abdominal midline surgical wound: cleanse with vashe wash, prep with skin prep and allow to dry, apply Xeraform/fluffs, cover with ABD (abdominal pad), and secure with tape. Change daily and as needed if the dressing is no longer intact. Review of the Physician Orders revealed these orders were not implemented. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed these treatments were not completed.			

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	Review of the Nurses Note dated 4/3/25 revealed "Drsg D/I [dressing dry and intact] to LL [left lower] abdominal wound. Colostomy intact ..." The medical record did not reflect what dressing was in place or when it was applied. Review of the Nurses Note dated 4/4/25 revealed "Resident surgical incision has grayish colored drainage with no odor noted with sutures in place". Review of the Nurses Note dated 4/5/25 revealed "Resident surgical incision has grayish colored drainage with no odor noted with sutures in place". Review of the Alert Note dated 4/6/25 revealed "Residents [sic] had an old wound that opened back up. Some milky drainage noted. Open area cleaned and calcium alginate, kerlix and abdominal pads applied to the open incision. [Doctor] made aware of the drainage and open incision. Per Physician he would like an [sic] culture collected from the drainage." Review of the Health Status Note dated 4/6/2025 revealed "Nurse was alerted by aide that resident was requesting to be sent to hospital. When nurse spoke with resident, resident stated that she did not feel well and she was concerned that she had an infection from abdominal incision dehiscence. Aide got vitals on resident and BP [blood pressure]			

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	was 101/63, Temp [temperature] 103.7, RR [respiratory rate] 16, HR [heart rate] 106, O2 [oxygen saturation] 90% on room air. Resident complained of discomfort, but no complaint of pain. After nursing assessment of resident, nurse decided to call emergency transport to take resident to the hospital for further evaluation." Review of the culture obtained from the abdominal wound on 4/4/25 with results available on 4/7/25 revealed the wound was positive for many Escherichia coli (E-coli), few klebsiella pneumoniae, rare staphylococcus aureus, and few pseudomonas aeruginosa. The culture results revealed "this organism [klebsiella pneumoniae] has been determined to produce an extended spectrum beta lactamase (ESBL) and is considered to show multiple drug resistance, requiring that the patient be placed in contact precautions In a telephone interview on 05/08/25 at 12:23 PM, Registered Nurse (RN) "P" reported they worked with R67 on the night of 4/4/25. RN "P" reported they received in report that R67 had just received a wound vac that day (two days after admission). When asked about any treatment for the midline abdominal surgical incision, RN "P" reported the wound was "seeping continuously" and a dry 4x4 sponge gauze was used after cleansing with saline. In a telephone interview on 05/08/25 at 12:31 PM, RN "EE" reported R67 did not have a wound vac placed upon admission. RN "EE"			

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	reported they believed R67 had wound orders in place while waiting for the wound vac but could not recall which dressing/treatment was used. In an interview on 05/08/25 at 12:45 PM, Director of Nursing (DON) "B" reported R67 showed signs and symptoms of infection upon admission to the facility. DON "B" reported they did not visualize R67's wounds upon admission. DON "B" reported R67's admission assessment did not reflect any abdominal wounds. When asked about treatments for R67's abdominal wounds, DON "B" reported the first treatment ordered was dated 4/6/25, the day R67 transferred to the hospital.. DON "B" reported they would have to consult with Assistant Director of Nursing (ADON) "J" for further information. ADON "J" joined the interview at 1:03 PM. ADON "J" reported the facility was informed that R67 needed a wound vac and that the facility had a wound vac available. ADON "J" reported when R67 arrived, it was determined that R67 needed two wound vacs and the physician was contacted for a treatment order until the second wound vac arrived. ADON "J" reported it took two to three days for the second wound vac to arrive. DON "B" and ADON "J" reported they could not locate any wound treatment orders or documentation that wound treatments were completed prior to 4/6/25.			
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1)	F0686	F686 – Treatment/Services to Prevent/Heal Pressure Ulcers	6/20/2025

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SS= G	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 1) failed to implement and update Physician orders, 2) accurately assess and document a pressure ulcer, 3) failed to ensure pressure ulcer prevention interventions were implemented, 4) failed to adequately assess and treat pain prior to wound care and 5) failed to prevent the development of pressure ulcers for 2 (Resident #11, Resident #20) out of 3 reviewed for pressure ulcers resulting in worsening of a pressure ulcer, unrelieved pain during wound care, and an increased risk of further skin breakdown. Findings include: Resident #20 (R20) Review of the medical record reflected that Resident #20 was admitted to the facility on		Element #1 R11's Pressure ulcer was reassessed by the Wound NP. Wound measurements were updated, appropriate treatment orders were obtained, and pain management interventions were implemented prior to wound care. R20's new pressure ulcer was staged, documented, and entered into the treatment administration record. Physician orders were obtained and implemented. Preventive interventions were put in place. Element #2 The Director of Nursing and/or designee conducted a 100% audit of residents with existing pressure ulcers and residents at high risk for skin breakdown. The audit included verification of physician orders, review of treatment records, and assessment of pressure-relieving interventions. Pain assessments during wound care were also reviewed to identify any documentation or treatment gaps. Element #3 The Administrator reviewed the policy on Pressure Injury Prevention and revised as necessary. Licensed Nurses were provided education on timely and accurate wound assessment and staging, implementation and documentation of pressure ulcer prevention interventions, communication of wound care orders, and ensuring pain management is in place before treatment. Element #4 The Director of Nursing or designee will conduct weekly audits of all residents with pressure ulcers and those identified as high-risk (Braden score =18) for 12 weeks to ensure accurate documentation, orders, and treatment. Results of the audits will be	

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	10/07/22 and readmitted on 02/07/25, with diagnoses that included muscle weakness, contractures of both right and left legs, pressure-induced deep tissue damage of the left heel, dementia, and acute and chronic respiratory failure with hypoxia. The Minimum Data Set (MDS), with an Assessment Reference Date of 02/10/25, reflected that Resident #20 scored 3 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Resident #20 was not interviewable. On 05/05/25 at 10:07 AM, Resident #20 was observed seated in the dining room wearing pressure-relieving ankle-foot orthosis (PRAFO) boots on both feet. However, the right boot was nearly detached from Resident #20's foot. During an interview conducted on 05/05/25 at 10:43 AM, Family Member "O" reported that Resident #20 had developed a sore on his heel. Family Member "O" stated that Resident #20 was unable to move his legs independently due to muscle atrophy and contractures. A review of the Activities of Daily Living Care Plan indicated that Resident #20 required maximum assistance of two persons for bed mobility. A skin assessment dated 02/05/24, completed upon readmission, described an		brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	unstageable pressure ulcer on the left heel with a length of 5 centimeters and a width of 7 centimeters. The Skin Integrity Care Plan for Resident #20 included an intervention dated 02/06/25 that stated, " I need to wear off-loading boots for heel protection. " A review of the Physician's Orders revealed an active order initiated on 03/13/25, which stated "Cleanse left heel deep tissue injury with Dakin's solution, pat dry, apply hydrogel, cover with Kerlix gauze. Change dressing daily and as needed. Resident to have pressure-relieving ankle-foot orthosis boots on at all times. " An outside wound care service note dated 04/21/25 described the left heel wound as an unstageable, pressure-induced tissue injury measuring 7.2 centimeters in length by 5.6 centimeters in width, with an undetermined depth. The wound bed was described as 10 percent granulation tissue, 20 percent slough, and 70 percent eschar. Treatment instructions included " Clean with Dakin's solution, apply Santyl and alginate. " A facility Weekly Wound Healing Record dated 04/21/25 assessed the same wound as a suspected deep tissue injury. The facility nurse described the wound bed as having granulation tissue and 20 percent slough, with measurements of 7.2 centimeters in length by 5.6 centimeters in width and an			

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	undetermined depth. The treatment plan included "Cleanse with normal saline, apply Santyl and alginate topically, wrap with Kerlix daily. " The corresponding physician's order was not updated to reflect these changes in treatment. An outside wound care service note dated 04/28/25 described the left heel wound as an unstageable, pressure-induced tissue injury measuring 7.0 centimeters by 4.7 centimeters, with an undetermined depth. The wound was noted to have 20 percent granulation tissue, 20 percent slough, and 60 percent eschar. Treatment instructions included " Clean with normal saline and apply Santyl and alginate daily. Cover with an abdominal pad and wrap with Kerlix. " A Weekly Wound Healing Record dated 04/28/25 documented the wound as a suspected deep tissue injury with measurements of 7.2 centimeters in length by 4.9 centimeters in width, and no depth recorded. The wound bed was noted to contain 20 percent slough. The treatment plan included "Cleanse with normal saline, apply Santyl and alginate daily. " Review of the Physician's Orders revealed that the orders still reflected the prior, outdated treatment: "Cleanse left heel deep tissue injury with Dakin's solution, pat dry, apply hydrogel, cover with Kerlix gauze.			

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	Change daily and as needed. " No update had been made to reflect the current wound care plan. On 05/07/25 at 09:24 AM, Resident #20 was observed lying flat in bed without wearing PRAFO boots. The boots were seen on the resident's wheelchair. At 09:47 AM on 05/07/25, Registered Nurses "Q" and "J" gathered supplies to perform wound care for Resident #20. The resident remained in bed, lying flat and without the boots. Registered Nurse "Q" verified the current physician order and gathered Dakin's solution and hydrogel as per the outdated order. Registered Nurse "J" confirmed that the left heel wound was a suspected deep tissue injury and stated she participates in wound rounds with the nurse practitioner weekly and updates orders based on the plan of care. During the procedure, Registered Nurse "Q" removed the dressing and described the wound as an open area with slough. She applied Dakin ' s solution, then hydrogel, covered the wound with an abdominal pad, and secured it with Kerlix and tape. Resident #20 verbalized "ouch" multiple times during the dressing change. Following the dressing change, Registered Nurse "Q" applied the PRAFO boots and stated she would notify the assigned nurse that Resident #20 required acetaminophen for pain.			

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

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	At 10:27 AM on 05/07/25, Certified Nursing Assistant "R" stated she was familiar with Resident #20's care and confirmed that the resident does not refuse care, including wearing the PRAFO boots. On 05/08/25 at 11:35 AM, Director of Nursing "B" explained that an outside wound care provider visits the facility, assesses wounds, and recommends treatment changes. She confirmed that facility staff are responsible for updating the physician's orders accordingly. After reviewing the Weekly Wound Healing Record, the Director of Nursing agreed that the facility's assessment of the left heel wound was inaccurate, as it continued to describe the injury as a suspected deep tissue injury rather than an unstageable pressure ulcer. At 12:12 PM on 05/08/25, Registered Nurse "J" reviewed the nurse practitioner's wound treatment recommendations alongside the current physician's orders in the electronic medical record. Registered Nurse "F" agreed that the physician orders did not match the nurse practitioner's plan of care. She updated the physician's order to "Cleanse with normal saline, apply Santyl and alginate, and cover with Kerlix gauze. " Additionally, review of the Medication Administration Record revealed that Resident #20 did not receive as-needed acetaminophen for pain until after the wound care procedure had been completed.			

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	Resident #11 (R11): Review of the medical record reflected R11 admitted to the facility 7/3/14 and readmitted 11/13/24, with diagnoses that included vascular dementia, dependence on wheelchair and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R11's cognition and mood were not assessed. The same MDS reflected R11 did not walk, was dependent for transfers and required substantial/maximal assistance with personal hygiene and partial/moderate assistance with rolling left and right. Weekly Wound Healing Records, dated 4/21/25 and 4/28/25, reflected R11 had a facility-acquired pressure ulcer to the posterior (back) scrotum, which developed 4/18/25. The wound was documented as stage II (two) (partial thickness loss of dermis/middle layer of skin, presenting as a shallow open ulcer with a red/pink wound bed; may also present as an intact or open/ruptured blister), measuring 0.9 centimeters (cm) in length by 0.9 cm in width and 0.1 cm in depth. The appearance of the wound bed was not documented. Weekly Wound Healing Records, dated 4/21/25 and 4/28/25, reflected R11 had a facility-acquired pressure ulcer to left intergluteal (between the buttocks) region, which developed 4/18/25. The wound was			

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	documented as stage II, measuring 0.9 cm in length by 0.5 cm in width and 0.1 cm in depth. The appearance of the wound bed was not documented. On 05/06/25 at 9:21 AM, R11 was observed seated in a wheelchair, in the hallway. A seating cushion was not observed in the wheelchair. On 05/06/25 at 12:44 PM, R11 was observed seated in their wheelchair, in the hallway. A seating cushion was not observed in the wheelchair. On 05/06/25 at 2:10 PM, R11 was observed seated in their wheelchair, in the main dining room. A seating cushion was not observed in the wheelchair. On 05/06/25, R11 was observed seated in their wheelchair, without a seating cushion at 3:42 PM, 4:05 PM and 4:52 PM. On 05/07/25 at 8:12 AM, R11 was observed seated in their wheelchair, in the hallway. A seating cushion was not observed in the wheelchair. On 05/07/25 at 8:22 AM, a request was made, to staff, to observe R11's skin during care that day. On 05/07/25 at 9:22 AM, Certified Nurse Aide (CNA) "W" and CNA "V" began care, including preparing to transfer R11 to bed as			

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	Licensed Practical Nurse (LPN) "X" prepared wound care supplies. Once LPN "X" had gathered wound care supplies and returned to the room, R11 refused assessment and treatment of their wounds. On 05/07/25 at 11:00 AM, R11 was observed lying in bed, on a standard mattress, positioned towards their right side. An additional mattress was on the floor at the right bedside. R11's wheelchair was observed in the room, with a seating cushion in place. On 05/07/25 at 1:31 PM, R11 was observed lying in bed, on a standard mattress, positioned towards their right side. An additional mattress was on the floor at the right bedside. On 05/07/25 at 2:52 PM, R11 was observed lying in bed, on a standard mattress, positioned towards their right side. An additional mattress was on the floor at the right bedside. In an interview on 05/07/25 at 2:54 PM, CNA "W" reported R2 received a wheelchair cushion from the Therapy Department that morning, after being transferred from their wheelchair to bed. CNA "W" reported sometimes, R2 did not have a wheelchair seating cushion for weeks at a time. During a phone interview on 05/08/25 at 1:11 PM, Nurse Practitioner (NP) "AA" reported visiting the facility weekly for wounds. NP			

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	"AA" reported they had seen R11 two to three times, and R11's stage II pressure ulcers had remained stable. NP "AA" stated they had recommended a low air loss mattress (specialty mattress) and a cushion for R11's wheelchair. Regarding the type of wheelchair cushion recommended, NP "AA" reported they usually recommended Roho cushions (specialty cushion for pressure relief). According to NP "AA", their recommendations had been conveyed to the facility. NP "AA"'s visit notes for 4/21/25 and 4/28/25 reflected, "...The patient is noncompliant with repositioning...Change positions often to keep pressure off the wound, and spread body weight evenly with cushions, mattresses, pillows, foam wedges, or other pressure-relieving devices..." A risk for skin breakdown Care Plan reflected it was created on 7/9/2014 and was initiated 3/5/25. An additional Care Plan, initiated on 5/5/25, reflected R11 had impaired skin integrity on the scrotum and intragluteal region. R11's Care Plan did not reflect the presence of pressure ulcers, nor interventions for pressure relief.			
F0689 SS= J	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident	F0689	F689 – Free of Accidents/Hazards/Supervision/Devices DPS A: 1. 100% of community residents were assessed by the Director of Nursing and designees on 05/06/25 to ensure no negative	6/20/2025

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	receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation has two separate DPS's: A and B. DPS A) Based on observation, interview, and record review, the facility failed to ensure hot water temperatures were in the comfortable range of 100-120 degrees Fahrenheit for two of 20 residents who resided in the dementia unit (Resident #31 and 39), resulting in Immediate Jeopardy when R31, who was independent with ambulation had a bathroom water temperature of 150 degrees Fahrenheit; and R39 who and was independent with ambulation, had a bathroom water temperature of 144.6 degrees Fahrenheit; and 2) facility wide resident bathroom water temperatures that tempted at greater than 120 degrees Fahrenheit with potential for second and/or third degree burns. Findings Included: Resident #31 (R31) A review of the medical record showed that Resident #31 (R31) was admitted to the facility on 4/22/22 and readmitted on 3/5/25. Diagnoses included generalized anxiety disorder, wandering, type 2 diabetes mellitus, psychotic disorder with delusions, dementia, and Alzheimer ' s disease. According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/25, R31 scored 1 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Resident #39 (R39)		effects related to water temperatures. Resident showers were taken offline to ensure safety of water temperatures, to include bed baths. 2. The water temperature was adjusted to ensure temperatures within regulatory standard. The Maintenance Director and designee conducted a 100% community audit of resident area water sources to ensure appropriate temperatures per regulatory guidance. 3. The Administrator reviewed the policy and procedure related to Safe Water Temperatures on 05/06/2025 with changes completed as necessary. Community staff will be educated on the policy for Safe Water Temperatures, with all staff completed or removed from the schedule by 05/09/25. 4. The Maintenance Director or designee will conduct an audit of resident room water temperatures daily, on both shifts for seven days, then twice weekly thereafter to ensure water temps meet regulatory standards. Results of the audits will be brought to the Quality Assurance Performance Improvement Committee for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 06.20.2025 DPS B: Element #1: R58 was assessed by the Director of Nursing or designee to ensure incident report, care	

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	Resident #39 (R39) was admitted on 6/15/22 with diagnoses including generalized anxiety disorder, psychotic disorder with delusions, dementia, and Alzheimer ' s disease. The MDS with an ARD of 4/5/25 reflected a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Domestic hot water temperatures were measured on multiple occasions in where both R31 and R39 resided: On 05/05/25 at 1:03 PM: R 39s Room= 152.6°F On 05/06/25 at 1:15 PM: R 31s Room =137.9°F and R 39s Room 147.9°F, On 5/06/25 at 3:45 PM for R 31s Room =150.7°F and R 39s Room =144.6°F Temperatures above 120°F are considered hazardous and pose a risk of scalding, especially for vulnerable populations such as those with cognitive impairment. On 05/06/2025 at 5:00 PM, the Administrator was notified of the Immediate Jeopardy that was identified on 5/6/2025, and began on 5/6/2025 when two identified residents (Resident #31 and 39) bathroom water temperatures were found to be greater than 120 degrees Fahrenheit. On 5/12/2025 the surveyor verified the facility implemented the following corrective action to remove the Immediate Jeopardy on 05/06/2025: 1. 100% of community residents were assessed by the Director of Nursing and designees on 05/06/25 to ensure no negative effects related to water temperatures. Resident showers were taken offline to ensure safety of water temperatures, to include bed baths.		plan, and interventions are updated to reflect resident current status. R38 was assessed by the Director of Nursing or designee to ensure no adverse effects related to their use of chewing tobacco. Behavior was care-planned and interventions put in place to prevent recurrence. Element #2: The Director of Nursing and/or designee conducted a 100% audit of residents with falls in the last 30 days to ensure documentation is complete to include updated care plans and interventions. The Director of Nursing and/or designee will conduct a 100% sweep of resident rooms to ensure no tobacco products are improperly stored. Element #3: The Administrator reviewed the policies related to Fall Prevention Program and Resident Smokeless Tobacco and revised as necessary. Community staff were provided education regarding the fall prevention program and smokeless tobacco. Element #4: The Director of Nursing and/or designee will conduct an audit of 10 residents weekly for 12 weeks to ensure appropriate documentation, care planning and interventions related to resident incidents. The Director of Nursing and/or designee will conduct an audit of 10 resident rooms weekly to ensure no tobacco products are stored inappropriately. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	2. The water temperature was adjusted to ensure temperatures within regulatory standard. The Maintenance Director and designee conducted a 100% community audit of resident area water sources to ensure appropriate temperatures per regulatory guidance. 3. The Administrator reviewed the policy and procedure related to Safe Water Temperatures on 05/06/2025 with changes completed as necessary. Community staff will be educated on the policy for Safe Water Temperatures, with all staff completed or removed from the schedule by 05/09/25. 4. The Maintenance Director or designee will conduct an audit of resident room water temperatures daily, on both shifts for seven days, then twice weekly thereafter to ensure water temps meet regulatory standards. Results of the audits will be brought to the Quality Assurance Performance Improvement Committee for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Although the Immediate Jeopardy was removed on 5/6/2025, the facility remained out of compliance at a scope of widespread and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance had not been verified by the state agency. On 05/05/25 at 01:03 P.M., Domestic hot water temperatures were monitored utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following domestic hot water temperatures were recorded:			

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	Resident Room 110: 128.9 degrees Fahrenheit* Resident Room 116: 136.7 degrees Fahrenheit* Resident Room 119: 152.6 degrees Fahrenheit* Resident Room 124: 145.6 degrees Fahrenheit* Resident Room 130: 106.9 degrees Fahrenheit Resident Room 136: 105.0 degrees Fahrenheit Resident Room 141: 111.7 degrees Fahrenheit On 05/05/25 at 01:45 P.M., An interview was conducted with Environmental Services Director (ESD) "E" regarding domestic hot water temperature monitoring and documentation log sheets. (ESD) "E" stated: "We routinely monitor hot water temperatures." (ESD) "E" also stated: "The temperatures are recorded on the log sheet." On 05/06/25 at 01:15 P.M., Domestic hot water temperatures were monitored utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following domestic hot water temperatures were recorded:			

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	South Unit Resident Room 123: 142.7 degrees Fahrenheit* North Unit (Memory Care) Resident Room 104: 105.5 degrees Fahrenheit Resident Room 109: 126.9 degrees Fahrenheit* Resident Room 110: 129.9 degrees Fahrenheit* Resident Room 111: 129.8 degrees Fahrenheit* Resident Room 112: 134.6 degrees Fahrenheit* Resident Room 116: 147.1 degrees Fahrenheit* Resident Room 118: 137.9 degrees Fahrenheit* Resident Room 119: 147.9 degrees Fahrenheit* On 05/06/25 at 03:15 P.M., Domestic hot water monitoring log sheets were requested from (ESD) "E". (ESD) "E" stated: "I know I have all of the temperature log sheets."			

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	On 05/06/25 at 03:24 P.M., An interview was conducted with (ESD) "E" regarding facility domestic hot water monitoring. (ESD) "E" stated: "Maintenance Technician "F" usually takes water temperatures." (ESD) "E" also stated: "I have taken hot water temperatures occasionally." On 05/06/25 at 03:38 P.M., An interview was conducted with Maintenance Technician "F" regarding the device currently used to monitor facility domestic hot water temperatures. Maintenance Technician "F" stated: "I use a Weber digital thermometer." Maintenance Technician "F" also stated: "I dropped the old thermometer and broke it." On 05/06/25 at 03:45 P.M., Domestic hot water temperatures were monitored by this surveyor utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following domestic hot water temperatures were recorded: Resident Room 109: 127.6 degrees Fahrenheit* Resident Room 110: 137.1 degrees Fahrenheit* Resident Room 111: 137.1 degrees Fahrenheit* Resident Room 112: 143.0 degrees Fahrenheit*			

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	Resident Room 116: 138.2 degrees Fahrenheit* Resident Room 118: 150.7 degrees Fahrenheit* Resident Room 119: 144.6 degrees Fahrenheit* Resident Room 124: 142.3 degrees Fahrenheit* Resident Room 130: 124.2 degrees Fahrenheit* Resident Room 141: 125.0 degrees Fahrenheit* On 05/06/25 at 03:45 P.M., Domestic hot water temperatures were monitored by Maintenance Technician "F" utilizing a "Weber" (no model number) digital thermometer. The following domestic hot water temperatures were recorded: Resident Room 109: 127.4 degrees Fahrenheit* Resident Room 110: 136.2 degrees Fahrenheit* Resident Room 111: 136.4 degrees Fahrenheit* Resident Room 112: 143.4 degrees Fahrenheit*			

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	Resident Room 116: 137.4 degrees Fahrenheit* Resident Room 118: 150.0 degrees Fahrenheit* Resident Room 119: 144.6 degrees Fahrenheit* Resident Room 124: 141.6 degrees Fahrenheit* Resident Room 130: 123.8 degrees Fahrenheit* Resident Room 141: 124.8 degrees Fahrenheit* On 05/06/2025 at 04:30 P.M., Record review of the (Corporation Name) Immediate Jeopardy (IJ) Removal Plan revealed the following narrative: During annual survey, it was identified that water temperatures in resident room bathrooms were exceeding the regulatory standard. Below are the immediate action items completed in proposal for removal of the (IJ). 1. 100% of community residents were assessed by the Director of Nursing and designees on 05/06/25 to ensure no negative effects related to water temperatures. Resident showers were taken offline to ensure safety of water temperatures, to			

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	include bed baths. 2. The water temperature was adjusted to ensure temperatures within regulatory standard. The Maintenance Director and designee conducted a 100% community audit of resident area water sources to ensure appropriate temperatures per regulatory guidance. 3. The Administrator reviewed the policy and procedure related to Safe Water Temperatures on 05/06/2025 with changes completed as necessary. Community staff will be educated on the policy for Safe Water Temperatures, with all staff completed or removed from the schedule by 05/09/25. 4. The Maintenance Director or designee will conduct an audit of resident room water temperatures daily, on both shifts for seven days, then twice weekly thereafter to ensure water temps meet regulatory standards. Results of the audits will be brought to the Quality Assurance Performance Improvement Committee for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. On 05/06/25 at 04:45 P.M., Domestic hot water temperatures were monitored utilizing a "ThermoWorks SuperFast Thermapen" model CR2032 digital thermometer. The following temperature was recorded:			

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

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	Staff/Visitor Restroom Hand Sink - 155.0 degrees Fahrenheit*. The State Operations Manual (SOM) Appendix PP section F689 Accidents states: Note: (*) Water Temperature - Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. Some States have regulations regarding allowable maximum water temperature. Table 1 illustrates damage to skin in relation to the temperature of the water and the length of time of exposure. Table 1. Time and Temperature Relationship to Serious Burns Water Time Required for a 3rd Degree			

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	Temperature Burn to Occur _____ _____ 155°F 68°C 1 sec 148°F 64°C 2 sec 140°F 60°C 5 sec 133°F 56°C 15 sec 127°F 52°C 1 min 124°F 51°C 3 min 120°F 48°C 5 min 100°F 37°C Safe Temperatures for Bathing (see Note) _____ _____ NOTE: Burns can occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure. Based upon the time of exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn, as follows.			

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	o First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling. o Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin. o Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black. On 05/07/25 at 09:14 A.M., An interview was conducted with (ESD) "E" regarding the domestic hot water supply. (ESD) "E" stated: "We consulted with Facilities Supervisor for the Battle Creek Fire Department (FS) "G". (ESD) "E" also stated: "He [(FS) "G"] suggested a regulator was going out on the South Unit water heater." (ESD) "E" additionally stated: "We bled out the hot water from the hot water storage tanks." (ESD) "E" further stated: "Room 118 was at 118.2 degrees Fahrenheit." (ESD) "E" also stated: "Room 119 was at 120.5 degrees Fahrenheit." (ESD) "E" additionally stated: "Room 121 was at 124.0 degrees			

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	Fahrenheit." (ESD) "E" further stated: "The staff/visitor restroom hand sink was at 125.0 degrees Fahrenheit." (ESD) "E" also stated: "Temperatures were monitored at approximately 7:00 AM this morning." On 05/07/25 at 09:40 A.M., An environmental tour of sampled resident rooms was conducted with Housekeeper "H". Domestic hot water temperatures were monitored utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following restroom hand sinks domestic hot water temperatures were noted: 117: 125.1 degrees Fahrenheit* 122: 128.1 degrees Fahrenheit* 123: 128.8 degrees Fahrenheit* 124: 130.3 degrees Fahrenheit* 128: 124.0 degrees Fahrenheit* 129: 124.5 degrees Fahrenheit* 131: 121.3 degrees Fahrenheit* On 05/07/25 at 12:06 P.M., An interview was conducted with (ESD) "E" regarding the facility maintenance work order system. (ESD) "E" stated: "We have TELS." On 05/07/25 at 12:23 P.M., Domestic hot			

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	water temperatures were monitored utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following domestic hot water temperatures were recorded: South Unit Shower Room Hand Sink - 123.8 degrees Fahrenheit* On 05/07/25 at 12:30 P.M., An interview was conducted with Maintenance Technician "F" regarding the South Unit Shower Room floor drain concern. Maintenance Technician "F" stated: "We have contacted (Contractual Vendor Name) for commercial repairs related to both plumbing and hot water heater issues." On 05/07/25 at 01:26 P.M., Domestic hot water temperatures were monitored utilizing a "ThermoWorks Super-Fast Thermapen" model CR2032 digital thermometer. The following domestic hot water temperatures were recorded: Staff/Visitor Restroom: Hand Sink - 126.4 degrees Fahrenheit* On 05/07/25 at 01:33 P.M., An interview was conducted with Nursing Home Administrator (NHA) "A" regarding removal of the domestic hot water supply excessive hot water temperature immediacy. (NHA) "A" stated: "We are not providing showers or bed baths			

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	until further notice." (NHA) "A" also stated: "We have posted signage in all resident rooms and shower rooms." On 05/07/25 at 01:41 P.M., Record review of the resident room and shower room posted signage revealed the following narratives: Resident Room posted signage states: "Please do not use water without first calling for staff assist." Shower Room posted signage states: "Showers are out of order until further notice." On 05/07/25 at 03:50 P.M., An interview was conducted with Commercial Contractor (CC) "I" regarding the domestic hot water temperature concern. (CC) "I" stated: "The recirculation pump switch was turned off." (CC) "I" also stated: "If the recirculation pump is off, you can't get consistent hot water temperatures." (CC) "I" further stated: "The cold-water supply was also closed to the tempering system." On 05/08/25 at 08:45 A.M., Record review of the Policy/Procedure entitled: "Safe Water Temperatures" dated (no date) revealed under Policy: "It is the policy of this facility to maintain appropriate water temperatures in resident care areas." Record review of the Policy/Procedure entitled: "Safe Water Temperatures" dated (no date) further revealed under Policy Explanation and			

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	Compliance Guidelines: "(4) Staff will report abnormal findings, such as complaints of water too cold of hot, burns or redness, or any problems with water temperature (ex. water is painful to touch or causes redness) to the supervisor and/or maintenance staff. (5) Water temperatures will be set to a temperature of no more than (120 degrees Fahrenheit) or (49 degrees Celsius), or the state's allowable maximum water temperature. (6) Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water circuits weekly and as needed. (7) Documentation of testing will be maintained for 3 years and kept in the maintenance office." On 05/08/25 at 09:00 A.M., Record review of the "Hot Water Temperature Monitoring Log Sheets" for the last 126 days revealed no specific entries related to excessive domestic hot water temperatures. Note: Numerous "Hot Water Temperature Monitoring Log Sheets" were observed completely missing from the requested timeframe. DPS B) Based on observation, interview and record review, the facility failed to 1) investigate falls, develop and implement post fall interventions, and prevent further falls for one of one (Resident #58) reviewed for falls and 2) facility failed to ensure resident was free from potential accidents or hazards by allowing unsupervised access to chewing tobacco for one (R38) of three residents reviewed for accidents.			

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	Findings include: Resident #58 A review of the medical record revealed that Resident #58 (R58) was admitted to the facility on 10/17/2024, with diagnoses including difficulty walking, muscle weakness, wandering, and dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/24/2025, indicated that R58 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS), reflecting severe cognitive impairment. On 5/05/2025 at 12:19 PM, R58 was observed ambulating independently and attempting to exit the locked memory care unit. When redirected, she became agitated and expressed a desire to go outside. R58 was noted to be pleasantly confused and non-interviewable. During an interview conducted on 5/05/2025 at 12:13 PM, Family Member "DD" reported that R58 had experienced multiple falls, including one that resulted in hospitalization. A review of incident and accident reports, as well as progress notes, revealed the following fall incidents: On 10/26/2024 at 6:35 PM, R58 was found sitting on the floor next to her bed. The care plan was updated to ensure that R58's walker remained within reach while she was in bed. On 1/28/2025 at 1:39 AM, R58 was discovered lying on her back on the floor of			

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	her room. A moderate amount of blood was noted around her head, and a laceration was observed on the left parietal region. She was transferred to a local emergency department, where she received one staple to close the head wound. Per the incident report, staff stated she had been ambulating with her walker at the time of the fall. Despite the severity of this incident, no new fall interventions were added to her care plan, no incident report was completed, and no investigation was initiated. On 1/29/2025 at 7:45 AM, R58 stood up from her wheelchair, lost her balance, and fell backward, striking her head against the medication cart. Although no apparent injuries were noted, this was R58's second fall in two days. Again, the care plan was not updated to include new fall interventions-only a request for a therapy screen was noted. No incident report was created, and no investigation occurred. On 3/12/2025 at 6:00 AM, R58 was found lying on her left side on the floor, leaning against the closet in her room. No injuries were reported, yet no additional fall prevention strategies were added to her care plan. Further observation on 5/07/2025 at 9:45 AM revealed that R58 was in bed with her call light draped over the headboard, out of her reach, and her walker placed against the wall, also out of reach, raising ongoing safety concerns. In an interview on 5/08/2025 at 11:22 AM, the Director of Nursing (DON) "B" stated that the facility's expectations following a fall include completing an incident report and			

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	implementing an immediate intervention to prevent recurrence. Resident # 38 (R38) Review of the medical record revealed R38 was admitted to the facility on 10/3/24 with diagnoses that included: legal blindness, muscle weakness, need for assistance with personal care, anxiety disorder, and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/25 revealed R38 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 5/5/25 at 10:15 AM, R38 was observed asleep on his back with a can of chewing tobacco on his bedside tray table, as well as a Styrofoam cup with tobacco spit in it. On 5/5/25 at 12:24 PM, a staff member was observed entering R38's room to see if he was done with his lunch tray. This staff member exited the room and reported that R38 was still eating his lunch. The chewing tobacco and cup with spit in it was easily visible on R38's bedside table, next to his lunch tray. On 5/5/25 at 12:28 PM R38 was queried about the chewing tobacco on his bedside table, R38 reported that he was told prior to his admission that it was ok for him to have it on him and to use it in his room, "they let me			

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	have it here". On 5/6/25 at 2:07 PM, R38 was observed to still have chewing tobacco and a spit cup on his bedside table. On 5/6/25 at 2:12 PM, the director of nursing (DON) was asked what the facilities policy on chewing tobacco was. She reported that she would have to look it up. On 5/6/25 at 2:14 PM, DON and this surveyor entered R38's room. DON stated that she would clean up the dry tobacco on resident's clothing and bedside table. DON removed the can of tobacco and the cup of tobacco spit. DON reported that she believed chewing tobacco should be treated like a medication and would need to be assessed to determine if it would be safe for the resident to have at his bedside. On 05/08/25 at 12:54 PM, during an interview with CNA "II" reported that she was aware that R38 had chewing tobacco and had observed it at his bedside. She reported that it was "something new". CNA "II" further stated that the resident was not supposed to have it unless he went outside to use it. On 5/12/25 at 8:19 PM during a telephone interview with R38's family member (FM "KK"), they reported that they had been bringing in chewing tobacco to R38 for a few months and that the staff was aware and that there wasn't a problem with it until this week.			

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	On 5/08/25 at 2:01 PM, during an interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON), it was reported to her that a review of the smoking policy revealed that it does not specifically address chewing tobacco and how was the facility planning to address it, she stated that what she had done for R38 specifically was talked to social services staff to do an assessment to if R38 could self-administer. She further stated that he could use it during smoking breaks and that she plans to bring it to QAPI (Quality and Assurance Performance Improvement). DON reported that she took the tobacco to the nurse and had her lock it up in the narcotic drawer in the medication cart and label it. Assistant director of nursing (ADON) reported that social services staff had placed it in the lock box with the other resident's cigarettes. When asked if they would agree that it isn't safe for a visually impaired resident to have access to chewing tobacco and associated spit cup both the DON and ADON agreed, with the ADON adding "especially unattended/unassisted. On 5/6/25 at 2:41 PM a request was made via email to the facility administrator (nursing home administrator-NHA) to clarify whether the facility had a policy that specifically addressed chewing tobacco and on 5/6/25 at 2:50 PM, NHA responded that they have searched and do not have anything specific to chewing tobacco.			

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	Review of the facilities policy titled "Pinnacle Care of Battle Creek Smoking Contract", documented in part "I am not allowed to have my own cigarettes, E-cigarettes, vape pens, matches of lighters while I reside at the facility. If I have any cigarettes, E-cigarettes, vape pens, matches or lighters on my person, I will turn all smoking materials in to the Activities Director before returning inside the facility ... I am not allowed to give, get, or request cigarettes, E-cigarettes, or vape pens from any other resident at any time ..."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §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 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	F0692	F692 – Nutrition/Hydration Status Maintenance Element #1: R20's diet orders and care plan were reviewed and modified as needed. R20 was assessed by the Director of Nursing and/or designee to ensure no lasting effects from missing double portions. Element #2: The RD and/or designee conducted an audit of community residents with orders for double protein portions to ensure care plans and interventions are accurate per resident current status. Element #3: The Administrator reviewed the policy on Nutrition and Hydration and revised as necessary. Community staff were provided education on following orders, and verification of information on tray tickets to ensure residents receive meals as ordered. Element #4: The RD and/or designee will review 10 residents weekly for 12 weeks to ensure meals are delivered in accordance with the orders and preferences indicated on their tray	6/20/2025

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	review the facility failed to properly adhere to the physician's order for double protein portions for one resident (Resident #20) out of one reviewed for nutrition. Resident #20 A review of the medical record indicates that Resident #20 was admitted to the facility on 10/07/22 and readmitted on 02/07/25. Diagnoses include heart failure and both acute and chronic respiratory failure with hypoxia. On 05/05/25 at 11:54 AM, Resident #20 was observed seated in the dining room, where their lunch consisted of two chicken tenders, potatoes, and coleslaw. Upon further observation, it was noted that the portion size of Resident #20's meal was consistent with that of the other residents in the dining room. The medical record shows that Resident #20's weight was recorded on the following dates: 2/28/25, 3/1/25, 3/14/25, 4/18/25, and 5/2/25. The recorded weights were as follows: 222.0 pounds on 3/14/25, 211.5 pounds on 4/18/25, and 210.2 pounds on 5/2/25. A Physician's Order dated 2/21/25 indicated that double protein portions were to be provided, with the order initially implemented on 10/19/25 and revised on 4/21/25. On 05/07/25 at 12:14 PM, Resident #20's lunch was observed and did not include the double protein portions as per the order. On 05/08/25 at 2:05 PM, Registered Dietitian (RD) "M" reported that she had noticed		ticket. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	recent weight loss in Resident #20 and, in response, had implemented the intervention of double protein portions, as she was aware that Resident #20 was a good eater. RD "M" stated that the expectation was to adhere to the order and provide Resident #20 with double protein portions.			
F0725 SS= E	Sufficient Nursing Staff §483.35 Nursing Services. 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 accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §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 (f) 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 (f) 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 ensure sufficient	F0725	F725 – Sufficient Nursing Staff Element #1 Residents #2, #25, and #37 were individually assessed to ensure their current needs were being met without delay. Their care plans were reviewed and updated as needed to include prompt response protocols and individualized care interventions. Element #2 A facility-wide audit will be completed by the Director of Nursing and/or designee to evaluate call light response times and overall resident satisfaction with care timeliness. Resident Council concerns were formally reviewed during the June meeting and integrated into the action plan. Element #3 The Administrator reviewed the policy on Call Light Accessibility and Timely Response, and revised as necessary. Community staff were provided education on the policy to include timely response standards and the importance of resident-centered care. Element #4 The Director of Nursing and/or designee will conduct random call light response audits for 10 residents weekly for 12 weeks. In addition, 5 resident interviews regarding call light responsiveness and care timeliness will be completed weekly by Social Services. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is	6/20/2025

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	nursing staff to respond to resident needs timely for three (R2, R25 and R37) and the Resident Council, from a census of 61 residents. Findings include: Resident #2 (R2): Review of the medical record reflected R2 admitted to the facility on 11/9/15 and readmitted 4/25/25, with diagnoses that included chronic obstructive pulmonary disease and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/1/25, reflected R2 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 05/05/25 at 11:39 AM, R2 was observed in a wheelchair, in their room. R2 reported call light response times of 35 minutes to one hour and 45 minutes. R2 reported the extended call light response times could be on any shift, depending on who was working. R2 reported they were able to determine their call light response times using the clock in their room. Resident #25 (R25): Review of the medical record reflected R25 admitted to the facility on 8/12/21, with diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and		responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	hemiparesis (weakness on one side of the body) following cerebral infarction (stroke). The Quarterly MDS, with an ARD of 2/20/25, reflected R25 scored nine out of 15 (moderate cognitive impairment) on the BIMS. On 05/05/25 at 1:06 PM, R25 was observed lying in bed. R25 reported at times, they had to sit in feces for hours at a time, mostly on the day shift. R25 reported it took more than one person to change them. Resident #37 (R37): Review of the medical record reflected R37 admitted to the facility on 11/6/24 and readmitted 3/6/25, with diagnoses that included iron deficiency anemia due to blood loss, muscle weakness, difficulty walking and need for assistance with personal care. The Quarterly MDS, with an ARD of 2/13/25, reflected R37 scored 15 out of 15 (cognitively intact) on the BIMS. On 05/05/25 at 11:11 AM, R37 was observed seated in a wheelchair, in their room. R37 reported at times, it took one hour for their call light to be answered on day shift. R37 also reported staff would respond to the call light, say they would be back but would not return. The extended call light wait times occurred when R37 wanted to get out of bed for the day. R37 reported they liked to be out of bed between 9:30 AM and 10:00 AM.			

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	In an interview on 05/08/25 at 10:49 AM, Certified Nurse Aide (CNA) "N" reported when the facility was not able to cover shifts, they worked short-handed. CNA "N" reported that occurred more on the weekends and approximately three times in the prior three months. In an interview on 05/12/25 at 12:06 PM, Scheduler "U" reported the facility staffed based on census and acuity. Regarding extended call light response times, Scheduler "U" reported there was a resident that required a higher number of staff to assist with care, which could be time consuming. When the Restorative Aide was working, they assisted with getting that resident up. On 5/7/25 at 12:24 PM, during a confidential Resident Council meeting, when asked if the residents get the help and care they need without waiting a long time and if staff respond to their call lights timely, responses included: One resident laughed and replied "not on nights" "Usually takes at least a half an hour." "Staff turn off call lights and don't take care of the need." "It depends on who is working, with certain people I have to wait 45 minutes"			

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	When asked if there is enough staff, 10 of 10 residents responded "no" and provided the following responses: "We are always short that is why we have to wait so long for call lights." "Nights is worse." "Good luck getting something done after 6pm (resident mentioned specific concerns with delay in getting brief changed)"			
F0732 SS= C	Posted Nurse Staffing Information §483.35(i) Nurse Staffing Information. §483.35(i)(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(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(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, staff, and visitors. §483.35(i)(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(i)(4) Facility data retention requirements. The facility must maintain the	F0732	F732 – Posted Nurse Staffing Information Element #1: On 5/09/2025, the Staffing Coordinator updated the posted nurse staffing forms to include the full date, including the year, and added the actual hours worked per category (RN, LPN, CNA) for both shifts. Element #2: An audit of staffing postings for the prior 30 days was conducted by Human Resources to ensure historical compliance and address any discrepancies. Element #3: The Administrator reviewed the policy for Nurse Staffing Posting Information and revised as necessary. Community staff were provided education regarding posted nursing staffing data and the requirements. Element #4: The Scheduler and/or designee will audit staffing postings daily, Monday through Friday, for 12 weeks to verify they are accurate, complete, and posted timely. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The	6/20/2025

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	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: Based on interview and record review, the facility failed to ensure the daily nurse staffing posting was dated with the year and included the actual hours worked by category of licensed and unlicensed nursing staff (i.e., Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nurse Aide (CNA)) directly responsible for resident care per shift. Findings include: On 05/05/25 at approximately 1:30 PM, the daily nursing staffing posting was noted on a table, in the main lobby. The posting was dated, "May 5th" and included the total amount of hours worked for day shift and night shift for RNs, LPNs and CNAs. The current year and shift times were not included on the posting. On 05/06/25 at 2:11 PM, the daily nursing staffing posting was noted in the main lobby. The posting was dated, "May 6th" and included the total amount of hours worked for day shift and night shift for RNs, LPNs and CNAs. The current year and shift times were not included on the posting. On 05/07/25 at 8:11 AM, the daily nursing staffing posting was noted in the main lobby.		Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	The posting was dated, "May 7th" and included the total amount of hours worked for day shift and night shift for RNs, LPNs and CNAs. The current year and shift times were not included on the posting. In an interview on 05/08/25 at 2:48 PM, Director of Nursing (DON) "B" reported the Scheduler was responsible for the daily staffing posting and may have been using a form that was passed down.			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his	F0756	F756 – Drug Regimen Review, Report Irregular; Act On Element #1: The pharmacy consultant reviewed the resident medication regimen for R9, R33, R40, R41, and submitted recommendations to the attending physician. The physician acknowledged the recommendations and documented follow-up actions. Element #2: An audit of pharmacy consultant reports from the last 60 days was initiated to verify timely review, physician acknowledgment, and appropriate follow-up on identified concerns. Element #3: The Medication Regimen Review policy was reviewed by the Administrator and revised as necessary. Licensed Nurses and the Provider group were re-educated on the policy and procedure. Element #4: The Director of Nursing and/or designee will audit 5 resident records per week for 12 weeks to ensure all pharmacist recommendations are documented and acted upon. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be	6/20/2025

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	or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to perform drug regimen reviews at least once a month by a licensed pharmacist for five Residents (#9,#33, #40, #41, and #49) of five Residents reviewed. Findings Included: Resident #40 (R40) Review of the medical record demonstrated R40 had been admitted to the facility 01/31/2025 with diagnoses chronic obstructive pulmonary disease (COPD), asthma, type 2 diabetes, stage 4 pressure ulcer of sacral region, stage 3 pressure ulcer of right buttock, muscle weakness, bone density disorder, hyperlipidemia (high fat content in flood), urinary retention, gastro-esophageal reflux, anemia, and left below knee amputation. Review of R40's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/2025, revealed R40 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive		determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	impairment) out of 15. Review of R40's medical record did not demonstrate that a Pharmacy Medication Regimen Review had been completed for March 2025. Resident #49 (R49) Review of the medical record demonstrated R49 had been admitted to the facility 09/17/2024 with diagnoses osteomyelitis (bone infection), malnutrition, asthma, paraplegia (paralysis that affects lower part of the body), stage 4 pressure ulcer sacral region, anxiety, depression, left lower leg non pressure ulcer, neuromuscular dysfunction of bladder, hypertension, atrial fibrillation, hypotension, anemia (low red blood cells), nicotine dependance, and chronic pain. Review of R49's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/2024, revealed R49 had a Brief interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Review of R49's medical record did not demonstrate that a Pharmacy Mediation Regimen Review had been completed for March 2025. During an interview on 05/28/2025 at 12:45 p.m. Director of Nursing (DON) "B" explained that a pharmacist reviewed all Resident medication orders monthly. DON "B" was asked to provide March 2025 Pharmacy			

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	Medication Regimen Reviews for R40 and R49. DON "B" explained that if they were not located in the Residents medical record that they would not have been completed. DON "B" could not verify that March 2025 Pharmacy Medication Regimen Reviews had been completed for R40 and R49. DON "B" could not explain why the March 2025 Pharmacy Medication Regimen Reviews had not been completed. Resident #9 (R9): Review of the medical record reflected R9 admitted to the facility on 1/25/23 and readmitted 11/14/24, with diagnoses that included dementia, major depressive disorder, insomnia, Alzheimer's and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R9's cognition and mood were not assessed. R9's medical record did not reflect evidence that monthly Pharmacy Medication Regimen Reviews had been conducted for July 2024, August 2024, September 2024, October 2024 and March 2025. On 05/07/25 at 12:59 PM, an email request was sent to Nursing Home Administrator (NHA) "A" and Director of Nursing (DON) "B" for monthly Pharmacy Medication Regimen Reviews, Pharmacy recommendations and follow-up actions for R9 since 5/1/24.			

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	On 05/07/25 at 2:28 PM, DON "B" reported if the Pharmacy Medication Regimen Reviews were not in the medical record, they did not have them. During a phone interview on 05/08/25 at 11:59 AM, Pharmacist "Z" reported their pharmacy provided medications to the facility and reviewed medications upon request of the nursing staff. Pharmacist "Z" reported an outsourced, third-party Pharmacist conducted the monthly Pharmacy Medication Regimen Reviews. Pharmacist "Z" reported the monthly Medication Regimen Reviews were not a service their pharmacy provided to the facility. Resident #33 (R33) Review of the medical record reflected R33 was admitted to the facility on 12/6/21, with diagnoses that included major depressive disorder and Alzheimer's with early onset. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/31/25, reflected R33 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Medical Record revealed that Monthly Medication Reviews did not occur on July 2024, August 2024, September 2024 , October 2024 and March 2025. Resident #41 (R41) Review of the medical record reflected R41			

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	was admitted to the facility on 7/6/22 and readmitted on 12/3/22, with diagnoses that included dementia. R41 was not interviewable. Review of the Medical Record revealed that Monthly Medication Reviews did not occur on July 2024, August 2024, September 2024, October 2024 and March 2025. During an interview on 05/28/2025 at 12:45 p.m. Director of Nursing (DON) "B" explained that a pharmacist reviewed all Resident medication orders monthly. DON "B" was asked to provide the missing Pharmacy Medication Regimen Reviews. DON "B" explained that if they were not located in the Residents medical record that they would not have been completed.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5% for three observed medication errors out of 25 opportunities, resulting in a medication error rate of 12%. Findings Included: During an observation of a medication administration on 5/06/2025 at 8:10 AM, Registered Nurse (RN) "EE" was observed to obtain an iron pill from a bottle to administer to a	F0759	F759 – Free of Medication Error Rates =5% Element #1: On 5/27/2025, the licensed nurse involved in the medication error received immediate re-education on proper medication administration protocols and documentation. Element #2: A full-house audit was conducted to ensure expired medications are disposed of appropriately, and that medication orders are complete to include dosage and parameters if necessary. Element #3: The Administrator reviewed the policy on Medication Administration and revised as necessary. Licensed Nurses were re-educated on the policy and procedure for medication administration. Element #4: The Director of Nursing and/or designee will perform 5 random medication administration	6/20/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE CARE OF BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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	resident. RN "EE" was asked why was the observed handwritten date on the bottle there, RN "EE" stated she did not know other than the nurse were to write the date of the bottle being opened, but stated it meant "nothing". A review of the bottle of iron revealed the bottle did not have a manufacture's expiration date on the bottle. RN "EE" was asked what needed to have been done with the bottle of iron, seems it was not possible to know the expiration date of the iron pills, in which RN "EE" stated that she would give the iron to the resident because that was what she was supposed to do, but said she did not know the expiration date of the iron pills. RN "EE" was observed to administered the iron to the resident then returned the bottle to the medication cart for future use, and did not dispose of the iron pills. During another medication pass with Licensed Practical Nurse (LPN) "X" on 5/07/2025 at 7:20 AM, LPN "X" was observed to administer a Senna Plus 8.6/50 mg tablet to the resident whom she was passing medications to. Review of the Physician's orders revealed that the order for the Senna was not for Senna Plus 8.6/50 mg, but rather did not state a dose at all, "Active Order Summary: Senna Oral Tablet (Sennosides) Give 1 tablet by mouth one time a day for constipation." In an interview on 5/07/2025 at 12:19 PM, LPN "X" was asked what the Physician's order was for the Senna medication. LPN "X" reviewed the Physician's order, and stated that because the Physician's order did not state 8.6 mg for the dose, and did not state the dose at all, she gave the Senna (laxative) plus (stool softener) 8.6/50 mg (respectfully). Observation of a medication pass on 5/07/2025 at 7:45 AM, LPN "GG" was observed during a		observations weekly for 12 weeks. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	medication administration. Amalodepine was ordered to be administered, but held for a blood pressure less than 94/64. Per LPN "GG" the resident's blood pressure was less that 94/64 so the Amalodepine was not to be administered. LPN "GG" was observed to place all medications into a med cup along with pudding. Included in the medications was Losartin 50 mg two tabs to be held for blood pressure less than 100. Prior to LPN "GG" administering the Losartin 50 mg LPN "GG" was asked if there were any blood pressure parameters for the Losartin. LPN "GG" did not believe so, however did check the Physician's orders, and then discovered there were parameters for the Losartin.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F0761	F761 – Label/Store Drugs & Biologicals Element #1: Resident #35 and #36 were assessed by the Director of Nursing or Designee to ensure no lasting effects related to the improper storage of medications. Element #2: A full-house medication storage audit was conducted across units to identify and correct any additional labeling or storage violations. Element #3: The Administrator reviewed the policy on Medication Storage, and Destruction of Unused Drugs and updated as necessary. Licensed Nurses will be re-educated on the policy and procedures for Medication Storage and the Destruction of Unused Drugs. Element #4: The Director of Nursing and/or designee will conduct weekly inspections of the medication storage areas and medication carts to ensure compliance with storage and destruction. The Social Service Director and/or designee will conduct a weekly sweep of 10 resident rooms to ensure residents without approved assessments and equipment are not self-	6/20/2025

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	Based on observation, interview, and record review the facility failed to ensure medications were properly labeled and stored per professional standards of practice for two residents (R35 and R36) and a medication cart in a current facility census of 61 residents. Findings Included: During an observation of a medication administration on 5/06/2025 at 8:10 AM, Registered Nurse (RN) "EE" was observed to obtain an iron pill from a bottle to administer to a resident. RN "EE" was asked why was the observed handwritten date on the bottle there, RN "EE" stated she did not know other than the nurse were to write the date of the bottle being opened, but stated it meant "nothing". A review of the bottle of iron revealed the bottle did not have a manufacture's expiration date on the bottle. RN "EE" was asked what needed to have been done with the bottle of iron, seems it was not possible to know the expiration date of the iron pills, in which RN "EE" stated that she would give the iron to the resident because that was what she was supposed to do, but said she did not know the expiration date of the iron pills. RN "EE" was observed to administered the iron to the resident then returned the bottle to the medication cart for future use, and did not dispose of the iron pills. In an observation and interview on 5/07/2025 at 7:45 AM, Licensed Practical Nurse (LPN) "GG" was observed to put pills into a medication cup and place pudding in over the pills. Prior to LPN "GG" administering the medications to the resident LPN "GG" discovered that she needed to remove two of the pills from the cup of pudding. LPN "GG" was observed to take a plastic spoon and remove one of the pills, and then take another		administering. Compliance Date: 6/20/2025	

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	plastic spoon and remove the other pill. Both pills remained on the spoons, and were observed to be tossed into the garbage can that was attached to the side medication cart. The garbage can did not have a lid, and both spoons were stuck at the top of the can on the plastic can liner due to the pudding. Both pills were visible and exposed, and easily accessible to other residents. LPN "GG" was observed to leave the medication cart unattended. There were observed to be three residents in the room where the medication cart was left, and two of the three residents were ambulatory. LPN "GG" was asked about the facility's policy for medication disposal, in which LPN "GG" stated she did not know what the facility's policy and procedure was for non-controlled substances, medication disposal. Resident #36 (R36) Review of the medical record reflected R36 admitted to the facility on 12/11/24, with diagnoses that included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, vascular dementia and chronic kidney disease. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/18/25, reflected R36's cognitive status was not assessed. On 05/06/25 at 9:55 AM, R36 was not observed in their room. A medication cup with four pills was observed on R36's overbed table, including two round, white pills and			

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	two round pills that were orange/pink in color. R36's roommate was observed in the room. On 05/06/25 at 10:07 AM, Licensed Practical Nurse (LPN) "T" reported administering medications to R36 that morning, including amlodipine (medication used to treat high blood pressure), hydrochlorothiazide (diuretic/water pill used to treat high blood pressure), metoprolol (medication used to treat high blood pressure) and hydralazine (medication used to treat high blood pressure). LPN "T" reported she took R36's medications to their room between 8 AM and 9 AM that morning but did not observe R36 consuming the medications. Upon entering R36's room with LPN "T", she removed the pills from R36's bedside and stated those were the medications she provided to R36 that morning. LPN "T" stated she was not supposed to leave the medications at bedside for R36. R36's May 2025 Medication Administration Record (MAR) reflected orders for morning medications, which included amlodipine 10 milligrams (mg) daily for high blood pressure, hydrochlorothiazide 25 mg daily for high blood pressure, hydralazine 25 mg twice daily for high blood pressure and metoprolol 25 mg twice daily for high blood pressure. In an interview on 05/08/25 at 8:48 AM, Director of Nursing (DON) "B" reported the nurses were supposed to observe residents			

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	taking their medications, then mark them as administered. Resident # 35 (R35) Review of the medical record revealed R35 was admitted to the facility on 10/2/24 with diagnoses that included: depression and repeated falls. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed R35 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). A review of R35's chart revealed: Nursing progress note, 12/28/24 at 19:00, "This resident (R35) had a visitor at about 1 p.m. this afternoon who stayed only a few minutes. Shortly after the resident's visitor left, one of the CNAs (certified nursing assistant) reported to this writer that this resident (R35) has marijuana gummies in his room, and that this resident had already given at least one gummy to the resident in room (room number redacted), initials (initials redacted). This writer asked this resident if he did indeed have marijuana gummies in his room. He admitted to having them, but refused to tell me where they were. This writer told the resident that they cannot stay in his room, and that he certainly cannot give these to other residents. At about 1:45 p.m. this resident gave this writer an opened bag of 200 mg gummies. There were two			

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	gummies in the bag. This writer placed the bag in the Boardwalk med cart's narcotic box. This resident's vital signs were within normal limits, as were his affect and movements. This resident's provider was notified by voice mail; this writer awaits a response." A request for any incident or accident reports for R35 was made via email on 5/7/25 at 10:18 AM. No associated incident or accident reports were provided prior to survey end. On 5/8/25 at 2:08 PM, during an interview with the director of nursing (DON) and assistance director of nursing (ADON), both reported to not have any knowledge of R35 having had cannabis gummies and/or that he shared them with another resident. When asked what the facilities policy is related to cannabis products, DON reported that she would need to look it up but would assume no drugs in the building, doesn't matter if it is gummies. DON/ADON both reported if there was any additional information they would provide it prior to survey exit. No additional information was provided. A review of the facilities policy titled, "Cannabidiol (CBD)", documented in part "It is the policy of the facility to honor a resident's right to receive Cannabidiol (CBD) within the limits of the law. CBD will be administered in oral form (oil/gummies, etc) or via vape to residents with a physician's order. (The legality of CBD and whether or not CBD is considered a controlled substance			

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	varies by state ...Like all other medications, CBD will be given by licensed nurses by the physician ...CBD will be considered a controlled substance in the facility and amounts will be counted at the beginning and end of each shift and signed by the licensed nurse completing the count to ensure accuracy of amounts on hand ...CBD administration will be documented in the same manner as all other controlled substances."			
F0809 SS= E	Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to consistently offer bedtime snacks to nine of ten residents who attended	F0809	F809 – Frequency of Meals/Snacks at Bedtime Element #1: The Administrator attended Resident Council on 06.04.2025 to discuss the plan for HS Snack delivery, and Food Committee was held with residents immediately afterward. Element #2: The Dietary Manager will conduct a full-house audit to ensure that all residents are offered an HS snack whether based on physician order or resident preference. Element #3: The Administrator reviewed the policy on Offering / Serving Bedtime Snacks, and revised as necessary. Community staff will be provided re-education on the policy and procedure. Element #4: The Dining Services Manager and/or designee will audit the delivery and documentation of snacks on night shift three times per week for 12 weeks. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance.	6/20/2025

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	the confidential Resident Council Meeting. Findings include: On 5/7/25 at 12:24 PM, during the confidential Resident Council meeting, when asked if residents were offered snacks at bedtime, nine of ten reported that snacks were not offered and they would like them. Responses included: "No bedtime snacks." "They do not offer every night, it is rare when they come in and offer (several residents nodded in agreement or verbalized agreement)" "They don't always have snacks available." "I use to get cottage cheese but they don't have a variety of snacks anymore, mostly only peanut butter sandwiches." "The previous kitchen staff use to be really good at asking and offering snacks every night." A review of the resident council meeting minutes revealed the following: January 2, 2025 "Please describe the concern: snacks at night" February 5, 2025 "Please describe the concern: not getting snacks at night"		Compliance Date: 6/20/2025	

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	On 5/8/25 at 10:48 AM, during an interview with dietary cook "JJ", she reported that the dietary staff provide each unit with a tray of snacks each day (around dinner time) and that the nursing staff on each unit is responsible for offering and providing them to the residents each night. Dietary Cook "JJ" reported that there are days when the kitchen staff delivers the snacks and the trays from the day before have zero or only few items missing, indicating they may not have been offered to the residents. Review of the facilities policy, titled "Offering/Serving Bedtime Snacks", documented in part "It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences and requests at bedtime on a daily basis ...Dietary services staff delivers bedtime snacks to each nurses' station. Nursing staff is made aware of the delivery of the snacks ...Nursing staff delivers and serves snacks to residents."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §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	F0812	F812 – Food Procurement, Store/Prepare/Serve – Sanitary Element #1: Dining staff immediately corrected the following concerns: - Milk observed without proper date-marking was disposed of. - Non-pasteurized eggs were discarded. - The can opener was deep cleaned. - The oven was deep cleaned. - The coffee machine was deep cleaned. - The microwave was replaced.	6/20/2025

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	food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to: (1) effectively clean and maintain food service equipment, and (2) effectively date mark all potentially hazardous ready-to-eat food products effecting 61 residents who consume food, resulting in the increased likelihood for cross-contamination, bacterial harborage, and resident foodborne illness. Findings include: On 05/05/25 at 09:10 A.M., An initial tour of the food service was conducted with Dietary Head Cook (DHC) "K". The following items were noted: One gallon (one-sixteenth full) of "Kemps Select 2% Milk" was observed, within the "Arctic Air" 2-door reach-in cooler, without an effective open or discard date. The manufacturer's use-by-date read 5-15-25. One gallon (one-eighth full) of "Kemps Select Whole Milk" was observed, within the walk-in cooler, without an effective open or discard date. The manufacturer's use-by-date was		- Dish machine will be repaired to ensure PSI within manufacturer recommended guidelines by the compliance date. - Walk-in cooler will be repaired to ensure the door to the walk-in cooler closes to a positive latch by the compliance date. - Maintenance replaced the anti-slip strips in the walk-in cooler. Element #2: The Dietary Manager conducted a full sanitation inspection of food storage and preparation areas to identify and correct additional risks. Element #3: The Administrator reviewed the policy on Date Marking for Food Safety, and Sanitation Inspection. Dining Services staff were provided re-education on the policies for date marking and sanitation. Element #4: The Dietary Manager and/or designee will perform kitchen sanitation inspections 3x weekly for 12 weeks to ensure compliance with food safety and sanitation protocols. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	observed to read 5-15-25. The "2022 FDA Model Food Code" section 3-501.17 states: "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1." Non-pasteurized shell eggs (7) were observed within the "Arctic Air" 2-door reach-in cooler. (DHC) "K" stated: "We use the eggs for breakfast." (DHC) "K" also stated: "We do eggs over easy for those who want them." The "2022 FDA Model Food Code" section 3-202.14 states: "(A) EGG PRODUCTS shall be obtained pasteurized. (B) Fluid and dry milk and milk products shall: (1) Be obtained pasteurized; and (2) Comply with GRADE A STANDARDS as specified in LAW. (C) Frozen milk products, such as ice cream, shall be obtained pasteurized as specified in 21 CFR 135 - Frozen desserts. (D) Cheese shall be obtained pasteurized unless alternative procedures to pasteurization are specified in			

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	the CFR, such as 21 CFR 133 - Cheeses and related cheese products, for curing certain cheese varieties." The can opener assembly was observed soiled with accumulated and encrusted food residue. (DHC) "K" stated: "We clean the can opener every Monday and Wednesday." 1 of 2 "Garland" convection oven interior and exterior surfaces were observed soiled with accumulated and encrusted food residue. The "Bunn" Coffee Machine (backsplash, under splash, drip tray) was observed soiled with accumulated and encrusted food residue. The coffee machine drip tray was also observed completely full of liquid waste. (DHC) "K" stated: "We clean the coffee machine daily." The "Panasonic" microwave oven interior was observed soiled with accumulated and encrusted food residue. The "2022 FDA Model Food Code" section 4-601.11 states: "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."			

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

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	The "Panasonic" microwave oven interior door surface protective mesh screen was observed (etched, scored, torn), creating a microwave safety issue. The damaged door screen measured approximately .25-inches wide by 2-inches-long. The "2022 FDA Model Food Code" section 4-501.13 states: "Microwave ovens shall meet the safety standards specified in 21 CFR 1030.10 Microwave ovens. Failure of microwave ovens to meet the CFR standards could result in human exposure to radiation leakage, resulting in possible medical problems to consumers and employees using the machines." The "Ecolab" mechanical dish machine pounds-per-square inch (PSI) gauge was observed to read 33 (PSI) during the final rinse cycle. The (PSI) reading should be between 5-30 (PSI) during the final rinse cycle. (DHC) "K" indicated she would have Dietary Manager "L" contact the contractual vendor for necessary repairs as soon as possible. The "2022 FDA Model Food Code" section 4-501.113 states: "The flow pressure of the fresh hot water SANITIZING rinse in a WAREWASHING machine, as measured in the water line immediately downstream or upstream from the fresh hot water SANITIZING rinse control value, shall be within the range specified on the machine			

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	manufacturer's data plate and may not be less than 35 kilopascals (5 pounds per square inch) or more than 200 kilopascals (30 pounds per square inch)." The Walk-In Cooler flooring surface was observed covered with laminate pattern rolled vinyl. 2 of 3 anti-skid strips near the entrance of the Walk-In Cooler were also observed loose-to-mount and partially missing. The "2022 FDA Model Food Code" section 6-201.11 states: "Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE." The Walk-In Cooler automatic door closer assembly was observed out-of-adjustment, allowing the door to not close and latch completely. The "2022 FDA Model Food Code" section 4-501.11 states: "(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept			

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	sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened." On 05/08/25 at 12:00 P.M., Record review of the Policy/Procedure entitled: "Sanitation Inspection" dated (no date) revealed under Policy: "It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations. Record review of the Policy/Procedure entitled: "Sanitation Inspection" dated (no date) further revealed under Policy Explanation and Compliance Guidelines: "(1) All food service areas shall be kept clean, sanitary, free from litter, rubbish, and protected from rodents, roaches, flies, and other insects." On 05/08/25 at 12:15 P.M., Record review of the Policy/Procedure entitled: "Cleaning and Sanitizing Dietary Areas and Equipment" dated (no date) revealed under Policy: "All kitchen areas and equipment shall be maintained in a sanitary manner and be free of buildup of food, grease, or other soil. The facility will provide sanitary foodservice that meets state and federal regulations." On 05/08/25 at 12:30 P.M., Record review of the Policy/Procedure entitled: "Culinary Operating Procedures 501 Sanitation-General" dated (no date) revealed under Policy: "It is the policy of this facility to			

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	maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule." On 05/08/25 at 12:45 P.M., Record review of the Policy/Procedure entitled: "Culinary Operating Procedures 502 Cleaning Equipment and Utensils" dated (no date) revealed under Policy: "Equipment and utensils will be properly cleaned, sanitized, and stored to prevent contamination." On 05/08/25 at 12:55 P.M., Record review of the Policy/Procedure entitled: "Date Marking for Food Safety" dated (no date) revealed under Policy: "The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food." Record review of the Policy/Procedure entitled: "Date Marking for Food Safety" dated (no date) further revealed under Policy Explanation and Compliance Guidelines for Staffing: "(1) Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41 degrees or less for a maximum of 7 days. (2) The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. (5) The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.)"			

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F0865 SS= F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and	F0865	F865 – QAPI Program/Plan, Disclosure/Good Faith Attempt Element #1: The facility's QAPI plan was updated on 5/27/2025 to include specific goals and performance indicators. The QAPI committee was re-structured to ensure monthly meetings with effective data analysis and prioritization of performance improvement projects. Element #2: The Administrator initiated a QAPI participation review to ensure all department heads are submitting routine data and quality indicators for review and action planning. Element #3: The Administrator reviewed the policy on Quality Assurance Performance Improvement and revised as necessary. Community staff were provided education on QAPI. Element #4: The Administrator and/or designee will audit QAPI meeting minutes for 3 months to ensure compliance with active, data-driven performance improvement projects. QAPI effectiveness will also be evaluated monthly by ownership. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	6/20/2025

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	measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as			

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	evidenced by: Based on interview and record review the facility failed to maintain an effective Quality Assurance and Performance Improvement program that identified areas of focus and improvement in a current facility census of 61 residents. Findings Included: During the survey a concern was identified at an Immediate Jeopardy level regarding hot water temperatures in which the facility was unaware off. Also, it was identified during the survey a concern of accommodation of resident needs regarding call light accessibility. Review of resident council meeting minutes, dated 3/5/2025, revealed a concern was brought up regarding not having hot water in the resident rooms. The facility's response was to check the hot water temperatures, and to also check them weekly. Review of QAPI minutes revealed no further discussion of weekly hot water temperatures, nor were any documented logs noted. In an interview on 5/08/2025 at 2:35 PM, Administrator "A" was not able to verify that a QAPI meeting had been held for the month of April 2025. Administrator "A" stated that she had no idea if there had been QAPI discussion regarding water temperatures not being at a comfortable level. Administrator "A" also stated that she was not aware of any perfomance improvement plan (PIP) that was in place regarding the resident call light system or accessibility.			

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F0880 SS= D	Infection Prevention & Control §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; (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	F0880	F880 – Infection Prevention & Control Element #1: R#61 was assessed by the Director of Nursing or designee to ensure no lasting effects related to outdated oxygen tubing. Element #2: A facility-wide audit will be completed by the Director of Nursing and/or designee to ensure compliance with changes to oxygen tubing. Element #3: The Administrator reviewed the policy on Oxygen Administration and revised as necessary. Clinical staff were provided re-education related to infection control and oxygen administration. Element #4: The Infection Preventionist and/or designee will conduct rounds 3 times per week for 12 weeks to monitor infection control practices and ensure oxygen tubing is changed per policy. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	6/20/2025

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	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 ensure oxygen tubing was changed every seven days for one out of two residents (Resident #61). Findings Included: In an observation on 5/05/2025 at 12:25 PM, an oxygen concentrator (tank that delivers oxygen) was observed to be on. Tubing was observed to go from the tank to Resident #61's (R61) nose and was administering oxygen to the R61. The tubing was observed to have a tapped label on it which had a date of 4/20/2025. In another observation on 5/07/2025 at 3:07 PM, R61 was observed to have the same oxygen tubing in place as observed on 5/5/2024 and was still labeled 4/20/2025. In an interview on 5/07/2025 at 3:45 PM, Infection Control Preventionist (ICP), who was also a Registered Nurse (RN) "J" stated that she did not monitor and track the use of oxygen tubing via the infection control program. ICP/RN			

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	"J" stated she did not perform audits to ensure oxygen tubing was being changed every seven days. In an interview on 5/07/2025 at 3:59 PM, the Director of Nursing (DON) "B" stated the oxygen tubing was to be changed every seven days and dated. DON "B" stated her that her expectation was that the ICP/RN "J" perform monthly audits and random checks of resident's oxygen tubing for dates, assuring staff are changing the tubing per policy. Review of the facility policy and procedure, not dated, revealed oxygen tubing was to be changed weekly and as needed. The policy revealed under #5. "b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated."			
F0883 SS= D	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F0883	F883 – Influenza and Pneumococcal Immunizations Element #1: Resident #2 and #22 were assessed to ensure no lasting effects related to insufficient education regarding vaccine administration. Element #2: The Director of Nursing and/or designee conducted a full-house audit to ensure residents receiving immunizations have been provided the appropriate education. Element #3: The Administrator reviewed the policy General Immunization and revised as necessary. Licensed Nurses were provided education on the policy and the need for resident/ responsible party education regarding vaccinations. Element #4: The Director of Nursing and/or designee will conduct weekly audits of immunization status for 12 weeks to ensure appropriate education	6/20/2025

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	immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document education provided regarding the benefits and potential side effects of the pneumococcal immunization for two (R2 and R22) of five reviewed. Findings include:		is provided. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	Resident #22 (R22) Review of the medical record revealed R22 admitted to the facility on 10/8/18 with diagnoses that included chronic obstructive pulmonary disease (COPD) and diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/23/25 revealed R22's cognitive skills for daily decision making were not assessed. The MDS with an ARD of 12/21/24 revealed R22 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Pneumonia Vaccine Consent Form revealed R22 declined the pneumonia vaccine on 5/9/24. Review of the Nurses Note dated 8/28/24 revealed "PCP [primary care physician] ordered pneumonia immunization, resident consented ..." R22 received the pneumonia vaccine on 8/30/24. The medical record did not reflect the education provided to R22 regarding the benefits and potential side effects of the pneumonia vaccine. In an interview on 05/08/25 at 1:14 PM, Director of Nursing (DON) "B" and Assistant Director of Nursing/Infection Preventionist (ADON/IP) "J" reported they were not employed at the facility when R22's pneumonia vaccine was administered. DON			

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	"B" and ADON/IP "J" reported the Centers for Disease Control and Prevention Vaccine Information Statement should be given prior to any vaccine administered. Further information was requested regarding the documentation of the education given to R22 prior to administering the pneumonia vaccine. Documentation was not received prior to the survey exit. Resident #2 (R2): Review of the medical record reflected R2 admitted to the facility on 11/9/15 and readmitted 4/25/25, with diagnoses that included chronic obstructive pulmonary disease and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/1/25, reflected R2 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Pneumonia Vaccine Consent Form reflected R2 declined the pneumonia vaccine on 4/22/24. The medical record reflected R2 received the Prevnar 20 pneumococcal (pneumonia) immunization on 8/30/24. A Progress Note for 8/30/24 reflected, "Resident received prevnar20 and shingles immunization to deltoid. Resident tolerated administration well..."			

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	134140	A. BUILDING _____ B. WING _____	5/12/2025

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	The medical record did not reflect the education provided to R2 regarding the benefits and potential side effects of the pneumonia immunization. In an interview on 05/08/25 at 9:42 AM Director of Nursing (DON) "B" and Assistant Director of Nursing/Infection Preventionist (ADON/IP) "J" reported the Centers for Disease Control and Prevention Vaccine Information Statement should have been provided prior to any vaccine administered. On 05/08/25 at approximately 10:30 AM, R2 was observed in their room. R2 acknowledged providing consent for the facility to administer a pneumococcal immunization, however, when asked if they had been provided with education on the risks and/or benefits of the pneumococcal immunization, R2 reported they had not received education.			
F0887 SS= B	COVID-19 Immunization §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before	F0887	F887 – COVID-19 Immunization Element #1: Resident #33 was assessed by the Director of Nursing and/or designee to ensure no lasting effects related to not receiving Covid-19 immunization. Element #2: The Director of Nursing and/or designee reviewed the last 60 days of resident documentation to ensure residents were offered and provided immunization based on consent. Element #3: The Administrator reviewed the policy on General Immunization and revised and	6/20/2025

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	offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:		necessary. Licensed Nurses were provided re-education on the vaccine policy and procedure to ensure residents consenting to vaccines receive them timely. Element #4: The Director of Nursing and/or designee will audit new admissions weekly to ensure any resident consenting to a vaccination receives it in a timely manner. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	Based on interview and record review, the facility failed to administer a COVID-19 vaccine per consent for one (R33) of five reviewed. Findings include: Review of the medical record revealed R33 was admitted to the facility on 12/6/21 with diagnoses that included Alzheimer's Disease and diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/25 revealed R33 scored 00 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R33's spouse was their Durable Power of Attorney (DPOA) for Healthcare. According to R33's immunization history, the most recent COVID-19 vaccine was administered on 11/7/23. Review of the COVID-19 Vaccine Consent Form revealed R33's DPOA gave verbal consent for the COVID-19 vaccine on 8/28/24. R33 did not receive the COVID-19 vaccine per consent. In an interview on 05/08/25 at 1:14 PM, Director of Nursing (DON) "B" and Assistant Director of Nursing/Infection Preventionist (ADON/IP) "J" were not able to provide documentation or information as to why R33 did not receive an updated COVID-19 vaccine.			

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F0919 SS= E	Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to effectively maintain the resident call system effecting 61 residents, resulting in the increased likelihood for delayed emergency response and/or negative resident outcomes. Findings include: On 05/06/25 at 02:01 P.M., The resident call system was monitored for functionality for the following resident rooms: South Unit Resident Room 121: Functioning Resident Room 122: Functioning Resident Room 123: Functioning Resident Room 124: Functioning Resident Room 125: Functioning	F0919	F919 – Resident Call System Element #1: The Maintenance Department repaired the cited inoperable call bell systems and ensured that the documented resident call lights were functioning properly. Element #2: The Maintenance Director and/or designee will conduct a 100% audit of call systems to ensure each resident has a call light that is appropriate for their current status and properly functioning. Element #3: The Administrator reviewed the policy on Call Lights and revised as necessary. Community staff were re-educated on the policy to include reporting of inoperable equipment. Element #4: The Maintenance Director and/or designee will perform a weekly facility-wide call system inspection for 12 weeks and log all maintenance responses. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	6/20/2025

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	Resident Room 126: Functioning Resident Room 127: Functioning Resident Room 128: Functioning Resident Room 129: Functioning Resident Room 130: Functioning On 05/06/25 at 02:55 P.M., An interview was conducted with R25 regarding the resident call system provided by the facility. R25 stated: "I wish I had the old call system to push." On 05/07/25 at 12:06 P.M., An interview was conducted with Environmental Services Director (ESD) "E" regarding the facility maintenance work order system. (ESD) "E" stated: "We have TELS." On 05/08/25 at 10:30 A.M., Record review of the Policy/Procedure entitled: "Call Lights: Accessibility and Timely Response" dated (no date) revealed under Policy: "The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response." Record review of the Policy/Procedure entitled: "Call Lights: Accessibility and Timely Response" dated (no date) further revealed under Policy			

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	Explanation and Compliance Guidelines: "(1) All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. (2) All residents will be educated on how to call for help by using the resident call system. (5) Staff will ensure the call light is within reach of residents and secured, as needed. (8) Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace "call light", provide a bell or whistle, increase frequency of rounding, etc.). (9) Ensure the call system alerts staff members directly or goes to a centralized staff work area." On 05/08/25 at 01:00 P.M., Record review of the "Direct Supply TELS Work Orders" for the last 60 days revealed no specific entries related to the resident call system.			
F0921 SS= F	Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 61	F0921	F921 – Safe/Functional/Sanitary/Comfortable Environment Element #1: Environmental deficiencies listed below will be addressed: - The wall-mounted grab bars in therapy near the scale were repaired. - Damaged chairs in therapy were replaced. - Shower wand assemblies were equipped with an atmospheric vacuum breaker. - The floor and mop sink basin in the janitor's closet were cleaned.	6/20/2025

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	residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, decreased air quality, and potential cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies. Findings include: On 05/06/25 at 09:20 A.M., A common area environmental tour was conducted with Environmental Services Director (ESD) "E". The following items were noted: South Unit Occupational Therapy/Physical Therapy: The wall mounted grab bar, located directly in front of the wheelchair scale, was observed loose-to-mount. 2 of 2 oval shaped mobile swivel chair cushions were also observed (etched, scored, particulate). 1 of 2 chair cushions were additionally observed with green duct tape covering the damaged vinyl surface. (ESD) "E" indicated she would have staff repair the loose-to-mount grab bar and remove the damaged chairs as soon as possible. Shower Room: 2 of 2 shower wand assemblies were observed missing an atmospheric vacuum breaker. (ESD) "E" stated: "I will have them installed this week." Janitor Closet: The flooring surface and mop sink basin were observed soiled with		- Return air exhaust ventilation grills were cleaned in the nurse station restroom, the soiled utility room, the activities storage room, Rm 124 restroom, Rm 130 restroom, Rm 131 restroom. - Overhead light assemblies were repaired and/or cleaned in the lift storage room, the main dining room, Rm 102 bed 2, Rm 117 bed 1, Rm 122 bed 1, Rm 123 bed 1, Rm 128 bed 1, Rm 129 bed 2, Rm 135 bed, Rm 135 restroom, and Rm 143 entrance light. - Beauty shop hand sink basins were repaired to ensure proper drainage. - Flooring was repaired in the storage room. - Commode base caulking was repaired in Rm 101, Rm 102, Rm 111, Rm 122, Rm 124, Rm 128, Rm 130, Rm 131, Rm 135, and Rm 143. - Rm 101: drywall was cleaned above the waste receptacle. - Rm 117: Restroom door was repaired to ensure proper mounting and close to a positive latch. - Rm 122: The wall-mounted thermostat, and restroom faucet assembly were repaired. - Rm 123: The commode seat and cove base were repaired. - Rm 127: Bed 2 metal frame was assessed and repaired. - Rm 128: The commode seat was repaired. - Rm 133: The commode support and seat were repaired. Restroom interior door was repaired. - Rm 135: Bed 2 enabler bar and restroom toilet paper holder were repaired. The restroom was cleaned. Element #2: The Maintenance Director initiated a full facility walkthrough to identify and resolve any additional safety, sanitation, or functional issues. Element #3:	

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	accumulated and encrusted dust/dirt and debris (paper products, dust balls, etc.). (ESD) "E" indicated she would have housekeeping staff thoroughly clean the room as soon as possible. Nurses Station: The restroom return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. (ESD) "E" indicated she would have housekeeping staff thoroughly clean the ventilation grill as soon as possible. Soiled Utility Room: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. (ESD) "E" indicated she would have housekeeping staff thoroughly clean the ventilation grill as soon as possible. Lift Storage Room: 2 of 2 overhead light assemblies were observed non-functional. (ESD) "E" indicated she would have staff make necessary repairs as soon as possible. North Unit Dining Room: 9 of 9 overhead light assembly clear plastic protective lens covers were observed soiled with accumulated and encrusted (dust, dirt, dead insect carcasses). (ESD) "E" indicated she would have staff thoroughly clean the soiled lens covers as soon as possible. Activities Storage Room: The return-air-		The Administrator reviewed the policy on Resident Environmental Quality, and Routine Cleaning and Disinfection, and revised as necessary. Community staff were re-educated on the policies. Element #4: The Maintenance Director and/or designee will conduct weekly environmental rounds for 12 weeks to ensure compliance with the regulation. Results of the audits will be brought to the QAPI Committee monthly for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible to attain and maintain compliance. Compliance Date: 6/20/2025	

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	exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. (ESD) "E" indicated she would have housekeeping staff thoroughly clean the ventilation grill as soon as possible. Beauty Shop: 2 of 2 hand sink basins were observed draining very slowly. (ESD) "E" stated: "I will have (Maintenance Technician "F") clear the drains." Storage Room: The flooring surface was observed missing vinyl tiles. The damaged flooring surface measured approximately 3 feet-wide by 5 feet-long. (ESD) "E" indicated she would have staff make necessary repairs as soon as possible. On 05/07/25 at 09:40 A.M., An environmental tour of sampled resident rooms was conducted with Housekeeper "H". The following items were noted: 101: The Bed 2 overbed light assembly clear plastic protective lens cover was observed cracked/broken. Human fecal material was also observed on the drywall surface, located directly above the restroom waste receptacle. The restroom commode base caulking was additionally observed (etched, scored, stained, particulate). 102: The restroom commode base caulking was observed (etched, scored, stained, particulate).			

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	111: The restroom commode base caulking was observed (etched, scored, stained, particulate). 117: The Bed 1 overbed light assembly lower 48-inch-long fluorescent bulb was observed non-functional. The restroom entrance door was also observed ill-mounted and not latching. 122: The Bed 1 overbed light assembly was observed missing the light switch and pull string extension. The wall mounted thermostat was also observed loose-to-mount and missing a protective cover plate. The restroom hand sink faucet assembly was additionally observed loose-to-mount. The restroom commode base caulking was further observed (etched, scored, stained, particulate). 123: The restroom commode seat was observed loose-to-mount. The Bed 1 overbed light assembly pull string extension was also observed missing. The vinyl base coving strip was further observed loose-to-mount. The damaged vinyl base coving strip measured approximately 6-inches-wide by 6-inches-long, along the corner edge of the drywall partition. 124: The restroom return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The restroom commode base caulking was also observed (etched, scored,			

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	stained, particulate). 127: The Bed 2 metal frame was observed in the retracted position without a mattress, creating a potential safety hazard for R21. 128: The Bed 1 overbed light assembly pull string extension was observed missing. The restroom commode base caulking was also observed missing. The restroom commode seat was additionally observed loose-to-mount. 129: The Bed 2 overbed light assembly pull string extension was observed missing. 130: The restroom commode base caulking was observed missing. The restroom return-air-exhaust ventilation grill was also observed heavily soiled with accumulated and encrusted dust/dirt deposits. 131: The restroom commode base caulking was observed missing. The restroom return-air-exhaust ventilation grill was also observed heavily soiled with accumulated and encrusted dust/dirt deposits. 133: The restroom commode support was observed loose-to-mount. The restroom commode seat was also observed loose-to-mount. The restroom interior door surfaces were additionally observed (etched, scored, particulate). 135: The Bed 1 overbed light assembly upper			

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	48-inch-long fluorescent bulb was observed non-functional. The Bed 1 overbed light assembly pull string extension was also observed missing. The Bed 2 enable bar was additionally observed loose-to-mount. The restroom shower stall overhead light assembly was further observed non-functional. Human fecal material was also observed, adjacent to the restroom shower stall unit. The restroom toilet tissue holder center pin was also observed missing. The restroom commode base caulking was additionally observed missing. 143: The restroom commode base caulking was observed missing. The resident room entrance overhead light assembly clear plastic protective lens cover was also observed soiled with (dust, dirt, dead insect carcasses). On 05/07/25 at 12:06 P.M., An interview was conducted with (ESD) "E" regarding the facility maintenance work order system. (ESD) "E" stated: "We have TELS." On 05/07/25 at 12:30 P.M., An interview was conducted with Maintenance Technician "F" regarding the South Unit Shower Room floor drain concern. Maintenance Technician "F" stated: "We have contacted (Contractual Vendor Name) for commercial repairs related to both plumbing and hot water heater issues." On 05/08/25 at 11:00 A.M., Record review of			

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	the Policy/Procedure entitled: "Maintenance Inspection" dated (no date) revealed under Policy: "It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." On 05/08/25 at 11:15 A.M., Record review of the Policy/Procedure entitled: "Preventative Maintenance Program" dated (no date) revealed under Policy: "A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." Record review of the Policy/Procedure entitled: "Preventative Maintenance Program" dated (no date) further revealed under Policy Explanation and Compliance Guidelines: "(1) The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner." On 05/08/25 at 11:30 A.M., Record review of the Policy/Procedure entitled: "Routine Cleaning and Disinfection" dated (no date) revealed under Policy: "It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment, and to prevent the development and transmission of infections to the extent possible." Record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	134140	A. BUILDING _____ B. WING _____	5/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	review of the Policy/Procedure entitled: "Routine Cleaning and Disinfection" dated (no date) further revealed under Policy Explanation and Compliance Guidelines: "(1) Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge." On 05/08/25 at 11:45 P.M., Record review of the "Direct Supply TELS Work Orders" for the last 60 days revealed no specific items related to the aforementioned maintenance concerns.			