STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394160	A. BUILDING _____ B. WING _____	**6/4/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	**2575 N DRAKE ROAD KALAMAZOO, MI 49006**

(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 Medilodge of Westwood was surveyed for a Recertification survey on 6/4/2025. Intakes: MI00151177, MI00151219, MI00151267, MI00152353, MI00152360 Census: 90	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	F0550	Element 1 Resident #590 was interviewed by SWD / designee to ensure no ill outcomes from not eating with peers at the table Resident #50 was interviewed by SWD / designee to ensure no ill outcomes from not eating with peers at the table Element 2 Residents who reside in the facility have the potential to be affected. A onetime observation of meal service was conducted to ensure residents at the same table were served together. Element 3 The Administrator and DON reviewed the resident rights policy and deemed it appropriate. Policy reviewed at QAPI. Staff will be re- educated on the resident rights policy by the DON/Designee Staff overseeing dining service will let dietary	6/23/2025

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

Electronically Signed | 06/23/2025

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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	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 under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a dignified dining experience for 2 (Residents #590 and #50) of 4 residents reviewed for a dignified dining experience, resulting in the potential for feelings of frustration and loss of self-worth. Findings include: During a dining observation in the main dining room on 6/3/25 beginning at 12:09 PM, it was noted that Resident #56 and Resident #590 were seated at the same table. Resident #56 had received his lunch meal and was eating, while Resident #590 had not. At 12:12 PM, 2 additional residents arrived at the same table, Resident #50 and an unnamed male resident. At 12:17 PM, the unnamed male received his lunch meal and began eating. Resident #56 continued to eat his meal as well. Neither Resident #590 nor Resident #50 had their meals. At 12:24 PM, the unnamed male finished eating his meal and left the table. At 12:30 PM, Resident #56 finished eating and left the table and Resident #590 was served her lunch meal. At 12:32 PM, Resident #50 took a baggie with an uneaten slice of bread from the place where the unnamed male had been eating and began to consume the slice of bread. At 12:36 PM, Resident #590 left the table with her meal uneaten. Resident #50 remained at the table alone. At 12:37 PM, Resident #50 was served his meal tray. In an interview on 6/3/25 at 1:27 PM, "Regional		staff know if a resident does not get their meal served at the same time as their table mates. Element 4 The administrator/ designee will audit dining services 5 times per week to ensure residents at the same table are being served at the same time. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The DON is responsible for compliance.	

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	Registered Dietitian" (RRD) "MM" reported if residents are seated at the same table, they should get their meals at the same time. RRD "MM" reported when a resident arrived at a table with others already eating, that resident should be the next tray to be served or as soon as possible. RRD "MM" reported waiting 20 minutes or more to be served a tray when other residents were eating was a bit longer than normal.			
F0582 SS= D	Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a	F0582	Element 1 Resident #642 was discharged on 1/25/25. No known ill effects from not receiving NOMNC/ABN Resident #643 was discharged on 2/19/25. No known ill effects from not receiving NOMNC/ABN Element 2 Residents who reside in the facility and who have had their Medicare services discontinued are at risk to be affected. Residents who reside in the facility, and had their Medicare services discontinued within the last 30 days were reviewed to ensure NOMNCs issued and ABN notice issued as necessary. Follow up conducted if necessary. Element 3 The Administrator and DON reviewed the NOMNC and ABN policies and deemed it appropriate. Policy reviewed at QAPI. BOM and Social work were educated on the procedures of issuing ABN / NONMC	6/23/2025

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	resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a "Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage" (SNF-ABN) and Notice of Medicare Non-coverage" (NOMNC) to 2 (Resident #642 and Resident #643) of 3 residents reviewed for proper notification related to Medicare A insurance Coverage, resulting in the potential for the loss of the right to appeal insurance benefit coverage. Findings include: Resident #642 Review of an "Admission Record" revealed Resident #642 was a female who was originally admitted to the facility on 1/6/25 and had pertinent diagnoses which included: malignant neoplasm of the upper lobe right bronchus or lung (metastatic lung cancer), chronic obstructive		During the next stand up meeting any residents who have had their Medicare services discontinued from insurance will be reviewed to ensure NONMC and ABN was issued if required. Element 4 The administrator/ designee will audit the Medicare discontinuations to ensure residents received the proper notice weekly x 4 weeks then monthly X2. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	pulmonary disease (COPD), and weakness. Resident #642 discharged from the facility on 1/25/25. Resident #643 Review of an "Admission Record" revealed Resident #643 was a female who was originally admitted to the facility on 1/30/25 and had pertinent diagnoses which included: malnutrition (inadequate nutritional intake) and a cognitive deficit. Resident #643 discharged from the facility on 2/20/25. On 6/3/25 at 9:36 am, via e-mail, a request was made to "Regional Director of Operations" (RDO) "C" for a copy of the SNF-ABN and the NOMNC forms that were provided to Resident #642 and Resident #643 prior to their discharges from the facility. On 6/3/25 at 3:00 pm "Social Services Director" (SSD) "D" reported she was responsible for issuing SNF-ABN and NMNOC forms to residents two days prior to their discharge from the facility. SSD "D" reported she took over the role of director in the middle of February, and that she did not issue SNF-ABN or NMNOC forms until she was in the director role. SSD "D" reported she was not able to locate SNF-ABN nor NMNOC forms for Resident #642 nor Resident #643. On 6/3/25 at 3:09 pm, RDO "C" reported there was a transition with social services directors during the time of Resident #642 and #643's stays, and the forms were not being completed as they should have been. RDO "C" reported she could not locate the SNF-ABN and NMNOC forms for Resident #642 and Resident #643. No SNF-ABN nor NMNOC forms were provided			

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	to surveyors for Resident #642 and Resident #643 by the time of exit.			
F0585 SS= E	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with	F0585	Element 1 Resident #34 Grievance form was reviewed and follow up was completed and resolved. Resident #2 Grievance form was reviewed and follow up was completed and resolved. Resident #52 Grievance form was reviewed and follow up was completed and resolved. Resident #55 Grievance form was reviewed and follow up was completed and resolved. Resident #26 Grievance form was reviewed and follow up was completed and resolved. Resident #15 Grievance form was reviewed and follow up was completed and resolved. Resident #17 Grievance form was reviewed. Applying for new passport. Resident #12 Grievance form was reviewed and follow up was completed and resolved. Resident #65 Grievance form was reviewed and follow up was completed and call placed to family multiple times and no call back. Resident unable to state what is missing. Closing concern until family identifies items missing. Resident #5 Grievance form was reviewed and follow up was completed and resolved. Resident #32 Grievance form was reviewed and follow up was completed and resolved.	6/23/2025

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	whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents'		Resident #54 Grievance form was reviewed and follow up was completed and resolved. Element 2 Residents who reside in the facility have the potential to be affected A onetime interview was conducted with residents with BIMS 10 or higher residing in the facility for any outstanding grievance concerns. Concerns will be addressed. A onetime audit of resident grievance forms for the last 60 days was completed to ensure follow up completed to the extent possible. Outstanding concerns will be addressed. Element 3 The Administrator and DON reviewed the Quality Assistance policy and deemed it appropriate. Policy reviewed at QAPI. Administrator was re-educated on the quality assistance policy. Activity Director educated on ensuring old business reviewed during resident council. Outstanding quality assistance forms will be reviewed at morning meetings until follow through completed. Element 4 The administrator/ designee will audit concern forms weekly to ensure follow up is completed	

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	rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00152360 and MI00153353. Based on observation, interview, and record review, the facility failed to follow up and resolve grievances for 12 residents (R34, R2, R52, R15, R26, R17, R54, R12, R65, R5, R32, R55) of 12 reviewed for grievances and 3 of 7 residents in Resident Council resulting in residents missing items and the potential for further unresolved grievances to occur. Findings include: Resident #34(R34) Review of the Admission Record and Minimum Data Set (MDS) dated 5/14/2025 revealed R34 admitted to the facility on 8/7/2023. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R34 was cognitively intact (13 to 15 cognitively intact). During an interview on 6/02/2025 at 9:23 AM, R34 reported that on 4/8/2025 during the overnight shift she had $150 in her phone wallet and when she woke up, her phone wallet was moved and out of reach and her money was gone.		x 4 weeks then monthly x2. The administrator/ designee will audit resident council minutes to ensure old business discussed x 3 months. Audits will be reviewed at QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for compliance.	

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	R34 said the facility looked into her concern but she didn't hear anything about the outcome of whether she would be reimbursed for her missing money. Review of R34's Quality Assistance form dated 4/9/2025 revealed "Details: Money was taken from her wallet phone. $150 cash was in her wallet. She noticed the money missing at 6am on 4/9/25 .... Findings: Administrator notified at 10:21 am on 4/10/25. Interviewed resident 10:30 am on 4/10/25 ..." Plan/Actions, whether the concern was resolved, whether the results were reported to R34, whether R34 was satisfied with the resolution, and signatures of completion were blank. During an interview on 6/3/2025 at 7:45 AM, Social Services Director (SSD) "D" reported that she wasn't involved with the investigation of R34's missing money. SSD "D" said the previous Nursing Home Administrator (NHA) "E" was taking care of the incident but she thought R34 was reimbursed the money. Review of R2's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing, lost item. Details: Jeans, scarf, and a list she (resident) has already inquired about .... Findings: Unable to find items." Plan/Actions, whether the concern was resolved, whether the results were reported to R2, and whether R2 was satisfied with the resolution were blank. Review of R52's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing. Details:1 pair of sweatpants, med (medium) blue with hole in thigh of L (left) leg-XL (extra-large) ...Findings .... unable to locate..." The form didn't indicate whether the concern was resolved, whether the results were reported to			

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	R52, and whether R52 was satisfied with the resolution. Review of R15's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost item. Details: Phone cord. Findings ....R15 claims it is rainbow colored ...Plan/Actions: check inventory list-phone cord was placed on inventory list. Search for phone cord in resident room." The form didn't indicate whether the concern was resolved, whether the results were reported to R15, and whether R15 was satisfied with the resolution. Review of R26's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing. Details: 2 shirts (blue, Pfizer), 2 scrub pants, 1 camo pants .... Findings ...checked closet and lost and found-unable to find ...." The form didn't indicate whether the concern was resolved, whether the results were reported to R26, and whether R26 was satisfied with the resolution. Another Quality Assistance form for R26 dated 4/11/2025 revealed "Details: 2 light blue Pfizer t-shirts, 2 pairs grey scrub pants XL (extra-large), 2 black t-shirts (Bleached), camo pants-hole, black .... Findings .... unable to find Pfizer t-shirts and grey scrub pants ..." Plan/Actions, whether the concern was resolved, whether the results were reported to R26 and whether R26 was satisfied with the resolution were blank. Review of R17's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost item. Details: Passport .... Findings ...found bag, passport not in bag. Resident does have papers and documents stacked up throughout room. Passport missing for months ...." The form didn't indicate whether the concern was resolved, whether the results were reported to R32, and whether R32 was satisfied with the resolution.			

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	Review of R54's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing. Details: 4 t-shirts, black pants w/ (with) zipper on side-XL (extra-large), shrinkage sock for leg-grey .... Findings ...unable to locate items in room, laundry room or lost and found ..." Plan/Actions, whether the concern was resolved, whether the results were reported to R54 and whether R54 was satisfied with the resolution were blank. Review of R12's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing, lost item. Details: 2-3 shirts, 2 lounge wear pants ...Findings ...unable to locate any of these items in room, laundry or lost and found. ..." The form didn't indicate whether the concern was resolved, whether the results were reported to R12, and whether R12 was satisfied with the resolution. Review of R65's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing. Details: clothing (not sure what clothes)-Resident states this was before she switched rooms. She asked about the clothes and never got them back ...." The form didn't indicate whether the concern was resolved, whether the results were reported to R65, and whether R65 was satisfied with the resolution. Review of R5's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing. Details: 1 pair of socks and 2 shirts ..." The form didn't indicate whether the concern was resolved, whether the results were reported to R5, and whether R5 was satisfied with the resolution. Review of R32's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing, lost item. Details: 1 pair of socks, pastel colors, tube socks .... Findings ...not in laundry,			

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	resident room or lost and found. Wears size 8W ..." The form didn't indicate whether the concern was resolved, whether the results were reported to R32, and whether R32 was satisfied with the resolution. Review of R55's Quality Assistance form dated 4/10/2025 revealed "Assistance needed: lost clothing, lost item. Details: 1 pair of jeans and 1 belt ...Findings ...unable to locate items ..." The form didn't indicate whether the concern was resolved, whether the results were reported to R55, and whether R55 was satisfied with the resolution. Review of Resident Council Minutes dated 4/23/2025 revealed "Laundry is not coming back .... some residents are missing things that go to laundry and they don't come back ...." Review of the Quality Assistance form dated 4/23/2025 from the Resident Council Meeting revealed "Laundry is not coming back on time and lost clothing. Potential Department involved: Laundry ...." Findings and Plan/Actions were blank. Review of Resident Council Minutes dated 5/21/2025 revealed " ...Old Business Review: Issue: Old Business Review ..." Status Update and Person Responsible were blank. There was no mention of April's meeting and concerns regarding laundry. Review of Resident Council Minutes dated 5/24/2025 revealed " ...Old Business Review ...." There was no mention of April's meeting and concerns regarding laundry. An email received from NHA "A" on 6/2/2025 at 2:59 PM revealed "We do not have a specific policy regarding missing items. However, if the			

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	394160	A. BUILDING _____ B. WING _____	6/4/2025

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	facility is at fault for the missing item, we will replace the item." During an interview on 6/3/2025 at 12:02 PM, Regional Director of Operations (RDO) "C" acknowledged that the forms did not have a thorough investigation, resolution and the residents weren't informed of the resolution. RDO "C' reported that she realized the facility was late in resolving these grievances but a staff member was going around and checking with these residents to see if their missing items concerns from April were resolved. RDO "C" said that she was going through Amazon to see if items were purchased for reimbursement for these specific residents. Review of the Quality Assistance Policy with a review date of 10/30/2023 revealed "Policy Explanation and Compliance Guidelines....4. Quality Assistance request may be submitted orally or in writing. The administrator may delegate the responsibility of Quality Assistance investigation to appropriate department manager. 5. Upon receipt of a written Quality Assistance Form/request, the department manager will investigate the allegations and submit a written report of such findings to the administrator 6. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken 7. The resident, or person filing the Quality Assistance Form on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems." Resident #55 Review of an "Admission Record" revealed Resident #55 was a male with pertinent diagnoses which included legal blindness, stroke, end stage			

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	renal disease, dialysis, and depression. Review of a current "Care Plan" for Resident #55, revised on 3/6/25, revealed the focus, "...Resident has visual impairment related to legally blind..." with the interventions "...Announce yourself when entering the resident's room/space...Encourage resident to keep call bell, water pitcher, and personal belongings in the same place..." In an interview on 06/02/25 at 10:55 AM, Resident #55 reported his debit care information was stolen. Resident #55 reported he had staff assist him with purchases at the facility when he was having issues using his phone applications. Resident #55 reported he was unsure what was happening with his concern as he had not heard anything from the facility administration or the local police. Resident #55 reported he had to call his bank and dispute the transactions. Resident #55 reported when he contacted one of the companies about the charge to his debit card, they suggested to him he should contact the police and file a report and Resident #55 reported he did contact the police. Resident #55 reported the card was used at (local grocery store) he had never shopped at, there were a couple transport service company charges on his card, and there were charges at (local restaurants) as well. Resident #55 reported there were cameras in the transport service company's vehicles the police should be able to determine who used the card. Resident #55 reported $202.00 was charged to his card and he was requesting to be discharged to another facility as he was concerned with the fact staff had used his card and he had items stolen when he was at the hospital and the facility had not followed up with him on the concerns. Resident #55 reported this morning the staff tried to give him clothes to wear that were another residents, and he has had multiple items of clothing lost even with the items labeled. Resident #55			

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	reported this happened quite frequently to him and other residents. Review of "Social Services Progress Notes" dated 5/20/2025 at 08:00 AM, revealed, "...SSD (Social Services Director) reported incident to administrator and wrote it on a concern form. The appropriate steps will be taken to make sure resident is reimbursed..." Review of "Social Services Progress Notes" dated 5/20/2025 at 11:56 AM, revealed, "...SSD spoke with resident in room regarding him wanting to be transferred out of the facility due to some suspicious activity. SSD told him they would put it on a concern form and let the administrator know. Resident disclosed there have been some odd charges on his card that he has never made before..." In an interview on 06/03/25 at 11:32 AM, SSD "D" reported Resident #55 had concerns with someone using his debit card. SSD "D" reported she let the previous administrator know right away and completed a concern form. SSD "D" reported he cancelled his debit card. SSD "D" reported she thought the facility was going to reimburse him for his losses when informed Resident #55's concerns had not been addressed. Review of a "Quality Assurance Form" for Resident #55, dated 5/20/25, revealed, "...Resident states toothbrush, shampoo, and conditioner were stolen when he was in the hospital. States there are charges on his credit card for (local grocery store), (local Mexican restaurant), (local chicken restaurant), and 2 (transportation services company) rides that he did not have. He states only (Receptionist "GG") and (CNA "N" or CNA "O") have helped him make purchases in the past..."			

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	Further review of the "Quality Assurance Form" for Resident #55, dated 5/20/25, revealed the concern was not assigned to a department head, investigation was not completed or follow up completed noted on the form. There was not a signature from Previous Nursing Home Administrator "E." Review of an "Incident Summary" for Resident #55 revealed, "...Resident alleging charges on debit card that he did not approve, for items he did not purchase...Resident alleges that receptionist or CNA must have stolen from him. Resident reports that his debit card is never off of his person, and that he has charges on his account that he does not recognize. He alleges that one of the staff members that have assisted him with transactions due to visual impairment had to have stolen his information. He alleges that (CNA, "N" or "O," or receptionist, "GG") must have stolen from him. Provider notified. Law enforcement notified. Alleged staff members suspended pending full investigation to follow. Resident will be monitored for changes in psychosocial well-being..." This writer attempted to contact Previous Nursing Home Administrator "E" to discuss investigation and was unable to speak to her prior to exit from facility. In an interview on 06/03/25 at 12:48 PM, Receptionist "GG" reported she had assisted Resident #55 with a food order for a local Chinese restaurant due to his (food ordering service app) was not working and she used her personal cell phone to call the restaurant. Receptionist "GG" reported the resident handed her his card and she had it long enough to give the number to the person on the phone taking the food order for the local Chinese restaurant.			

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	In an interview on 06/03/25 at 10:54 AM, Regional Director of Operations (RDO) "C" reported the staff were returned back to work following the investigation. This writer asked for the full investigation as the report indicated it was "Pending final investigation." This writer also inquired from RDO "C" what was the outcome of the investigation to the use of Resident #55's debit card as well as the replacement of the missing items, toothbrush, shampoo, and conditioner, which Resident #55 reported missing after his return from the hospital, and she indicated she would have to follow up on the concerns to ensure what the outcome was. In an interview on 06/03/25 at 12:41 PM, Human Resources "HH" reported the staff members were allowed to come back to work following the approval of the previous Nursing Home Administrator on 5/28/25. In an interview on 06/04/25 at 09:06 AM, Social Services Director (SSD) "D" reported she would assist Resident #55 with any assistance he needed and with financial transactions there would be a witness at all times. SSD "D" reported if she was unavailable to assist him then administration or a nurse would be the one to help him, no other staff members should be assisting him with any updating or ordering. In an interview on 06/04/25 at 01:51 PM, RDO "C" reported the police were unable to go any further with the investigation, therefore the facility was unable to substantiate the allegations. RDO "C" reported as Resident #55 did have a visual impairment, SSD "D" with another staff member present would assist Resident #55 with any financial needs he may have. RDO "C" reported there would be two staff members present for any transaction assistance. RDO "C" reported there was always a manager on duty in			

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	the building to assist him with any needs he may have outside of SSD "D"'s working hours. RDO "C" reported Resident #55 had not been reimbursed for the $202.00 used on his debit card as well as the personal care items missing upon his return from the hospital on 5/13/25. In a "Confidential Group Meeting" on 06/03/25 at 10:40 AM, 3 of 7 residents reported that their concerns and missing items were not being addressed and/or resolved.			
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 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.	F0628	Element 1 Resident #640 was discharged and Ombudsman has been sent notification of discharge. Resident #88 was discharged and Ombudsman has been sent notification of discharge. Element 2 One time audit for the last 4 months will be completed to ensure all appropriate notifications to ombudsman by compliance date. If concerns identified, the ombudsman will receive notification. Element 3 Notification to ombudsman process has been reviewed by Administrator and DON and has been deemed appropriate. Education has been provided to SWD to ensure the completion of the notification to ombudsman. Monthly the administrator will review to ensure	6/23/2025

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	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, 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		notification to the Ombudsman was completed. Element 4 Administrator/designee will audit notifications to ombudsman monthly x 3. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Administrator is responsible for substantial compliance.	

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	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). §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			

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	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). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility			

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	failed to ensure proper discharge notifications were completed in 2 residents (Resident #88 & #640) of 2 residents reviewed for discharge process, resulting in the State Long-Term Care (LTC) Ombudsman not receiving notification of resident's discharge to the hospital. Findings include: In an interview on 6/3/25 at 10:24 AM, State LTC Ombudsman "AAA" reported that the ombudsman's office had not received any discharge notifications from the facility for the past few months. Resident #88 Review of Resident #88's "Progress Note" dated 4/26/2025 revealed, "Per nurse client (Resident #88) will be sent ED (emergency department)..." Review of Resident #88's "Physician Orders" indicated that all orders were discontinued on 4/29/25. Resident #640 Review of Resident #640's "Progress Notes" dated 4/5/25 at 3:57 PM revealed, "...patient became unresponsive...nurse contacted provider and hospital...nurse sent patient to (name omitted) hospital..." In an interview on 06/03/25 at 02:23 PM, Social Worker (SW) "D" reported that she was not involved in discharge notifications to the ombudsman's office. SW "D" reported that she started about 3 months ago at the facility and received her official training about 2 weeks ago. In an interview on 06/03/25 at 03:26 PM, Nursing Home Administrator (NHA) "A" reported that			

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	SW "D" was responsible for notifying the ombudsman's office of all emergent hospital transfers. NHA "A" reported that a report should be sent monthly.			
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 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 interview and record review, the facility failed to ensure 1 resident (Resident #4) of 18 residents received an accurate clinical assessment, reflective of the resident's status at the time of the assessment, resulting in inaccurate diagnosis of schizophrenia documented on MDS (Minimum Data Set) assessment.	F0641	Element 1 Resident #4 had schizophrenia coded on section I6000 of 4/18/25 MDS with no evidence that diagnosis was active in the 7 day look back. Element 2 All current residents with a diagnosis of schizophrenia have been audited to ensure diagnosis meets RAI definition of active to be coded on MDS. Any inaccuracies found have been modified, with schizophrenia removed from MDS when not active. Element 3 Regional MDS will provide education to facility MDS staff on coding active diagnosis codes in section I. MDS Staff to be provided with section I of the RAI manual. MDS staff will refer to RAI manual for coding of active diagnosis codes. Element 4 MDS coordinator or designee will complete an audit of schizophrenia coding for 5 MDSs weekly x 4 weeks, and then 5 monthly x 2 months. Audit findings will be presented to the facility	6/23/2025

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	Findings include: Resident #4 Review of an "MDS" assessment for Resident #4, with a reference date of 4/25/25 revealed no behaviors of psychosis (mental disorder characterized by a disconnection from reality), and an "active diagnosis" of schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly)." Review of Resident #4's "Medical Diagnosis List" revealed, "Schizophrenia, unspecified, Medical Management dated 2/15/2012, created date 5/19/2023." In an interview on 06/03/25 at 02:31 PM, Social Worker (SW) "D" reported Resident #4 did not have any schizophrenia related behaviors that she was aware of. SW "D" reported that Resident #4's depression medication was being managed by a psychiatrist, and that she was not being treated for schizophrenia. In an interview on 06/04/25 at 12:50 PM, MDS/Registered Nurse (RN) "I" reported that Resident #4 was coded in the MDS assessment as having a diagnosis of schizophrenia, but had never been treated or prescribed antipsychotic medication while at the facility. Review of "MDS 3.0 RAI (Resident Assessment Instrument) manual" revealed, "...an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations...It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was		QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Administrator is responsible for sustained compliance.	

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	394160	A. BUILDING _____ B. WING _____	6/4/2025

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	during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment..." "...I: Active Diagnoses in the Last 7 Days (cont.) 4. The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards. Coding: Schizophrenia item (I6000), would not be checked. Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21 (b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required..."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow professional standards of nursing	F0658	Element 1 Resident #21 was reviewed by the physician to ensure no ill outcomes from not properly following medication orders. Resident #540 was reviewed by the physician to ensure no ill effects from missed dressing changes. Element 2	6/23/2025

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	practice related to physician ordered medication and treatments for 2 residents (Resident #21 & #540) of 18 residents reviewed for the provision of nursing services, resulting in false documentation of medication and treatment administration, the lack of physician notification of missed medication, and and the potential for the worsening of medical conditions. Findings include: Resident #21 Review of an "Admission Record" revealed Resident #21 was originally admitted to the facility on 4/29/22, with pertinent diagnoses which included: bipolar disorder (mental disorder characterized by periods of depression and periods of abnormal elevated mood), depression and suicidal ideations. Review of Resident #21's "Care Plan" revealed, "...at risk for an impaired mood/psychiatric status related to history of suicidal ideations (no plan or attempt) and bipolar disorder and depression. Date initiated: 8/17/2023...Interventions: Administer medications and treatments as ordered..." Review of Resident #21's "Medication Administration Record (MAR)" revealed orders for Wellbutrin (antidepressant medication) XL (extended-release) 24 hour 150 mg, give one pill in the morning for depression. The start date was 11/28/24. The record indicated that the medication was administered on 6/1/25 (by Registered Nurse (RN) "FF"), 6/2/25 (by RN "FF") and 6/4/25 (by RN "FF"), but was not given on 6/3/25 (by RN "EE") and noted to "see progress note". Review of Resident #21's "Progress Note (as		Residents who reside in the facility have the potential to be affected A onetime audit of residents with wound dressings was conducted for proper in accordance with physician orders. Follow up Conducted when necessary. The 24-hour report was reviewed for any changes in condition and provider notification as necessary. All concerns addressed as appropriate. Element 3 The Administrator and DON reviewed the Medication Administration policy and the provision of quality care policy and deemed appropriate. Policy reviewed at QAPI. Nursing staff was educated on the nursing administration policy, and reporting and documenting changes in condition. The DON/ designee will observe 5 wound dressings weekly to ensure dressing date is in accordance with physician orders. Element 4 The DON/ designee will observe 5 wound dressings weekly to ensure dressing date is in accordance with physician orders. The DON/designee will audit 15 residents weekly x4 weeks then monthly x2 for proper change in condition documentation including proper med administration, missed medication and potential for worsening medical conditions Audit findings will be presented to the facility QAPI Committee and will only be discontinued	

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	mentioned above)" written by RN "EE" revealed. "Wellbutrin XL 150 mg...on order." There was no documentation of the provider being notified. In an interview and observation on 06/04/25 at 09:49 AM, RN "FF" was assigned to the medication cart for Resident #21's hall and reported that she had administered Resident #21's Wellbutrin as scheduled that morning. Observed the medication cart's main drawer of medication cards with no Wellbutrin found for the resident. RN "FF" reported that she had made an error; she documented that she administered the medication, but did not. RN "FF" falsely documented the administration of Wellbutrin. In an interview on 06/04/25 at 11:07 AM, Nurse Practitioner (NP) "PP" reported that she had not been notified that the resident had missed any doses of Wellbutrin. Review of Fundamentals of Nursing (Potter and Perry) 10th edition revealed, "Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (p. 610). Elsevier Health Sciences. Kindle Edition. Resident #540: Review of an "Admission Record" revealed Resident #540 was a male with pertinent diagnoses which included right foot trans metatarsal amputation (partial foot amputation where the bones of the forefoot (metatarsals) are removed while preserving the ankle joint and most of the foot's length: often performed as a limb saving procedure for conditions like infection, gangrene, or diabetic ulcers), cellulitis		with substantial compliance and with approval of the facility QAPI Committee. The DON is responsible for compliance.	

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	of right lower limb, foot drop-right foot, edema, diabetes with right foot ulcer, right second toe amputation, and muscle weakness. Review of a current "Care Plan" for Resident #540, revised on 5/22/25, revealed the focus, "...Resident has impaired skin integrity as evidenced by (SPECIFY: wound type and location) related to..." with the interventions "...Administer treatment (s) per orders...Notify Nurse of any new areas of skin impairment noted during bathing or daily care...Notify physician/NP (Nurse Practitioner)/PA (Physician Assistant) of noted worsening skin condition or any new areas of skin impairment...Notify physician/NP/PA of signs/symptoms of infection..." Review of an "Order" dated 5/12/25 for Resident #540, revealed, "...Patient to consult wound clinic due to worsening foot wound..." Review of an "Order" dated 5/26/25 for Resident #540, revealed, "...Please have pt (patient) follow up with vascular (Name of Vascular surgeon) for possible wound dehiscence..." Review of an "Order" dated 5/26/25 for Resident #540, revealed, "...TX (treatment): R (right) foot surgical site: Cleanse area with normal saline and blot dry. Apply Bacitracin Zinc Ointment to surgical site BID (twice a day). Leave open to air. Monitor area for any worsening s/sx (signs and symptoms) of skin integrity. Notify MD/NP of any s/sx of infection. every day and evening shift for RLE (right lower extremity) stump wound..." Review of an "Order" dated 5/28/25 for Resident #540, revealed, "...TX: R foot: Encourage and assist resident with placement of BLUE BOOT/HEEL PROTECTOR to R foot r/t (related to) surgical site/skin protection to area. Monitor			

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	area daily for any worsening s/sx of skin integrity...every shift for Wound care, Skin Protection..." Review of a "Treatment Administration Record" (TAR) entry for Resident #540, dated 5/4/25, revealed, "...TX: cleanse right foot with dakins 1/4%. Pat dry. Apply medihoney to wound bed and cover with border gauze. Change daily at bedtime for wound tx (treatment)...Start date: 4/12/25 DC date: 5/14/25..." revealed, on 5/4/25 no treatment was documented. Review of the TAR for May 2025 revealed numerous omissions of completion of treatments for Resident #540. Review of the TAR for Resident #540 for May 2025 and June 2025, order dated 5/26/25, revealed, "...TX: R (right) foot surgical site: Cleanse area with normal saline and blot dry. Apply Bacitracin Zinc Ointment to surgical site BID (twice a day). Leave open to air. Monitor area for any worsening s/sx (signs and symptoms) of skin integrity. Notify MD/NP of any s/sx of infection. every day and evening shift for RLE (right lower extremity) stump wound ..." Noted on 5/30/25, Evening was documented as completed, on 5/31/25 Day and Evening was documented as completed, and 6/1/25 Day and Evening was documented as completed. Review of the Progress Notes for 5/30/25, 5/31/25, and 6/1/25 revealed no documentation of Resident #540 refusing treatment. During an observation and interview on 06/02/25 at 11:35 AM, Wound Care Nurse (WCN) "BB" had donned appropriate personal protective equipment (PPE) and entered Resident #540's room. WCN "BB" asked Resident #540 to lie down on his bed, she placed the blue boot for the			

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	right foot under his right calf area. WCN "BB" was attempting to remove Resident #540's heavily soiled nonslip sock, as she came to the end of his foot where the amputation was, she was attempting to remove the sock and it was stuck to the end of his foot where the surgical open site was. Observed no bandage covering the surgical site and WCN "BB" had to slowly remove the sock from his foot little by little. The bandage was observed under the pad of his foot. When requested to see the dated bandage, it was dated for 5/30/25 and initialed with WCN "BB"'s initials. WCN "BB" reported Resident #540's wound was last changed when she did the dressing change on 5/30/25, queried how often his treatment and dressing change was to be done, she reported twice a day. This writer had WCN "BB" clarify the treatment, and dressing had not been completed since 5/30/25, she indicated Yes. This writer observed the surgical site for the amputation and the wound appeared it was expected to dehisce (closed incision reopens exposing internal tissues) as it was swollen and red tissue was expanding out of the sutures where his second, third and first metatarsals were located, and the foot was swollen. WCN "BB" cleaned the wound as well as the area around the surgical site with normal saline. WCN "BB" measured his wound with the tablet to measure the area, length, and width of the wound. WCN "BB" sprayed the wound with skin prep, used swab to apply zinc ointment to the wound, placed gauze over the wound with the date and initials. Placed the blue boot back on his right foot. WCN "BB" sanitized her hands, tablet, and the wound cart. In an interview on 06/03/25 at 03:18 PM, WCN "BB" reported the surgical wound was beginning to dehisce and had light to moderate drainage today. WCN "BB" reported the provider completed an order to send him back to the vascular surgeon who did the surgery, but the			

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	same day placed on hospice so now can't send to vascular surgeon. WCN "BB" reported it was important the dressing was changed every day, twice a day as the provider ordered and it should be followed. WCN "BB" reported it was important for the staff to observe the wound to ensure it was healing appropriately, didn't have drainage, or wasn't dehiscing as it had started to do. WCN "BB" reviewed the treatment administration record (TAR), and it showed the nurses were able to click either yes, no or refused under the resident in the nurse's view. WCN "BB" went to the Orders Administration Treatment report, and it showed that Resident #540's dressings were documented as changed on 5/30/25 - PM shift, 5/31/25 AM & PM Shifts were selected as completed, and 6/1/25 AM & PM Shifts were selected as completed. WCN "BB" confirmed the dressing from yesterday's wound treatment was dated from the AM shift treatment she had completed on 5/30/25. In an interview on 06/04/25 at 09:43 AM, Registered Nurse (RN) "DD" reported if a resident refused cares, he would educate them and document in a progress note the resident refused the care. RN "DD" reported he couldn't remember if he did the treatments and dressing changes on Resident #540 over the weekend as he was the nurse on first shift (6AM to 6PM) on Saturday, 5/31/25 and Sunday 6/1/25. RN "DD" reported as the nurse he was responsible for the treatment and dressing changes for the resident when the wound nurse was not working. RN "DD" reported it would be documented in the treatment administration record (TAR) and if Resident #540 had refused he would have documented he had refused. RN "DD" when queried reported that sometimes the nurses get busy and forget to document refusals. In an interview on 06/04/25 01:34 PM, Director of Nursing (DON) "B" reported the nurse's would			

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	follow the order as specified. DON "B" reported if the resident refused treatment the nurses should notify the doctor of the refusal and direction, place a nursing note for the refusal, and notify the resident's responsible person, if they have one, hospice etc. DON "B" reported when the refusal was documented in the TAR it would bring up a prompt to enter a progress note, if it was documented as completed there would be no prompt to enter a note. Review of the policy, "Wound Treatment Management" reviewed/revised on 10/26/2023, revealed, "...1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes..." "The medical record is a legal document and is used to protect the patient as well as the professional practice of those in healthcare. Documentation of the care you give is proof of the care you provide...Charting is objective, not subjective. This means chart only what you see, hear, feel, measure, and count, not what you infer or assume. All nurses know that if it wasn't charted, it wasn't done....the patient's complete and accurate medical record the most reliable source of information on the care of that patient. Proper nursing documentation prevents errors and facilitates continuity of care." (https: //www. asrn.org/journal-chronicle-nursing/341-charting-and- documentation.html) "...The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient..." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle			

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	Locations 20717- 20719). Elsevier Health Sciences. Kindle Edition.			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide activities of daily living (ADLs) to a dependent resident, including shampooing of hair, for 1 (Resident #37) of 18 resident reviewed for activities of daily living, resulting in an unkempt appearance and the potential for feelings of diminished self-worth. Findings include: Review of an "Admission Record" revealed Resident #37 was a female who was originally admitted to the facility on 2/13/2024 and had pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, need for assistance with personal care, and reduced mobility. Review of a "Minimum Data Set" (MDS) assessment for Resident #37, with a reference date of 5/6/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 13/15 which indicated Resident #37 was cognitively intact. During an observation on 6/2/25 at 2:23 pm, Resident #37 was in bed wearing a light pink	F0677	ELEMENT #1 Resident #37 currently resides in facility. Resident was assessed and no ill effects noted. The residents hair was washed. Resident #37 had order placed into PCC to ensure completion of scheduled shower/bed bath/refusal and completion of hair washing. ELEMENT #2 All residents that reside in the facility are at risk of this deficient practice. Residents who are dependent on hair washing were audited to ensure hair was washed. . Bathing documentation for CENA completion was updated to show if hair was washed. ELEMENT #3 DON and NHA reviewed and approved ADL policy. QAPI committee has reviewed the Activities of Daily Living policy and deemed appropriate. Nursing staff received education on washing resident hair being a part of ADL care, even if resident receives bed bath. Nursing staff to report problems to UM or MD. DON/designee will audit of 5 residents shower dates weeklyx4 weeks then monthlyx2 to ensure completion of hair washing.	6/23/2025

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	colored shirt and her hair appeared to be unkept and greasy. During an observation on 6/3/25 at 11:18 am, Resident #37 was in bed wearing a dark pink colored shirt and her hair appeared to be very greasy. Review of "Task" for Resident #37 revealed " ... GG- Shower /bathe self-Wednesday and Saturday 1st shift." During an observation and interview on 6/4/25 at 9:49 am, Resident #37 was in bed wearing a dark pink colored shirt. The same shirt she was wearing the day before. Resident #37's hair appeared greasy and unkept. Resident #37 reported her hair would be washed once or twice a week. Resident #37 reported she would prefer for her hair to be washed three to four times a week since it was very oily. Resident #37 stated "I could not tell you the last time my hair was washed." Review of "Care Plan" for Resident #37 revealed " ...Resident has an ADL self-care performance deficit ... Resident prefers bed-baths ...with a date of 1/31/2025." Review of "Shower Documentation" for Resident #37 for the month of May 2025, indicated that a shower/bed bath was completed on 5/7, 5/10, 5/14, 5/21, 5/24, and 5/28. There was no documentation provided for the dates of 5/3, 5/17, and 5/31. In an interview on 6/4/25 at 9:50 am, "Certified Nurse Assistant" (CNA) "N' reported that shampooing hair was included in a shower assignment. CNA "N" reported that Resident #37 preferred bed bath and her hair was washed using a basin in bed or a shampooing cap that was		ELEMENT #4 DON or designee will complete and audit of 5 residents shower dates and ensure completion of hair washing. Audits will be completed weekly x4 then monthlyx2 thereafter. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. DON is responsible for continued compliance. The DON is responsible for compliance of this deficiency.	

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	available in the supply closet. In an interview on 6/4/25 at 11:30 am, CNA "WW" reported she was going to give Resident #37 her bed bath "in a bit" and it was Resident #37's shower day and she would get her hair washed. In an observation and interview on 6/4/25 at 12:45 pm, Resident #37 was lying in bed, wearing a white in color shirt, and her hair was noticeably combed, but appeared very greasy still. Resident #37 stated she did not get her hair washed. In an interview on 6/4/25 at 12:55 pm, CNA "WW" reported she did not wash Resident #37's hair. CNA "WW" stated "night shift had done Resident #37's "am care" and she had realized that Resident #37 had already been cleaned up for the day, so she did not have to give her a bath." When queried regarding Resident #37 getting her hair washed, CNA "WW" stated "it could still get done today." In an interview on 6/4/25 at 2:05 pm, "Unit Manager" (UM) "RR" reported residents should get their hair washed during their showers, on their shower days unless it was indicated to not be done. UM "RR" reported that Resident #37's hair should be washed on her shower days. UM "RR" reported there was no place for shampooing to be documented separately in CNA documentations, and the nurse would need to document a progress note if it wasn't done. Review of "Progress Notes" for Resident #37 for the month of May 2025, revealed no noted documented refusal of care, or incomplete showering, nor refused or incomplete shampooing.			

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	In an interview on 6/4/25 at 2:10 pm "Director of Nursing" (DON) "B" reported the expectations were that shampooing was a part of the shower care residents received, and if it was not performed it needed to be documented with a reason why it wasn't done.			
F0684 SS= D	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 ensure residents received care in accordance with professional standards in 2 residents (Resident #21 & #540) of 18 residents reviewed for quality of care, resulting in medication not being administered per physician order for the treatment of a mental disorder for Resident #21, wound care not provided per physician order for Resident #540, and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #21 Review of an "Admission Record" revealed Resident #21 was originally admitted to the facility on 4/29/22, with pertinent diagnoses	F0684	Element #1 Resident #21 Has been assessed and current medications reviewed by NP. Resident is receiving medications as ordered. Medications in cart were compared to MAR and all medication present. No negative effects in physical mental and psychosocial wellbeing and GDR in progress. Resident # 540 wound was assessed by physician. Physician orders reviewed and updated. No negative effects in physical mental and psychosocial wellbeing. Element #2 All residents have the potential to be affected by the alleged deficient practice. Current residents will have medications in med cart compared to MAR to ensure medications are available to give as ordered. A one-time audit of 24 hour report reviewed to identify any residents exhibiting any negative physical, mental or psycho social concerns and addressed as needed Residents who require wound care dressing changes were assessed to ensure that treatments were completed as ordered. Element #3	6/23/2025

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	which included: bipolar disorder (mental disorder characterized by periods of depression and periods of abnormal elevated mood), depression and suicidal ideations. Review of Resident #21's "Care Plan" revealed, "...at risk for an impaired mood/psychiatric status related to history of suicidal ideations (no plan or attempt) and bipolar disorder and depression. Date initiated: 8/17/2023...Interventions: Administer medications and treatments as ordered..." During an observation of medication administration on 06/03/25 at 08:48 AM with Registered Nurse (RN) "EE" for Resident #21 revealed that Resident #21 did not receive her Wellbutrin (antidepressant) 150 mg (milligram) as ordered. Observed RN "EE" prepare all of Resident #21's medications and report that Wellbutrin was not available to administer, but the medication was on order from the pharmacy. RN "EE" reported that some residents go several days without medications, and that she was not sure how long Resident #21 had been without her Wellbutrin. RN "EE" did not search the bottom drawer of the medication cart where extra medications are kept and did not notify the provider. Review of Resident #21's "Medication Administration Record (MAR)" revealed orders for Wellbutrin XL (extended-release) 24 hour 150 mg, give one pill in the morning for depression. The start date was 11/28/24. The record indicated that the medication was administered on 6/1/25 (by RN "FF"), 6/2/25 (by RN "FF") and 6/4/25 (by RN "FF"), but was not given on 6/3/25 (by RN "EE") and noted to "see progress note". Review of Resident #21's "Progress Note (as mentioned above)" written by RN "EE" revealed.		DON and NHA reviewed Medication Administration Policy and deemed appropriate. Provision of quality of care policy reviewed and deemed appropriate Extra medications storage was removed from bottom drawer and are to be stored in same area in medication cart. Licensed Nurses have been educated on the medication administration policy and administering medications as prescribed. Licensed Nurses have been educated on the process for completing treatments per physician order. Element #4 The DON/designee will observe 5 residents with wounds per week x 4 then monthly x 3 to ensure dressing changes are completed per physician order. The DON/Designee will observe Med pass 3 x weekly x 4 weeks then monthly x 3 to ensure medications given as ordered. The DON/designee will review 24 hr report daily Mon-Friday to monitor for any medications not available and any noted negative effects in physical/mental/psychosocial wellbeing x 4 weeks Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary. Director of Nursing is responsible for	

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	"Wellbutrin XL 150 mg...on order." In an interview and observation on 06/04/25 at 09:49 AM, RN "FF" was assigned to the medication cart for Resident #21's hall and reported that she had administered Resident #21's Wellbutrin as scheduled that morning. Observed the medication cart's main drawer of medication cards with no Wellbutrin found for the resident. RN "FF" reported that she had made an error; she documented that she administered the medication, but did not. RN "FF" then looked in the bottom drawer that contained extra medication and found a new card of Wellbutrin dated 5/20/25 (14 days ago) for the resident. RN "FF" reported that she did not remember when Resident #21 ran out of the medication, but that she would administer it immediately. RN "FF" falsely documented the administration of Wellbutrin. In an interview on 06/04/25 at 10:02 AM, UM "RR" reported that per the Wellbutrin order audit report, Resident #21's Wellbutrin was due to exhaust on 5/20/25 (14 days ago) and was refilled/dispensed automatically by the pharmacy that same day. UM "RR" reported that there was no way to determine how many doses Resident #21 had been missed, considering that the nursing staff had documented administering Wellbutrin every day since 5/20/25, except for 6/3/25 when this surveyor was observing medication pass. UM "RR" reported that the pharmacy only sends a 30 day supply. In an interview on 06/04/25 at 11:07 AM, Nurse Practitioner (NP) "PP" reported that Resident #21 was being followed closely for her mental health and recently had new medication added due to an increase in symptoms of depression. NP "PP" reported that she had not been notified that the resident had missed any doses of her Wellbutrin and that Wellbutrin was important due to		achieving and sustaining compliance.	

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	Resident #21's complex psychological issues and trying to find a balance to control her depression. Review of Resident #21's "Psychiatry Visit Note" dated 5/28/25 revealed, "...Chief Complaint: Bipolar disorder...moderate depression, irritability, anxiety, and occasional insomnia...intermittent thoughts that she would be better off dead. However, denies suicidal ideation, plan or intent...Medications: ...Lamictal (delays mood episodes of bipolar)...for bipolar 2 disorder, ...Wellbutrin XL 150 mg...1 tablet in the morning for depression... Sertraline (antidepressant) 100 mg tablet...for depression..." Gradual dose reduction was noted to be contraindicated for all of the above medications. Resident #540: Review of an "Admission Record" revealed Resident #540 was a male with pertinent diagnoses which included right foot trans metatarsal amputation (partial foot amputation where the bones of the forefoot (metatarsals) are removed while preserving the ankle joint and most of the foot's length: often performed as a limb saving procedure for conditions like infection, gangrene, or diabetic ulcers), cellulitis of right lower limb, foot drop-right foot, edema, diabetes with right foot ulcer, right second toe amputation, and muscle weakness. Review of a current "Care Plan" for Resident #540, revised on 5/22/25, revealed the focus, "...Resident has impaired skin integrity as evidenced by (SPECIFY: wound type and location) related to..." with the interventions "...Administer treatment (s) per orders...Notify Nurse of any new areas of skin impairment noted during bathing or daily care...Notify physician/NP (Nurse Practitioner)/PA (Physician Assistant) of noted worsening skin condition or			

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	any new areas of skin impairment...Notify physician/NP/PA of signs/symptoms of infection..." Review of an "Order" dated 5/12/25 for Resident #540, revealed, "...Patient to consult wound clinic due to worsening foot wound..." Review of an "Order" dated 5/26/25 for Resident #540, revealed, "...Please have pt (patient) follow up with vascular (Name of Vascular surgeon) for possible wound dehiscence..." Review of an "Order" dated 5/26/24 for Resident #540, revealed, "...TX (treatment): R (right) foot surgical site: Cleanse area with normal saline and blot dry. Apply Bacitracin Zinc Ointment to surgical site BID (twice a day). Leave open to air. Monitor area for any worsening s/sx (signs and symptoms) of skin integrity. Notify MD/NP of any s/sx of infection. every day and evening shift for RLE (right lower extremity) stump wound..." Review of an "Order" dated 5/28/25 for Resident #540, revealed, "...TX: R foot: Encourage and assist resident with placement of BLUE BOOT/HEEL PROTECTOR to R foot r/t (related to) surgical site/skin protection to area. Monitor area daily for any worsening s/sx of skin integrity...every shift for Wound care, Skin Protection..." Review of a "Treatment Administration Record" (TAR) entry for Resident #540, dated 5/4/25, revealed, "...TX: cleanse right foot with dakins 1/4%. Pat dry. Apply medihoney to wound bed and cover with border gauze. Change daily at bedtime for wound tx (treatment)...Start date: 4/12/25 DC date: 5/14/25..." revealed, on 5/4/25 no treatment was documented. Review of the TAR for May 2025 revealed			

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	numerous omissions of completion of treatments for Resident #540. Review of the TAR for Resident #540 for May 2025 and June 2025, revealed, "...TX: R (right) foot surgical site: Cleanse area with normal saline and blot dry. Apply Bacitracin Zinc Ointment to surgical site BID (twice a day). Leave open to air. Monitor area for any worsening s/sx (signs and symptoms) of skin integrity. Notify MD/NP of any s/sx of infection. every day and evening shift for RLE (right lower extremity) stump wound ..." Noted on 5/30/25, Evening was documented as completed, on 5/31/25 Day and Evening was documented as completed, and 6/1/25 Day and Evening was documented as completed. Review of the Progress Notes for 5/30/25, 5/31/25, and 6/1/25 revealed no documentation of Resident #540 refusing treatment. Review of an "Authorization for Ancillary and Medical Services" form for Resident #540, in Admission Packet received on 6/4/25, revealed, Podiatry services were included with the signed authorization of services. Review of the "Admission Checklist" for Resident #540 revealed the Authorization Form for Ancillary & Medical Services was checked and the documented was signed by the Business Office and Administrator dated 11/12/18. Review of the medical record revealed no refusals documented for Podiatry services for Resident #540. In an interview on 06/02/25 at 10:37 AM, Resident #540 reported he had to have his toes amputated, it was healing but it was "kinda slow." Resident #540 reported no pain, but he doesn't feel his feet. Resident #540 reported he was			

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	taking an antibiotic for his surgical wound. During an observation and interview on 06/02/25 at 11:35 AM, Wound Care Nurse (WCN) "BB" had donned appropriate personal protective equipment (PPE) and entered Resident #540's room. WCN "BB" asked Resident #540 to lie down on his bed, she placed the blue boot for the right foot under his right calf area. WCN "BB" was attempting to remove Resident #540's heavily soiled nonslip sock, as she came to the end of his foot where the amputation was, she was attempting to remove the sock, and it was stuck to the end of his foot where the surgical open site was. Observed no bandage covering the surgical site and WCN "BB" had to slowly remove the sock from his foot little by little. The bandage was observed under the pad of his foot. When requested to see the dated bandage, it was dated for 5/30/25 and initialed with WCN "BB"'s initials. WCN "BB" reported Resident #540's wound was last changed when she did the dressing change on 5/30/25, queried how often his treatment and dressing change was to be done, she reported twice a day. This writer had WCN "BB" clarify the treatment, and dressing had not been completed since 5/30/25, she indicated Yes. This writer observed the surgical site for the amputation and the wound appeared it was expected to dehisce (closed incision reopens exposing internal tissues) as it was swollen and red tissue was expanding out of the sutures where his second, third and first metatarsals were located, and the foot was swollen. WCN "BB" cleaned the wound as well as the area around the surgical site with normal saline. WCN "BB" measured his wound with the tablet to measure the area, length, and width of the wound. WCN "BB" sprayed the wound with skin prep, used swab to apply zinc ointment to the wound, placed gauze over the wound with the date and initials. Placed the blue boot back on his right foot. WCN "BB" sanitized her hands, tablet, and the wound			

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	cart. Review of "Progress Notes" for Resident #540, dated 3/20/25 at 00:00 AM, revealed, "...Acute: Right foot wound...General: Patient is 68 y.o (year-old) male with PMH (primary medical history) including HTN (high blood pressure), leg edema, DM2 (diabetes), HLD (high levels of fat in the blood)...seen per nurse request to evaluate noted wound to right foot...Patient seen in room, is afebrile and in no distress at this time. Noted with gulf-ball (spelling?) size ulcer to planter surface of foot with eschars (Thick leathery, dead tissue layer that forms on the surface of a full thickness wound, such as a burn or pressure ulcer). Patient related that he did not know it was there as it does not hurt. No other acute concerns at this time...E11.621 - TYPE 2 DIABETESMELLITUS WITH FOOT ULCER: Ulcer to right foot plantar surface. Cleanse with wound wash, pat dry, apply medihoney, cover with border gauze, wrap secure with kerlix and change dressing daily...Get x-rays of right foot for further evaluation...Labs of 1/10/25 A1C=6.1 %. Continue diabetes regimen as ordered..." Review of "Xray Exam of Foot" for Resident #540, results dated 3/20/25, revealed, "...Rule out Osteomyelitis (infection in the bone when a bacterial or fungal infection spreads from another part of the body to the bone marrow)...IMPRESSION:1. Multiple toe amputations with post-surgical changes. No evidence of acute complications.2. Plantar calcaneal enthesophyte, suggesting chronic traction at the Achilles tendon insertion.3. No acute bony injury or dislocation.4. No significant soft tissue abnormality..." Review of "Skin & Wound Evaluation" for Resident #540, dated 3/20/25 at 1:03 PM, revealed, "...Diabetic...Right Plantar 1st			

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	Interdigital Space (Foot), Distal...Acquired: In house...How long has wound been present: Unknown...Staged by In house Nursing...Area: 8.8 CM, Length: 3.6...Width: 3.4...Depth: 0.4...10% of wound covered...Eschar...90% of wound filled...Odor noted after cleansing: Faint...Attached: Edge appears flush with wound bed or as a sloping edge...Rolled edge (Epibole): Edge appears curled under...Goal of Care: Not answered...Treatment: Missing...Generic wound cleanser...Debridement: Autolytic (breakdown of cellular components by own enzymes)...antimicrobial dressing...Hydrogel (water based gel that can absorb a large amount of water)...Bordered gauze...Stable...Infection: Not answered...." Review of "Progress Notes" for Resident #540, dated 3/25/25 at 00:00 AM, revealed, "...Continues with 2+ pitting edema to lower extremities...right foot ulcer with no signs of surrounding cellulitis...Skin: Positive: Dry, Warm, Wounds...Ulcer to planter surface of right foot...Blood sugars have been stable. Continue local wound care to right sole ulcer..." Review of "Progress Notes" dated 3/28/2025 at 00:00 AM, revealed, "...Wound Care...CHIEF COMPLAINT: Wound care...General: (Resident #540) is a 68-year-old male with Right Plantar 1st Interdigital Space wound that is being managed by wound services. Wound is still present. Wound services will continue to follow...,type 2 diabetes mellitus with foot ulcer, right second toes amputation, essential(primary) hypertension, elevated white blood cell count, unspecified, hyperlipidemia ...Patient was alert. Does not report pain during assessment or wound intervention. Will continue to apply medihoney and a bordered gauze. Will adjust treatment plan and reassess all sites in 1 week for progress...Skin: Positive: Wounds...Notes: 1. (2) Right Plantar 1st Interdigital Space Foot Diabetic			

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	- This wound measures 2.84 x 2.39 centimeters with a depth of 0.3 centimeters. This wound is full thickness. There is a light amount of serous drainage from this area. Wound bed consists of 60% granulation and 40% eschar tissue. Edges are attached and there is no eschar (note was 40% eschar), tunneling or undermining. The surrounding tissue is fragile...Tx: This area is to be cleaned daily with dakins. Apply medihoney to the wound and eschar tissue. Wound should be covered with a bordered gauze. Initial and date. Daily..." Review of "Progress Notes" for Resident #540 dated 4/2/25 at 00:00 AM, revealed, "...He is seen today acutely due to concern of right leg redness and swelling. He has been in bed the last few days which is unlike him. Had u/a (urinalysis) done yesterday which is pending...MODERATE: Localized swelling, mass and lump, right lower limb: Concern with swelling and redness of right leg, get ultrasound to rule out DVT (blood clot). If negative, likely treat as cellulitis. Get cbc (complete blood count) to rule out infection..." Review of "Progress Notes" for Resident #540 dated 4/3/25 at 00:00 AM, revealed, "...General: Patient is 68 y.o male with PMH (past medical history) including HTN (high blood pressure) , leg edema , DM2,HLD and ongoing disorganized thinking whom was evaluated for right leg edema on 4/2 with Doppler US (ultrasound) ordered and needs follow-up today. Also, he had urinalysis done for intermittent confusion. Patient is seen sitting up in wheel chair, is afebrile and in no distress. Able to make needs known. He denies pain to right leg and Doppler US (ultrasound) is negative for DVT (deep vein thrombosis). Continue with 2+ edema and mild warm with erythema (reddening of the skin)...Urine C&S (culture and sensitivity) is also pending...Risk of Complications and/or Morbidity or Mortality of Patient Management: MODERATE...Localized			

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	swelling, mass and lump, right lower limb: Doppler Ultrasound of 4/3/25 negative for DVT...CELLULITIS OF RIGHTLOWER LIMB: will treat with Keflex 500mg twice daily for 7 days...TYPE 2 DIABETESMELLITUS WITH FOOT ULCER: Right planter surface ulcer. Continue local wound care..." Review of "Progress Notes" for Resident #540, dated 4/14/2025 at 00:00 AM, revealed "...Edema...Positive: Edema in lower right extremities, Edema in lower left extremities Notes: 2+...Notes: Ulcer to planter surface of right foot...Temperature 97.3 degrees Fahrenheit...COVID positive..." Review of "Progress Notes" for Resident #540, dated 4/28/25 at 3:04 PM, revealed, "...Noted pitting edema 3+ B:E (bilateral extremities), notified NP (nurse practitioner) received new order, continue monitor..." Review of "Progress Notes" for Resident #540, dated 4/30/25 at 00:00 AM, revealed, "...Noted with increase edema to +2 to lower extremities...negative for DVT (deep vein thrombosis) on 4/3/25...no signs of cellulitis on exam...Lasix added to regimen on 4/29..." Review of "Progress Notes" for Resident #540, dated 5/5/25 at 00:00 AM, revealed, "...Weakness: R (right) hand weakness...new this AM...Temperature: 98.7 degrees Fahrenheit...weakness in BLE (bilateral lower extremities)...Send to ER (emergency room) to rule out stroke..." Review of "Progress Notes" for Resident #540, dated 5/12/25 at 00:00 AM, revealed, "...Chief Complaint: Planter wound with malodor (smelling very unpleasant)...seen to evaluate noted odor to right foot wound. Wound is deep			

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	with slough and drainage...Ascending ankle/foot continue with +2 tense edema (dent or indentation is seen after pressure is applied and it disappears within 15 seconds caused by excess fluid trapped in the body's tissues)....Edema in right lower and left lower extremities...Temperature: 97.9%...Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle: with correct infection Start doxycycline , 1 tablet twice daily for 7 days...Continue local wound dressing...Patient to consult with wound clinic..." Review of "Pertinent Charting-Infections/Signs Symptoms" for Resident #540, dated 5/13/2025 at 01:40 AM, revealed, "...Event Date: 05/12/2025...Site of infection: rt (right) foot...Reason on antibiotics/new signs &symptoms: infection rt foot..." Review of "Progress Notes" for Resident #540, dated 5/15/25 at 00:00 AM, revealed, "...Chief Complaint: Fall follow-up, right foot cellulitis...Seen to follow-up on fall and right foot cellulitis. Endorsed pain to right lower extremity and swelling in not receding. Of note, prior Doppler studies have been negative for DVT. Right foot sole wound with slough and drainage...Doxycycline Hyclate Tablet 100 MG: Give 1 tablet by mouth two times a day for infection-right foot wound infection for 7 Days / undefined tablet / May 15,2025 to May 20, 2025...E11.621 - TYPE 2 DIABETESMELLITUS WITH FOOT ULCER: Right foot planter wound slow to heal. Continue Bactrim until 5/20....Get right foot x-rays, 3 view to further evaluate for osteomyelitis...Check CBC, BMP, CRP...M62.81 - MUSCLE WEAKNESS(GENERALIZED): reported lower self to floor. No pain or injury...Patient reminded to call staff for assistance with ADLs (Activities of Daily Living)..."			

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	Review of "Nurses' Notes" for Resident #540, dated 5/16/2025 at 3:39 PM, revealed, "...Resident sent to (Local Hospital) ED (emergency department) for evaluation for right foot possible osteomyelitis seen in x-ray..." Review of "Progress Notes" for Resident #540, dated 5/22/2025 at 00:00 AM, revealed, "...Acute: Readmit right foot osteomyelitis...Admitted to hospital for right foot osteomyelitis and treated with IV antibiotics and tarsometatarsal amputation...Seen lying in bed, report fatigue and decrease in appetite..." Review of a "History and Physical" for Resident #540, dated 5/26/2025 at 00:00 AM, revealed, "...CHIEF COMPLAINT: osteomyelitis...General: 68 year old male with R osteomyelitis of metatarsal 2-5. ESBL Proteus and Bacteroides fragilis and Morganella, B-hemolytic strep, E faecalis Enterobacter placed on Ertapenem (an antibiotic). R (Right) TMA (Trans Metatarsal Amputation) 5/19 and started on Bactrim upon discharge. Pt (patient) injured foot and wound care nurse is concerned about dehiscence (closed incision reopens, exposing internal tissues). No bleeding or drainage. No fever..." In an interview on 06/03/25 at 03:18 PM, WCN "BB" reported the surgical wound was beginning to dehisce and had light to moderate drainage today. WCN "BB" reported the provider completed an order to send him back to the vascular surgeon who did the surgery, but the same day placed on hospice so now can't send to vascular surgeon. WCN "BB" reported it was important the dressing was changed every day, twice a day as the provider ordered and it should be followed. WCN "BB" reported it was important for the staff to observe the wound to ensure it was healing appropriately, didn't have			

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	drainage, or wasn't dehiscing as it had started to do. WCN "BB" reviewed the treatment administration record (TAR), and it showed the nurses were able to click either yes, no or refused under the resident in the nurse's view. WCN "BB" went to the Orders Administration Treatment report, and it showed that Resident #540's dressings were documented as changed on 5/30/25 - PM shift, 5/31/25 AM & PM Shifts were selected as completed, and 6/1/25 AM & PM Shifts were selected as completed. WCN "BB" confirmed the dressing from yesterday's wound treatment was dated from the AM shift treatment she had completed on 5/30/25. In an interview on 06/04/25 at 09:43 AM, "Registered Nurse" (RN) "DD" reported if a resident refused cares, he would educate them and document in a progress note the resident refused the care. RN "DD" reported he couldn't remember if he did the treatments and dressing changes on Resident #540 over the weekend as he was the nurse on first shift (6AM to 6PM) on Saturday, 5/31/25 and Sunday 6/1/25. RN "DD" reported as the nurse he was responsible for the treatment and dressing changes for the resident when the wound nurse was not working. RN "DD" reported it would be documented in the treatment administration record (TAR) and if Resident #540 had refused he would have documented he had refused. RN "DD" when queried reported that sometimes the nurses get busy and forget to document refusals. In an interview on 06/04/25 01:34 PM, "Director of Nursing" (DON) "B" reported the nurses should follow the order as specified. DON "B" reported if the resident refused treatment the nurses should then notify the doctor of the refusal and direction, place a nursing note for the refusal, and notify the resident's responsible person, if they have one, hospice etc. DON "B" reported when the refusal was documented in the TAR it			

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	would bring up a prompt to enter a progress note, if it was documented as completed there would be no prompt to enter a note. Review of the policy, "Wound Management" reviewed/revised on 10/26/2023, revealed, "...Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change...2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse....Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing...b. The dressing has dislodged...c. The dressing is soiled otherwise or is wet...1. Dressings will be applied in accordance with manufacturer recommendations...Treatment decisions will be based on: a. Etiology of the wound: 1. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage..."			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent	F0688	Element 1 Resident #56 was re-evaluated by therapy and plan of care revised. Element 2 Residents who reside in the facility and utilize splinting devices are at risk to be affected. One time audit of orders and care plans was	6/23/2025

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	further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a positioning device was consistently applied for 1 (Resident #56) of 1 resident reviewed for positioning, resulting in the potential for decreased range of motion and related complications, skin breakdown, worsening of contracture (hardening of the muscles, tendons, and other tissues) and pain. Findings include: Resident #56 Review of an "Admission Record" revealed Resident #56 was a male, with pertinent diagnoses which included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting right dominant side. Review of a "Minimum Data Set" (MDS) assessment for Resident #56, with a reference date of 3/9/25 revealed Resident #56 had a functional limitation in range of motion in upper extremity. Review of Resident #56's current "Care Plan" revealed a focus of "Resident has an ADL (activities of daily living) self-care performance deficit related to weakness, tremors, gout,		conducted to identify any issues with splint application. Orders and plan of care updated with application and removal times in accordance with therapy if needed. Element 3 The Administrator and DON reviewed the Range of motion policy and deemed it appropriate. Policy reviewed at QAPI. Splinting schedules will be placed on EMAR. Education provided to nurses on placing orders to apply and remove splints. Cenas educated on applying and removing splints per plan of care and documentation in task. Element 4 The DON/ designee will audit residents who require splints three times a week to ensure orders/plan of care current for splinting devices including donning and doffing orders and times and ensure residents are wearing device per plan of care. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The DON is responsible for compliance.	

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	hemiplegia, unsteady gait, dysphagia (swallowing difficulty), hearing loss, ataxia (impaired coordination), chronic pain" last revised 3/27/25 with care planned interventions which included "Other: Splinting: apply RUE (right upper extremity) Champ hand splint (a resting hand splint used for positioning to improve or prevent worsening of contracture) for 4 hours daily in the morning, then remove for the rest of the day. DO NOT leave on over night. Apply carrot splint (a splint used to position the fingers away from the palms of the hand to protect the skin) into right palmer surface of right hand as tolerates during the day and night" with a date initiated and revised of 11/20/23. Review of Resident #56's "Kardex" (an individualized care guide to direct staff on how to care for the resident) revealed, "ADL's ...Other: Splinting: apply RUE Champ hand splint for 4 hours daily in the morning, then remove for the rest of the day. DO NOT leave on over night. Apply carrot splint into right palmer surface of right hand as tolerates during day and night." During an observation on 6/3/25 at 8:23 AM, Resident #56 was seated in his wheelchair wheeling himself down the hallway. Resident #56 had a notable contracture of the right hand. There was no splint or other device applied to Resident #56's right hand. During an observation on 6/3/25 at 12:05 PM, Resident #56 was observed seated in his wheelchair wheeling himself to the dining room. There was no splint or other device applied to Resident #56's right hand. In an interview on 6/3/25 at 8:29 AM, "Certified Nurse Aide" (CNA) "Q" reported Resident #56 did not wear any type of brace or splint on his right hand. CNA "Q" reported in the seven			

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	months she had worked at the facility, she had not seen any type of brace or splint on Resident #56's right hand. In an interview on 6/3/25 at 10:09 AM, "Licensed Practical Nurse" (LPN) "Z" reported she did not know of any devices that Resident #56 was to wear on his right hand. LPN "Z" reported she was not aware of a splint for Resident #56 and that he did not have one on "yesterday or today." LPN "Z" reported she would have to follow up on whether or not Resident #56 was to wear a device on his right hand for his contracture. In an interview on 6/3/25 at 10:29 AM, "Senior Director of Nursing" (SDON) "NN" reported Resident #56's care plan and Kardex listed that he would have a splint and carrot applied daily. SDON "NN" reported since the splint and carrot were on the care plan and Kardex, the CNA should document in the tasks that they were applied. SDON "NN" reported there was no documentation in Resident #56's medical record that Resident #56's splint and carrot had been applied.			
F0689 SS= G	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 receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and implement appropriate care planned interventions to prevent a fall in 2 of 7	F0689	Element #1 Resident # 77 care plan has been reviewed and updated as needed Current interventions are implemented Resident # 75 Care plan has been reviewed and updated as needed. Gaitbelt is in room Element #2 Current residents in the facility have the potential to be effected. Current residents reviewed to ensure that safety interventions that were listed on the care plan and kardex were physically in place.	6/23/2025

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	residents (Resident #77, #75) reviewed for accidents and hazards, resulting in a fall with fracture for Resident #77 and the potential to negatively affect the residents' highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #77: Review of an "Admission Record" revealed Resident #77 was a female with pertinent diagnoses which included dementia, history of falling, multiple fractures of pelvis, unsteadiness on feet, insomnia, muscle weakness, reduced mobility, adult failure to thrive, aphasia ((loss of the ability to understand or express speech caused by brain damage, like with a stroke) and cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language). Review of a "Care Plan" for Resident #77 revised on 5/23/35 revealed the focus, "...Resident is at risk for falls/injury related to history of falling, adult failure to thrive, muscle weakness, arthritis, cognitive status, pelvic fractures..." with the intervention "...Bed in low position ...Frequent reorientation ...Activity program/group program ...Educate resident on safety interventions...Encourage resident to keep needed items within reach...Encourage resident to use call light...Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensuring there are no trip hazards, providing assistive devices)...Mat to floor next to bed on the left side...Bed against wall for better mobility around room, safety and to provide space to provide care in a safe manner..." Review of an "IDT Functional Abilities Assessment" for Resident #77, dated 3/19/25,		Current residents reviewed to ensure that current transfer status was appropriate and gait belts available for use. Element #3 Fall prevention policy and transfer policy reviewed by DON and NHA. Nursing staff educated on Falls prevention policy and transfer method utilizing gait belt. Education included ensuring all listed safety interventions were physically in place. Fall Risk Management reports will be reviewed during clinical meeting. Immediate interventions will be reviewed for appropriateness and ensure implementation. Gait belts placed in resident rooms for residents requiring use of gait bel Element #4 DON or designee will audit 5 residents weekly to ensure all items listed as in place prior to the fall were in place. DON /designee will observe 5 transfers a week to ensure that correct transfer is completed including use of gait belt if needed. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Administrator is responsible for sustained compliance.	

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	revealed, "...8. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair)...03. Partial/moderate assistance...10. Walk 10 feet...88. Not attempted due to medical condition or safety concerns..." Review of a "Therapy Fall Screen" for Resident #77, dated 4/5/25, revealed, "...Visual Observations: Transfer concerns - yes...Ambulation concerns...yes...Balance concerns...yes...Safety awareness concerns...yes...Pain concerns...yes...Staff Questions: Any noted change in mobility or ADLs?...yes...Any pain or change in ROM (range of motion)?...yes...Any therapy needs (PT,OT,SLP)?...yes..." Review of an "Encounter" note for Resident #77, dated 4/20/2025 at 00:00 AM, revealed, "...Reported unwitnessed fall at 2335 (11:35 PM). No injury noted, able to move all extremities and bear weight. Pt (Patient) is confused per baseline and unable to state how fall occurred. Neuro checks initiated. Monitoring..." Review of "Progress Notes" for Resident #77, dated 04/21/25 at 00:00 AM, revealed, "...Patient is 87- year-old female with history of diet controlled diabetes and dementia. She is being seen for follow-up following a reported fall with no injuries. Patient is seen today, no obvious injuries, or bruising. She denies pain. Due to advance dementia is unable to give any more valuable assessment data. Nursing has no concerns about her care at this time. Vitals reviewed and remain stable...ASSESSMENTS AND PLANS: Muscle weakness (generalized):Patient seen, no visible injuries , no indication for imaging at this time. Denies pain from fall and unable to give any more valuable details due to cognitive impairment. Nursing has no new concerns at this time...Continue fall and			

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	safety precautions as patient is confused at baseline..." Review of an "Alert Note" for Resident #77, dated 4/21/2025 at 03:16 AM, revealed, "...Was observed by both nurse and CNA (Certified Nursing Assistant), approximately 10-15 minutes prior to fall (in hall), laying in bed. Bed was at w/c (wheelchair) height and call light was within reach. This nurse was at med cart prior to fall, which was parked next to patient's room. At 2335 (11:35 PM), This nurse and CNA were walking down hall and observed resident sitting on the floor, in the hallway, across from room. She was sitting next to room 408 doorway with back against wall. She was sitting on her bottom with legs out in front of her and gown was half off. She was not wearing a brief ...She was trying to scoot towards her room. The floor was clean and dry in hallway where she was sitting and also in room. Call light was on bed and was not activated. When asked how she ended up on the floor in the hall, she stated, "I don't know" and "I guess I fell". Nursing assessment completed prior to assisting off of the floor with x2 assist. No injury was noted. Able to move all extremities and bear weight without difficulty. Was assisted into w/c and assisted to bathroom for toileting/incontinence cares. Wet brief was observed at the foot of the bed. Gripper socks put on and was assisted back into bed. Bed placed in low position and call light within reach...." Review of a "Therapy Screen" for Resident #77, dated 4/21/25, revealed, "...Provided to hall staff with importance for pt's (patient's) needs anticipation as pt is not alert enough to request for help..." Review of "Nurses' Notes" for Resident #77, dated 4/25/2025 at 13:41 PM (1:41 PM), revealed, "...Resident taken to (local hospital) via			

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	(Emergency Transport Company) at 1341. Increased pain in left hip. x-rays confirm fracture..." Review of "Progress Notes" for Resident #77, dated 4/25/25 at 00:00 AM, revealed, "...Received following message from nurse "resident returned from ER. Family declined hip surgery new order for Keflex 500mg QID for 7 DAYS". Notified rounding for follow up..." Review of an "Emergency Department (Local Hospital)" note for Resident #77, dated 4/25/25 revealed, "...Started cephalexin (Keflex)...Reason for Visit: Hip Injury...Diagnoses: - Fall at nursing home, initial encounter...Closed fracture of multiple pubic rami, initial encounter..." Review of "Progress Notes" for Resident #77, dated 4/28/2025 at 00:00 AM, revealed, "...Patient is 87-year-old female with history of diet controlled diabetes and dementia being seen to follow-up on ER visit of 4/25 where patient was evaluated for left hip fracture. Not a candidate for surgical intervention and return to facility same day pain /conservative management. Also noted with UTI (Urinary Tract Infection) and sent back to complete course of Keflex...Reported left hip pain when being assisted with ADLs...Apply lidocaine 4% patch daily. Continue Tylenol..." Review of a "Progress Note-General Note" for Resident #77, dated 4/29/2025 at 10:48 AM, revealed, "...(Resident #77) had a fall on 4/20/25, resulting in a "closed fracture of multiple pubic rami per x-ray. She has complaints of pain, reduced mobility, and has experienced a reduction in ADL's. It was determined by the IDT team that a significant change in status has occurred, and an assessment is scheduled. Based on the severity of her injury, a return to her			

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	baseline is not expected within 2 weeks. A referral to therapy has been placed..." During an observation on 06/03/25 at 08:51 AM, Resident #77 was lying in her bed, the lights were off. Observed no fall mat next to the side of her bed, wheelchair was not by the side of the bed as it was located at the end of the foot of the bed at an angle to the side of the foot of the bed, the seat of her wheelchair was facing away from the resident, and it was not in reach. During an observation on 06/03/25 at 09:44 AM, Resident #77 was observed in her bed, she did not have a fall mat next to the side of her bed per the care planned need. The fall mat was folded up and was placed behind the head of her bed. During an observation on 06/03/25 at 11:40 AM, Resident # 77 was observed lying in her bed, she did not have a fall mat next to the side of her bed. There was a blue mat folded up behind the head of her bed. The bed was observed to be low to the ground and her wheelchair was out of reach in the same position it was earlier. During an observation on 06/03/25 at 02:40 PM, Resident #77 was observed in the dining room unsupervised seated in her wheelchair with coloring papers all over the floor, no staff were observed in the small area of the dining room as well as the larger dining room area. Resident #77 was attempting to pick up the papers off the floor as she was leaning forward in her wheelchair attempting to grab a paper. During an observation on 06/04/25 at 10:28 AM, Resident #77 was observed lying in her bed, tray table over her bed, fall mat was on the floor but not next to the bed it was at an angle away from the side of the bed at the head of the bed providing no safety if Resident #77 fell and			

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	angled with the bottom more towards the foot of the bed. In an interview on 06/04/25 at 10:16 AM, "Unit Manager" (UM) "XX" reported staff had to keep a close eye on Resident #77 as she would "free roam" the halls and would go into other resident's rooms. UM "XX" reported activities staff help supervise Resident #77. In an interview on 06/04/25 at 01:19 PM, UM "RR" reviewed the record, reported Resident #77 had a fall on 4/20/25 and ultimately fractured her hip. UM "RR" reported for a resident who had a need for increase in supervision, the staff would want them in visible areas like the nurse's station or with activities. UM "RR" reported the facility did not send Resident #77 to the emergency room following her fall as she had not complained of any pain. UM "RR" reported after a few days, she noticed the resident wasn't weight bearing on that leg and sent her out for an x-ray and evaluation. In an interview on 06/04/25 at 09:52 AM, "Family Member" (FM) "VV" reported Resident #77 could be impulsive and the facility should keep a closer eye on her due to her impulsiveness and dementia. Review of "Fall Prevention Program" reviewed/revised on 1/1/2022, revealed, "...Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls...4. When a resident who does have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program...5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care...a. Interventions will be monitored for effectiveness...b. The plan of care will be revised			

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	as needed..." Resident #75 Review of an "Admission Record" revealed Resident #75 was a female with pertinent diagnoses which included stroke, paralysis on right dominant side, anxiety, muscle weakness, reduced mobility, lack of coordination, and bed confinement status. Review of a current "Care Plan" for Resident #75, revised on 3/24/25 revealed the focus, "...Care Plan: Resident has an ADL (Activities of Daily Living) self-care performance deficit related to generalized weakness following hospitalization for acute cystitis and encephalopathy, right sided weakness following stroke..." with the interventions "...AMBULATION: 2 person assist with use of FWW (four wheeled walker) until screened by therapy...TRANSFERS: 2 person assist...Reduce the risk of injury through the next review...2 person assist for toileting, transfers and ambulation until screened by therapy..." Review of an "IDT (Interdisciplinary Team) Functional Abilities Assessment" for Resident #75, dated 3/24/25 at 4:00 PM, revealed, "...B. Activities of Daily Living: 8. Chair/Bed to Chair Transfer: The ability to transfer to and from a bed to a chair (or wheelchair)...02. Substantial/Maximal assistance...10. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space...88. Not attempted due to medical condition or safety concerns..." During an observation on 06/02/25 at 10:30 AM, Resident #75 was observed in her room seated in her wheelchair. Resident #75 had her call light on and "Certified Nursing Assistant" (CNA) "II" responded. CNA "II" backed Resident #75's			

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	wheelchair to the head of the bed and placed it along the side of her bed. CNA "II" leaned over and told Resident #75 to "give her a hug", counted and then assisted her to her feet. CNA "II" did not have a gait belt around Resident #75's body for her safety. CNA "II" did not use the wheeled walker to assist with her mobility. CNA "II" prompted Resident #75 to shuffle her feet as she was assisting her in turning to back up and sit on the side of the bed. CNA "II" had her sit on the side of her bed while still "hugging" her. CNA "II" moved her wheelchair out of the way, had Resident #75 hug her again, stood her up, and had her sit down further back on the bed. CNA "II" did not have a gait belt around Resident #75 for safety. CNA "II" placed Resident #75's wheelchair out of her reach along the wall, at the foot of the bed, on the left side of her room, where her wheeled walker was located at as well. In an interview on 06/04/25 at 01:25 PM, "Unit Manager" (UM) "RR" reported a gait belt should be used every time the staff were to transfer a resident. Review of a document titled "Using a Gait Belt" received on 6/4/25, revealed, "...Why should I use a gait belt? Gait belts prevent falls...Use a gait belt whenever the person is weak or unsteady...gait belt should go at the patient's waist and be snug..."			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and	F0695	Element #1 Resident # 37 assessed to ensure no ill effects from administration of oxygen and current oxygen order matches the concentrator setting. Resident # 81 plan of care updated to include CPAP orders and routine cleaning. CPAP	6/23/2025

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	483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to 1). Ensure that supplemental oxygen was continuously supplied at the rate ordered by the physician for 1 (Resident #37) and 2). Obtain physician orders for use of a continuous positive airway pressure (CPAP) machine and provide routine cleaning of CPAP mask for 1 (Resident #81) of 2 total residents reviewed for respiratory care resulting in the potential for excessive oxygen administration, improper use and/or inaccurate settings of an CPAP machine, and respiratory infection. Findings include: Resident #37 Review of an "Admission Record" revealed Resident #37 was a female who was originally admitted to the facility on 2/13/2024 and had pertinent diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, need for assistance with personal care, and reduced mobility. Review of a "Minimum Data Set" (MDS) assessment for Resident #37, with a reference date of 5/6/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 13/15 which indicated Resident #37 was cognitively intact. During an observation on 6/2/25 at 1:33 pm, Resident #37 was lying in bed, oxygen nasal cannula (tubing that is connected to an oxygen concentrator machine on one end and the other		mask cleaned. Element #2 Residents who require oxygen/ CPAP/BIPAP have the potential to be affected. A one-time audit will be completed by the DON/designee on residents receiving oxygen to ensure oxygen is administered at the correct flow rate per physician order. A one -time audit will be completed to ensure residents who require Cpap/Bipap have a physician order and mask is clean. Concerns identified will be corrected. Element #3 The administrator and DON reviewed the Oxygen administration policy and CPAP/BiPap cleaning policy and deemed it appropriate. Policy reviewed at QAPI. Nursing staff will be re-educated on following oxygen administration policy which includes administration, physician orders and Cleaning of CPAP/BiPap mask During rounds DON/designee will ensure administration, flow rate and storage are appropriate. CPAP/BiPap mask are clean. Element #4 The DON/designee will audit and observe 5 residents per week with oxygen orders to ensure administration is per order, BIPAP/CPAP have current orders and mask are clean. Audits will be conducted x4 weeks	

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	end with two prongs were inserted into the person's nose to deliver supplemental oxygen) not correctly applied to her face, and the concentrator was noted to be set at 5 liters (L). Review of "Order Summary" for Resident #37 revealed " ...Oxygen: RUN @ (at) 2-4 L/Min via N/C ...24 hours a day continuous" with a start date of 1/31/2025. During an observation 6/3/25 at 11:18 am, Resident #37 was in bed sleeping, with her nasal cannula in place on her face and the oxygen concentrator was noted to be set at 5L. Review of "Care Plan" for Resident #37 revealed " ...Focus/Intervention ... Resident has an impaired cardiovascular status related to congestive heart failure ...Provide oxygen as ordered ...." With a start date of 1/31/2025. During an observation on 6/3/25 at 1:47 pm, Resident #37 was in bed with her nasal cannula in place on her face and her oxygen concentrator was noted to be set on 5L. During an observation on 6/3/25 at 2:29 pm, Resident #37 was in bed with her nasal cannula skewed on her face, and the nasal prongs not in both of her nostrils. Oxygen concentrator was noted to be set on 5L. In an interview on 6/3/25 at 2:33 pm, "Licensed Practical Nurse" (LPN) "Y" reported she did not have to do anything with resident's oxygen concentrators. During an observation on 6/4/25 at 8:41 am, Resident #37 was in bed, eating breakfast, with her nasal cannula in place and her oxygen concentrator was noted to be set on 5L.		and then monthly until sustained compliance. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The DON is responsible for sustained compliance.	

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	In an observation and interview on 6/4/25 at 9:30 am, "Unit Manager" (UM) "RR" reported the nurse was responsible for making sure the resident's oxygen setting was accurate and matched what was ordered. When queried, UM "RR" reviewed Resident #37's physician order for oxygen, reported her settings should be 2 to 4 liters. UM "RR" then accompanied this surveyor to Resident #37's room and observed the oxygen concentrator at her bedside. UM "RR" confirmed the setting on the oxygen concentrator was 4.5 to 5L. UM "RR" reported she would need to complete an assessment on Resident #37 and adjust her oxygen settings. In an interview on 6/4/25 at 9:05 am, "Director of Nursing" (DON) "B" reported her expectations were that the nurse verified the resident's oxygen settings every shift and follow the order. Resident #81 Review of an "Admission Record" revealed Resident #81 was a female who was originally admitted to the facility on 12/19/2024 and had pertinent diagnoses which included: Pulmonary embolism (blood clot in the lungs) and obstructive sleep apnea (periods of not breathing while sleeping). Review of a "Minimum Data Set" (MDS) assessment for Resident #81, with a reference date of 3/15/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #81 was cognitively intact. During an observation and interview on 6/2/25 at 2:34 pm. Resident #81 was in her room and was noted to have a CPAP mask laying across a CPAP machine on the bedside dresser. Resident #81 reported she was able to put the CPAP mask on, but they staff should clean it for her. When			

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	queried how often staff cleaned her CPAP mask Resident #81 stated "I wish they would! My CPAP mask has never been washed since I've been here." CPAP mask was noted to be soiled with dirt, debris, and skin oils. On 6/3/25 at 8:50 am Resident #81 was observed sleeping in her bed with her CPAP mask in place on her face. Review of "Order Summary" for Resident #81 revealed " ...Remove c-pap and rinse out mask in the morning ... : with a start date of 5/15/25 and "Wash C-pap straps by hand and leave out to dry in the morning every Mon ..." with a start date of 5/15/25. Review of Resident #81's medical record revealed no noted active order for CPAP use. Review of "Care Plan" for Resident #81 revealed "Focus/Intervention ...Resident has impaired pulmonary respiratory status related to sleep apnea ... CPAP ...machine as ordered ..." with an initiation date of 12/10/24. In an interview on 6/3/25 at 2:30 pm, LPN "Y" reported there was an order for Resident #81's CPAP mask to be rinsed every morning, and that the nurse was responsible for completing that task and documenting it in the treatment administration record (TAR). LPN "Y" reported today would be her first time completing that task. When queried, LPN "Y" confirmed that she was Resident #81's nurse the day before also but she had not rinsed the mask or cleaned the straps. Review of "TAR" for Resident #81 for the month of May 2025 revealed documentation that indicated that Resident #81's CPAP mask had been rinsed in the morning every day except 1			

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	between 5/15/25 when the order was started and the end of the month 5/31/25. 5/17/25 was blank, there was no documentation for that date. Documentation indicated that Resident #81's CPAP straps were washed and left out to dry in the morning on Mondays from the start date of 5/15/25 through the end of the month 5/31/25. In an interview on 6/3/25 at 2:40 pm, LPN "V" reported a physician order was required for CPAP use and the mask was to be cleaned when it was removed in the morning. In an interview on 6/3/25 at 2:42 pm, "Registered Nurse" (RN) "EE" reported a CPAP mask should be rinsed every morning after use and a physician order was required for a resident to use a CPAP. In an interview on 6/4/25 at 8:44 am, Resident #81 reported she used her CPAP last night. Resident #81 reported her CPAP mask had not been washed. Resident #81 reported it would be nice if the staff would clean it for her. In an interview on 6/4/25 at 8:54 am, UM "RR" reported CPAP use required a physician order and that the assigned nurse was to wash the mask every morning after use. UM "RR" reviewed Resident #81's record and confirmed there was no active order for her CPAP use. In an interview on 6/4/25 at 9:08 am, DON "B" reported her expectations were that there was an order in place for use and cleaning and that the mask should be rinsed daily and cleaned along with the tubing weekly. DON "B" reviewed Resident #81's record and confirmed there was no noted active order for CPAP use. Review of facility policy "CPAP/BiPAP/NIPPV (non-invasive positive pressure ventilation) support" with a revision date of 1/1/2021 revealed			

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	" ...CPAP is the continuous delivery of air under pressure to a residents airway commonly utilized of obstructive sleep apnea ...review the physician's order to determine the oxygen concentration or liter flow and the pressure ... for the machine ..."			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed ensure post dialysis assessment and monitoring was completed and documented for 1 (Resident #6) of 1 resident reviewed for dialysis care, resulting in the potential for the resident to not meet his highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #6 Review of an "Admission Record" revealed Resident #6 was a male, with pertinent diagnoses which included: end stage renal disease (a disease in which the kidneys don't filter excess waste and fluid from the blood effectively) and dependence on renal dialysis (a treatment that filters excess waste and fluid from the blood when the kidneys don't function properly). Review of Resident #6's current "Order Summary" revealed no physician's orders for monitoring and assessment of Resident #6 upon	F0698	Element 1 Resident # 6 No longer resides at facility Element 2 Current residents receiving dialysis residing in the facility have the potential to be affected. Residents receiving Dialysis have had plan of care reviewed and updated as needed. Dialysis centers contacted and educated on process for completing and returning dialysis forms. Element 3 DON and NHA reviewed the Care Planning Dialysis Special Needs Policy and deemed them appropriate. Policies to be reviewed at QAPI. Nursing staff will be educated on the Care Planning Dialysis Special Needs policy and completing the dialysis communication pre and post dialysis. Nurses also educated on process to call and have dialysis fax completed forms if not returned with resident. Residents receiving dialysis will be reviewed during clinical meeting to ensure communication forms was provided. Element 4 Director of Nursing/Designee will audit dialysis residents 2 x weekly for 4 weeks to ensure dialysis forms completed. After which, these items will be audited for dialysis residents at least 1 x weekly for 3 months. Results of audits will be brought to monthly QAPI x 3 months or until substantial	6/23/2025

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	return to the facility from his dialysis treatments. In an interview on 6/3/25 at 1:09 PM, "Licensed Practical Nurse" (LPN) "Z" reported when Resident #6 returned from dialysis, the nurse was supposed to check his weight and vital signs. In an interview on 6/4/25 at 9:50 AM, "Staff Development Nurse" (SDN) "KK" reported when a resident came back from dialysis, the nurse should obtain a post dialysis weight, vital signs, check the dialysis access site, and write a progress note stating when the resident got back to the building and what their transportation was and any concern that were noted. SDN "KK" reported the nurse should also check the "thrill" (a vibratory sensation) and "bruit" (a murmur) before the resident left the facility for dialysis and upon return from dialysis. SDN "KK" reported there would definitely need to be a progress note when the resident returned to the facility with the post-dialysis assessment information. SDN "KK" reported that was something the facility could improve upon. In an interview on 6/4/25 at 9:59 AM, "Registered Nurse" (RN) "I" reported when a resident returned from dialysis, there was a paper (referring to the hemodialysis communication record form) that should be filled out to document the post dialysis assessment of the resident. RN "I" reported the assessment entailed taking vitals, assessing how the resident was feeling, if the resident was in any pain, and checking the thrill and bruit three times a day." In an interview on 6/4/25 at 10:03 AM, RN "FF" reported when a resident returned from dialysis, the nurse should check the vitals, check for any bleeding, check the thrill and bruit, make sure the port at the dialysis site was capped, look for any signs and symptoms of infection and fill out the		compliance is achieved. NHA will be responsible for oversight and continued compliance.	

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	bottom of the communication record (referring to the hemodialysis communication record form) with all the pertinent information. A review of the "Hemodialysis Communication Record" form revealed, ..."To be completed by facility upon return from dialysis Vital Signs BP (blood pressure) Pulse Resp. (respirations) Temp (temperature) Shut Site: Observation ...Auscultation (listening for sound with a stethoscope) (bruit) ...Palpation (feeling the surface of the body at the access site) (thrill) ...Ports capped and clamped Yes No ...Resident reports pain Yes No ...Time of return from dialysis AM PM ..." Review of Resident #6's "Hemodialysis Communication Records" from 3/3/25 - 5/30/25 revealed no documentation on any of the communication records under the section "To be completed by facility upon return from dialysis". Review of a MARTAR (medication administration record treatment administration record) for Resident #6 for March, 2025 revealed, "Weight after dialysis every evening shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for post dialysis" Start Date 1/27/25 DC (discontinue) Date 3/27/25. There was documentation as ordered through 3/27/25. Review of a MARTAR for Resident #6 for March, 2025 revealed, "Vital signs before and after dialysis every day and evening shift every Mon, Wed, Fri for dialysis" Start Date 1/27/25 DC Date 3/27/25. There was documentation as ordered through 3/27/25. Review of a MARTAR for Resident #6 for March, 2025 revealed, "AV shunt site RIGHT intro-jugular Monitor for thrill and bruit every shift. Call provider if absent." Start Date 2/28/25			

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	DC Date 3/27/25 There was documentation as ordered through 3/27/25. Review of a MARTAR for Resident #6 for April, 2025 - June 3, 2025 revealed no documentation of weights, vital signs, or monitoring of thrill and bruit every shift as was the case through March 27, 2025. Review of Resident #6's "progress notes" from 3/27/25 to present revealed no documentation of post-dialysis assessment and monitoring following Resident #6's return from dialysis. In an interview on 6/3/25 at 1:40 PM "Director of Nursing" (DON) "B" reported Resident #6 had had orders in place for monitoring parameters post dialysis upon return to the facility, but they somehow got discontinued. DON "B" reported it was important to have orders in place for the nurse to document what was monitored. DON "B" reported if it was not charted, it was not done. In a follow-up interview on 6/3/25 at 4:08 PM, "Director of Nursing" (DON) "B" reported the facility had a "Hemodialysis Communication Record" form that was started by the facility prior to transfer to the dialysis facility and then the dialysis facility completed a portion and sent it back to the facility and that the bottom of the communication form was completed by the facility upon return to the facility for post-dialysis monitoring. In electronic correspondence on 6/4/25 at 9:26 AM, the DON was requested to provide this surveyor with any evidence for the last 3 months that Resident #6's post dialysis assessments were completed upon return to the facility. (Note that this would include time after 3/27/25.) In return electronic correspondence on 6/4/25 at			

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	11:05 AM, DON reported "unable to locate any."			
F0699 SS= D	Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify post-traumatic stress disorder (PTSD) triggers and develop individualized care plan interventions to mitigate triggers for 2 (Resident #83, #63) of 18 residents reviewed for trauma informed care, resulting in the potential of re-traumatization due to staff not being informed and knowledgeable of the resident's past trauma. Findings include: Resident #83 Review of an "Admission Record" revealed Resident #83 was a female with pertinent diagnoses which included below the knee amputation, bilaterally, frostbite with tissue necrosis of right foot, frostbite with tissue necrosis of left foot, gangrene, bipolar, schizophrenia, and respiratory failure with hypoxia. Review of current "Care Plan" for Resident #83, revised on 2/26/25, revealed the focus, "...Resident is at risk for an impaired	F0699	Element 1 Resident #63 was interviewed by social services/designee to identify potential triggers to post trauma. Any interventions identified were placed on her plan of care/kardex to assist the staff and resident. Resident #83 was interviewed by social services/designee to identify potential triggers to post trauma. Any interventions identified were placed on her plan of care/kardex to assist the staff and resident. Element 2 Residents with PTSD have the potential to be effected. Residents who have a diagnosis of PTSD were interviewed by social services/designee to identify potential triggers. Care plans have been updated to reflect interventions that assist with meeting their needs. Element 3 The NHA/DON has reviewed The Trauma Informed Care policy and deemed it appropriate. Social Services will receive re-education from the Director of Nursing and or designee on The trauma informed care policy with a focus on triggers, re-traumatization, and how to find interventions/approaches to assist with meeting their needs.	6/23/2025

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	mood/psychiatric status related to bipolar disorder, schizophrenia..." with the interventions "...Administer medications and treatments as ordered...Behavioral health consults as needed for meds and psychotherapy...Encourage resident to express their feelings..." Review of "Comprehensive Level II Evaluation" dated 4/4/25, revealed, "...Schizoaffective disorder: Bipolar type...Substance related disorder, secondary...Personality disorder...D. History of Presenting Problem: Resident #83 has a history of services with (Community Mental Health (CMH)) including case management, however, case management services were closed (October 2024) due to noncompliance with care. She continued to receive medication reviews. (CMH) records show she was hospitalized at (Psychiatric Hospital) for one month (8/29/24-10/3/24). When discharged, she requested being stepped up to case management. She was experiencing hallucinations, delusions, and depression. (Resident #83) reports four psychiatric inpatient hospitalizations. She was first referred to (CMH) in 2012. (CMH) diagnosis: schizoaffective disorder, tobacco use disorder, amphetamine type substance use disorder, cannabis use disorder, and cocaine use disorder. Her (CMH) notes reflect her grandfather, cousin, and uncle have history of suicide. Her daughter has bipolar, and her son has ADHD. She had domestic violence charge, and she was sent to (State Psychiatric) Evaluation Hospital which found her unfit to stand trial. The charge pled down to disturbing the peace. The incident occurred with her father and contributed to her becoming homeless...F. History of CPS involvement having her children temporarily removed and history of legal charges due to substance abuse. She has a history of sexual abuse...H. (Resident #83)'s father charged her with domestic violence on March 11, 2023. She was arrested and found not competent to stand		Social Services/designee will interview new admissions for potential past traumas, triggers, and interventions and update care plans/tasks accordingly and refer to behavioral health as necessary. Quarterly and when indicated, these interventions will be reviewed by the IDT to ensure that interventions remain appropriate to assist the residents and staff meet the resident focused goals of care. Element 4 Social Services and or designee will audit 3 residents weekly for 4 weeks then monthly x 2 or until substantial compliance is achieved who flagged as displaying behaviors to ensure interventions in place are effective related to past traumas. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible for achieving and maintaining compliance.	

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	trial. Her charges were reduced to disturbing the peace and she was released from jail May 18, 2023. She could not go back to her father. Before living with her father, she resided with her grandfather. She and her grandfather "clashed". She reported always living in private residence and no history of AFC (adult foster care) placement. She has primarily lived in the (local town) area, with family...I. Reports suicidal ideation contributed to inpatient psychiatric hospitalization at (Psychiatric Hospital)... (Resident #83) has additional diagnosis with (CMH) of amphetamine type substance use disorder, cannabis use disorder, and cocaine use disorder. (Resident #83) reported a history of being clean for six years until she relapsed. (CMH) notes reflect a history of SUD (substance use disorder) treatment. Resident #83 reports no current substance use. She reports currently being two months clean. She states relapse "won't be an issue". She did not wish to discuss her history of use any further...K. Discharging from the facility is distressing to her...Resident #83 presents with complex medical and mental health needs. She recently underwent bilateral below-knee amputations (BKA) and requires ongoing assistance with activities of daily living (ADLs). Additionally, she needs support in managing the multifaceted medical and emotional challenges associated with her recent amputations. Continued placement in a skilled nursing facility is essential to ensure appropriate care and comprehensive support during her recovery and adjustment process ...Psychiatric Assessment: A. She has been noted to be anxious, agitated, impulsive, and tearful ...Resident #83 admits to crying at least once since admitted to the facility. She has anxiety "in the chest" and can feel overwhelmed. She had a difficult time remembering her history of symptoms, but endorsed excessive energy, hallucinations, and delusions. She was paranoid and had a history of risky, unsafe behaviors. Currently she is stable			

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	...Her sleep is good with the Trazodone. She reports no concerns with appetite or energy. She continues to smoke up to five cigarettes per day. She reports no current substance use and no current triggers for use. She has a history of unstable relationships. She has been unable to maintain housing and met aspects of stable living. She has a history of aggression resulting in arrests. (CMH) reported a history of sexual abuse and CPS (Child Protective Services) involvement which resulted in temporary placement of her children...C. Her mood was euthymic (stable), affect flat (total absence of emotional responses). She often persevered (kept going) back to not wanting AFC placement and concerns with being discharged. She needed reassurance. She was guarded and suspicious...History of significant substance abuse but denies concerns with relapse. History of suicidal ideation...Family History of suicide...F. Schizoaffective disorder, bipolar typer: Resident #83 was hospitalized at (Psychiatric Hospital) (8/29/24-10/3/24) due to experiencing hallucinations, delusions, and depression. She is noted to be anxious, agitated, impulsive, and tearful. Resident #83 admits to crying at least once since admitted to the facility. She has anxiety "in the chest" and can feel overwhelmed. History of symptoms, but endorsed excessive energy, hallucinations, and delusions. She was paranoid and had a history of risky, unsafe behaviors..." Review of "Psychiatry Initial Evaluation" dated 5/14/25, revealed, "...Progress notes show that she was reporting nightmares to her PCP (primary care provider) and was started on Propranolol (this drug can cause drowsiness...helps reduce the physical symptoms of anxiety, does slow down your heart rate) which she has used in the past with good relief...She endorses moderate anxiety, moderate depression, agitation, and insomnia. She reports feeling "internally in contempt. I feel like I did something wrong in my life and I am being			

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	punished. I feel guilty." History of former use of marijuana, crack and methamphetamine...History of 6 psychiatric hospitalizations and 1 suicide attempt...History of homelessness...Judgment: Marginal..." Review of "Social Services Progress Review" dated 5/21/25, revealed, "...D. Mood/Behavior/Emotional Status: 8a. Mood: Feeling down, depressed, or hopeless: Yes...2. 7-11 days (half or more of the days)...21. history/diagnosis of polysubstance abuse (alcoholism/drug addition)?...Yes...Alcohol...She was homeless and had BKA (below the knee amputation) bilaterally in February...Trazadone - insomnia, Haldol - bipolar disorder, Zyprexa - bipolar disorder..." Review of "Progress Notes" dated 5/5/2025 at 00:00 AM, "...Chief Complaint: Nightmares...45 year old female with recent gangrene and BKA (below knee amputation) having nightmares. Used to be on propranolol for these and wants it restarted..." Review of medical record progress notes revealed no social service notes created by SSD "D." In an interview on 06/04/25 at 09:07 AM, Social Services Director (SSD) "D" reported she had completed the PHQ-9 (Depression Assessment) for Resident #83. SSD "D" reported Resident #83 had a past history of depression, and childhood trauma. She was referred to (behavioral services provider) and had an initial evaluation recently. Resident #83 will also see them for medication management. SSD "D" reported she had not assessed Resident #83 for trauma and there was no care plan to address trauma and potential triggers for facility staff when interacting with Resident #83.			

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	In an interview on 06/04/25 at 09:26 AM, Regional Director of Operations (RDO) "C" reported when the residents were admitted there were questions on the admission assessment. RDO "C" reported depending on each resident would determine the referral to psych services to come and complete an assessment with the resident. RDO "C" reported the resident's history in the community and events which had occurred would also determine their connection to services. RDO "C" reported a trauma assessment was completed initially and quarterly by the SSD it was built into the social services assessment. RDO "C" reported there was no trauma care plan or psychiatric care plan for Resident #83 based on the resident's history, recent experiences, information received from Obra, substance abuse, psychiatric hospitalizations, psychiatric diagnoses, her expression of nightmares but no indicated cause, the bilateral below the knee amputation due to gangrene and frostbite due to homelessness. Resident #63 Review of an "Admission Record" revealed Resident #63 was a female who was originally admitted to the facility on 3/25/25 and had pertinent diagnoses which included: acute respiratory failure, generalized anxiety disorder, and major depressive disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #63, with a reference date of 4/15/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 14/15 which indicated Resident #63 was cognitively intact. During an observation and interview on 6/2/25 at 11:50 am, Resident #63 reported she was "stuck" in the facility since she lost all of her identification papers in a house fire. Resident #63			

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	reported she had lived in that house for over 40 years, and it burned to the ground. Resident #63 was observed staring off, unfocused, emotional with tears in her eyes while talking about the fire that destroyed her home. When queried, Resident #63 reported she remember every single detail of the fire, stating "I'll never forget." Review of "Order Summary" for Resident #63 revealed "Consult with (Name Omitted) (psychological services) for anxiety ... " with a start date of 5/21/2025. Review of "IDT-Progress Note" for Resident #63 dated 4/17/25 at 13:07 (1:07 pm) revealed " ...D/C (discharge) plan is unknown at this time, but she would not like to stay long term. May need to look at D/c'ing to a shelter ..." Review of "Social Services Progress Note" dated 4/21/25 at 11:39 am, revealed " ...Resident disclosed her house had burned down and is working on getting housing ..." Review of "IDT-Progress Note" dated 4/24/25 at 13:09 (1:09 pm) revealed " ...DC Plan- homeless due to house fire ..." Review of "NHA-Asst NHA progress note" dated 5/2/25 revealed " ...informed resident that appeal has been denied." Review of "Social Services Progress Note" dated 5/5/24 revealed " ...she (resident) disclosed she was going to re-appeal again because she does not feel like she is ready to discharge ..." Review of "Progress Note" dated 5/15/25 revealed " ...Control anxiety with Xanax 0.25mg, 3 tables every 6 hours as needed. Will have patient consult with house psyche provided ..." authored by "Nurse Practitioner" (NP) "PP".			

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	Review of "Care Plan" for Resident #63 revealed Focus/Goal/Intervention " ...Resident has an impaired mood/psychiatric status relate to anxiety and depression ... Resident will have reduced complications related to altered mood/psychiatric status ...administer medications as ordered ...behavioral health consults as needed ... if resident presents/vocalizes self-harm ensure resident safety and notify nurse ...provide opportunity for the resident to communicate feeling regarding skilled nursing facility placement ... refer to social services as needed if resident communicates need to speak with someone ..." with an initiation date of 3/27/2025. In an observation and interview on 6/4/25 at 9:59 am, Resident #63 reported she did not feel her emotional needs were being met since she has been in the facility. Resident #63 reported she had a counselor before she came to the facility and the facility told her they would have someone for her to talk to, but she has not spoken to anyone since she has been here. Resident #63 stated "It has been very rough being here, very stressful. My house burnt to the ground, I lost my appeal for Medicaid insurance, the facility sent me a $3000 bill, I'm trying to find an apartment, but I cannot apply for anything because my legal identifications were lost in the fire, my daughter is sick and, in the hospital, and I can't go see her. Everything adds more stress." Resident #63 stated "It would be nice to have someone to talk to and someone to help me figure things out with where I go after here. I have no idea who to talk to about my living situation or to tell that I had to watch my dog take his last breath or how I felt being told my kitty was found dead later. Resident #63 was observed to be emotional, crying, and visibly shaking. During the conversation, Resident #63's talking became quicker and louder and the emotional stress was noted on her face and posture of her body as she continued to list each			

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	individual stressor she was trying to navigate. Resident #63 stated "I have so many unanswered questions with no guidance, and I need some help. I haven't even dealt with the trauma yet. I remember what happened (sic the fire), it was the most traumatic thing I have every been through in my life." In an interview on 6/4/25 at 11:28 am, "Director of Social Services" (DSS) "D" reported she was unsure of any care plan interventions for Resident #63's trauma. DDS "D" stated "I know her house burnt down and I think she is on medications for depression. DDS "D" reported there was nothing in her care plan regarding her being in a house fire or losing her pets. DSS "D" reported she had not referred Resident #63 to any psychological services or counseling since Resident #63 was supposed to be a short term stay in the facility. SSD "D" reported she was not aware of the physician order to refer Resident #63 to (Name Omitted) psychological services. Review of "Initial Social Service History Assessment" completed on 4/8/25 by SSD "D" revealed " ...I. Behavior medical and psychiatric history ...2. Document major health occurrences and the social, behavioral, emotional impact ... her home burning down and losing her animals ... discharge planning ...2. Current discharge goals/needs ... go home and find housing ..." According to, "National Alliance on Mental Illness" (NAMI) Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after someone experiences a traumatic event that caused intense fear, helplessness, or horror. PTSD can result from personally experienced traumas (e.g., rape, war, natural disasters, abuse, serious accidents, and captivity) or from the witnessing or learning of a violent or tragic event...While it is common to experience a brief state of anxiety or			

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	depression after such occurrences, people with PTSD continually re-experience the traumatic event; avoid individuals, thoughts, or situations associated with the event; and have symptoms of excessive emotions. People with this disorder have these symptoms for longer than one month and cannot function as well as they did before the traumatic event. PTSD symptoms usually appear within three months of the traumatic experience; however, they sometimes occur months or even years later..." https://namimi.org/mental-illness/ptsd According to Substance Abuse and Mental Health Services Administration (SAMHSA) publication, "Trauma- Informed Care in Behavioral Health Services" revealed, "...Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression ..." https://www.ncbi.nlm.nih.gov/books/NBK207191/			
F0740 SS= D	Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of	F0740	Element 1 Resident # 63 was referred to psych services and care plan updated. Element 2 Current residents receiving anti-depressants or anti-psychotics in the facility have the potential to be affected.	6/23/2025

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	care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide specialized and individual mental health services for 1 (Resident #63) of 1 resident reviewed for mental health services resulting in psychological support service recommendations not being addressed, support services not being initiated when ordered by the physician, and the potential for a decline in psychological well-being. Findings include: Resident #63 Review of an "Admission Record" revealed Resident #63 was a female who was originally admitted to the facility on 3/25/25 and had pertinent diagnoses which included: acute respiratory failure, generalized anxiety disorder, and major depressive disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #63, with a reference date of 4/15/2025 revealed a "Brief Interview for Mental Status" (BIMS) score of 14/15 which indicated Resident #63 was cognitively intact. In an interview on 6/4/25 at 9:59 am, Resident #63 reported she was told when she was first admitted to the facility, she would have someone talk to her about her emotional status, but that has not happened. Resident #63 reported she was rescued from a house fire and was in the facility		Residents receiving anti-depressants or anti-psychotics were audited and those not seen by psych services will be offered and referred. Element 3 DON and NHA reviewed the Behavioral Health Services Policy and deemed them appropriate. Policies to be reviewed at QAPI. Social services will be educated on the Behavioral Health Services policy and offering psych services and referring as agreed to. New Residents receiving anti-depressant and/or anti-psychotics will be reviewed daily and offered psych services during morning meeting . Element 4 Social Services Director/Designee will audit residents receiving anti-psychotics and anti-depressants weekly for 4 weeks then monthly to ensure offered services completed. Results of audits will be brought to monthly QAPI x3 months or until substantial compliance is achieved. NHA will be responsible for oversight and continued compliance.	

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	for rehabilitations. Resident #63 reported that she had a counselor when she lived at home. Resident #63 stated "I could really use some support since I lost everything in the fire. I need some help. I haven't dealt with the trauma (of the fire)(Sic)." Review of "Order Summary" for Resident #63 revealed "Consult with (Name Omitted) for anxiety ... " with a start date of 5/21/2025. Review of "Care Plan" for Resident #63 revealed Focus/Goal/Intervention " ...Resident has an impaired mood/psychiatric status relate to anxiety and depression ... Resident will have reduced complications related to altered mood/psychiatric status ...behavioral health consults as needed ...refer to social services as needed if resident communicates need to speak with someone ..." with an initiation date of 3/27/2025. In an interview on 6/4/25 at 11:28 am, "Director of Social Services" (DSS) "D" reported she had not referred Resident #63 to any psychological services or counseling since Resident #63 was supposed to be a short term stay in the facility. SSD "D" reported she was not aware of the physician order to refer Resident #63 to (Name Omitted) psychological services.			
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 maintain a medication error rate less than 5% in 2 residents (Resident #33 & #21) of 5 residents reviewed for	F0759	Element 1 Residents #21 and #33 were assessed by MD. No ill effects noted from failure to administer medications correctly. Element 2 All residents who reside in the facility have the potential to be effected. Residents were audited to ensure medications are available per MD order. Concerns were	6/23/2025

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	medication administration, resulting in the potential for medication adverse effects and complications. Findings include: Resident #33 During an observation of medication administration on 06/03/25 at 08:32 AM Registered Nurse (RN) "EE" prepared an insulin (used to manage blood sugar levels) injection (when a needle is used to administer medication) for Resident #33. The medication was labeled Lantus (a long acting insulin) Pen and was dated as opened on 4/26/25 (38 days ago). Observed RN "EE" inject 10 units of the Lantus into Resident #33's right abdomen. RN "EE" administered insulin from a pen that was over 28 days past the open date. In a subsequent interview on 6/3/25 at 8:35 AM, RN "EE" reported that the facility goes by the manufacturer expiration date for insulin pens and not the open date. During an observation of the medication cart of 100 hall on 6/3/25 at 10:30 AM with Unit Manager (UM) "RR" reported that the facility policy is to discard insulin pens 30 days after opening. UM "RR" reported that monitoring medication storage was a third shift task, but that every nurse should check dates prior to administering medications. UM "RR" reported that knowledge of when to discard insulin pens was taught in nursing school, and not part of the facility's orientation education. Review of the manufacturer guidelines for Lantus (insulin) dated 2018 revealed, "Do not use LANTUS after the expiration date stamped on the label or 28 days after you first use it (opened		immediately addressed with pharmacy and MD notified. Element 3 Director of Nursing and NHA reviewed the policy on Medication Administration and deemed it appropriate. Medication Administration Policy was reviewed by QAPI. The Staff Development Coordinator/designee re-educated licensed nurses on the Medication Administration Policy. Director of Nursing/designee will audit 5 medication passes weekly x4 weeks and monthly x2 months to ensure that medication are administered correctly, available per MD order, and proper notifications made for errors. Element 4 Director of Nursing/designee will audit 5 medication passes weekly x4 weeks then, monthly x2, to ensure medications are administered correctly, available and dosage per MD order. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Director of Nursing is responsible for sustaining compliance.	

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	date)." ©2018 sanofi-aventis U.S. LLC http://products.sanofi.us/lantus/lantus.html Resident #21 During an observation of medication administration on 06/03/25 at 08:48 AM with RN "EE" for Resident #21 revealed that Resident #21 did not receive Wellbutrin (antidepressant) 150 mg (milligram) as ordered. Observed RN "EE" prepare all of Resident #21's medications and report that Wellbutrin was not available to administer, but that it was on order from the pharmacy. RN "EE" reported that some residents go several days without medications, and that she was not sure how long Resident #21 had been without her Wellbutrin. RN "EE" did not search the bottom drawer of the medication cart where extra medications are kept. Review of Resident #21's "Medication Administration Record (MAR)" revealed orders for Wellbutrin XL (extended-release) 24 hour 150 mg, give one pill in the morning for depression. The start date was 11/28/24. The record indicated that the medication was administered on 6/1/25, 6/2/25, 6/4/25, and was not given on 6/3/25. In an interview and observation on 06/04/25 at 09:49 AM, RN "FF" reported that she had administered Resident #21's Wellbutrin as scheduled that morning. Observed the medication cart's main drawer of medication cards with no Wellbutrin for the resident. RN "FF" reported that she made an error; RN "FF" reported she documented that she administered the medication, but did not. RN "FF" then looked in the bottom drawer that contained extra medication and found a new card of Wellbutrin dated 5/20/25 for the resident. In an interview on 06/04/25 at 10:02 AM, UM			

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	"RR" reported that per the Wellbutrin order audit report, Resident #21's Wellbutrin was due to exhaust on 5/20/25 (14 days ago) and was refilled/dispensed automatically by the pharmacy on that day. UM "RR" reported that there was no way to determine how many doses Resident #21 had been missed, considering that the nursing staff had documented administering Wellbutrin everyday since 5/20/25, except for 6/3/25 when this surveyor was observing medication pass. UM "RR" reported that she would expect that staff search the bottom drawer of the medication cart prior to marking the medication as not available. During an observation of medication administration on 06/03/25 at 08:48 AM with RN "EE" for Resident #21 revealed that Resident #21 did not receive her scheduled dose of Morphine Sulfate (opioid pain reliever), but instead was given Oxycodone 5 mg. RN "EE" administered Resident #21's morning medications and also Oxycodone 5 mg. Review of Resident #21's "Medication Administration Record (MAR)" revealed orders for Morphine Sulfate ER (extended-release) give one tablet three times a day (every 8 hours) for pain, with a start 1/2/25. The record indicated that the resident received the medication as scheduled on 6/3/24. This was not accurate. Review of Resident #21's MAR revealed orders for Oxycodone (opioid pain reliever) 5 mg, give one tablet every 6 hours as needed for pain, with a start date of 4/25/24. The record indicated that the medication was last administered at 2:21 AM on 6/3/25. The medication had not been documented as administered as this surveyor observed at 8:48 AM.			

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	In an interview on 6/3/25 at 09:54 AM, RN "EE" reported that she accidentally administered Oxycodone 5 mg, instead of the resident's scheduled Morphine, and then documented it as Morphine being administered. RN "EE" reported that she would need to make corrections to the documentation. Unit Manager (UM) "RR" was assisting RN "EE" with medication pass and reported the Morphine should have been administered as scheduled with the morning medications, and then the Oxycodone 5 mg if the Morphine was not effective. Review of the facility policy "Medication Storage" dated 10/30/2020 revealed, "...It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations..." Review of the facility policy "Medication Administration" dated 10/30/2020 revealed "...1. Keep medication cart clean, organized, and stocked with adequate supplies...10. Review MAR to identify medication to be administered. 11. Compare medication source with MAR to verify...12. Identify expiration date..." Review of Fundamentals of Nursing (Potter and Perry) revealed, "Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010) ...apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle			

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	Locations 39307-39313). Elsevier Health Sciences. Kindle Edition.			
F0761 SS= D	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: Based on observation, interview, and record review, the facility failed to store drugs per manufacturer instructions and facility policy in 2 out of 6 medication carts, resulting in the potential for decreased efficacy of medications. Findings include: During an observation of medication administration on 06/03/25 at 08:32 AM on 100	F0761	Element 1 Resident #35 inhaler removed from room and replaced. Resident #140 inhaler removed from room and placed in medication cart. Element 2 All residents who resident in the facility are at risk with this deficient practice. An audit of the medication carts, medication rooms, and refrigerators has been completed by DON/designee with no further issues identified. Element 3 Licensed nurses were educated on the policy for medication storage. The Medication Storage policy was reviewed during QAPI and deemed appropriate. DON or designee will audit nursing medication carts weekly for 4 weeks and then monthly x2. Element 4 DON or designee will audit nursing medication carts weekly for 4 weeks and then monthly x2 until substantial compliance is achieved. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee.	6/23/2025

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	hall, Registered Nurse (RN) "EE" prepared an insulin (used to manage blood sugar levels) injection pen (when a needle is used to administer medication) for Resident #33. The medication was labeled Lantus pen (a long acting insulin) and was dated as opened on 4/26/25 (38 days ago) with an expiration date of 3/31/27. RN "EE" was observed injecting 10 units of the Lantus into Resident #33's right abdomen. The insulin was labeled "use within 28 days of opening" from the manufacturer. In a subsequent interview on 6/3/25 at 8:35 AM, RN "EE" also reported that the facility goes by the expiration date for insulin pens, and she had never came across one that was expired. During an observation of the medication cart of 100 hall on 6/3/25 at 10:30 AM with Unit Manager (UM) "RR" observed 2 additional Insulin pens that were dated as opened on 4/13/25 (51 days ago) and 5/1/25 (33 days ago). UM "RR" reported that the facility policy is to discard insulin pens 30 days after opening. UM "RR" reported that monitoring medication storage was a third shift task, but that every nurse should check dates prior to administering medications. UM "RR" reported that knowledge of when to discard insulin pens was taught in nursing school, and not part of the facility's orientation education. During an observation of medication administration on 06/03/25 at 08:46 AM a Anoro Ellipta inhaler (a medication that is inhaled into the lungs) was observed on the table in Resident #140's room. RN "EE" reported that it should be stored in the medication cart. During an observation of medication administration on 06/03/25 at 08:48 AM with RN "EE" reported that the medication cart is very disorganized and resident medication cards were		DON responsible for continued compliance.	

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	not alphabetized, nor were they separated by room. Review of the manufacturer guidelines for Lantus (insulin) dated 2018 revealed, "Do not use LANTUS after the expiration date stamped on the label or 28 days after you first use it." ©2018 sanofi-aventis U.S. LLC http://products.sanofi.us/lantus/lantus.html Resident #35 During an observation of medication administration on 06/04/25 at 09:15 AM on 400 hall, RN "KK" prepared medications for Resident #35. RN "KK" retrieved an Incruse Ellipta inhaler from the medication cart; the inhaler had no open date and indicated to discard after 6 weeks. RN "KK" reported she was not sure when the inhaler was opened. According to the manufacturer's guideline for "Incruse Ellipta" dated 8/23/23 revealed, "...Throw the inhaler away 6 weeks after opening..." Review of the facility policy "Medication Storage" dated 10/30/2020 revealed, "...It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations..." Review of the facility policy "Medication Administration" dated 10/30/2020 revealed "...1. Keep medication cart clean, organized, and stocked with adequate supplies...10. Review MAR to identify medication to be administered. 11. Compare medication source with MAR to verify...12. Identify expiration date..."			
F0813	Personal Food Policy §483.60(i)(3) Have a	F0813	Element 1	6/23/2025

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SS= D	policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to fully implement a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe storage and consumption. This deficient practice resulted in unknown discard dates and potentially hazardous foods being held passed their discard date, increasing the risk of contamination and food borne illness among residents who store personal food product in the facility. Findings include: During the initial kitchen tour with "Regional Registered Dietitian" (RRD) "MM" on 6/2/25 at 9:53 AM at the "Resident Refrigerator", the following was noted: prepared macaroni salad that was opened but not labeled with an opened or discard date; prepackaged apples with a "good through" date of 5/15/25; a bottle of sweet tea that was opened but not labeled with an opened or discard date; 2 bottles of thickened lemon water that were not labeled with an opened or discard date; and an opened bottle of ranch dressing that was not labeled with an opened or discard date. In an interview on 6/4/25 at 8:41 AM, RRD "MM" reported the resident refrigerator was the worst on Monday because of the weekend. RRD "MM" reported the Dietary Manager usually checked the refrigerator on Monday morning and discarded what was unlabeled or outdated. RRD "MM" reported items placed in the refrigerator		Items in the residents refrigerator that were not labeled or dated were discarded to include macaroni salad, apples, sweet tea, thickened lemon water, ranch dressing. Element 2 Residents who reside in the facility have the potential to be affected. No other shared resident refrigerators in the facility. Element 3 The Administrator and DON reviewed the Use and Storage of food brought in by family and visitors and deemed it appropriate. Policy reviewed at QAPI. Staff will be re- educated on the Use and Storage of food brought in by family and visitors policy by the Administrator/Designee Dietary will monitor refrigerator daily to ensure labeled and dated food. Element 4 The Administrator/ designee will audit residents fridge weekly to ensure all items are labeled and dated. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. Administrator is responsible for compliance.	

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	should be labeled with the resident name and discard date and opened items should have an opened and discard date. RRD "MM" reported the process needed to be tightened up a bit. Review of the policy "Use and Storage of Food Brought in by Family or Visitors" last revised 1/1/22 revealed, "Policy: It is the right of the residents of this facility to have food brought in by family or other visitors; however, the food must be handled in a way to ensure the safety of the resident. Policy Explanation and Compliance Guidelines ...2. All food items that are already prepared by the family or visitor brought in must be labeled with the content and dated ...b. The prepared food must be consumed by the resident within 3 days ..."			
F0880 SS= E	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	F0880	Element 1 Resident # 30 no longer requires EBP. Wound has healed. Orders and plan of care have been updated. Resident # 540 EBP sign is present on door, care plans and orders reviewed and reflect enhanced barriers. Resident # 37 no longer requires EBP. Wound has healed. Orders and plan of care have been updated. Resident # 33 Resident seen by physician for infection related to potential cross contamination All lifts cleaned and sanitized appropriately. Element 2 Current residents have the potential to be affected. Current infections reviewed to	6/23/2025

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	possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper infection control protocols and practices for 1. enhanced barrier precautions (EBP) for 3 residents (Resident #30, #540, #37) and 2. infection control practices with injections for 1 (Resident #33) and 3. soiled shared equipment		ensure no outbreak trends have occurred. Current residents in the facility with wound or medical indwelling devices have been assessed to ensure EBP are implemented including, signage, orders and care plans. Current residents receiving injections have been reviewed to ensure no ill effects from potential cross contamination. Element 3 The Administrator and DON have reviewed The infection Prevention and control Program, the EBP Guidelines and deemed them appropriate. Policies reviewed at QAPI. Staff will be re-educated by the DON/Designee on The infection Prevention and control Program with a focus on EBP, PPE standard precautions when giving injections Element 4 DON/Designee will complete 10 random audits of EBP signage and highlighting name plaque weekly x 4 weeks then monthly. DON/Designee will complete 10 random audits of staff use of PPE for residents with EBP weekly x 4 weeks and then monthly to ensure policies were followed. DON/ Designee will audit 5 staff for insulin injections weekly x 4 weeks and then monthly to ensure policies were followed. Audit findings will be presented to the facility	

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	from of total sample of 18 residents reviewed for infection control, resulting in the increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility. Findings include: Resident #30 Review of an "Admission Record" revealed Resident #30 was a male with pertinent diagnoses which included diabetes, heart failure, COPD, bipolar disorder, and mitral valve disorder. Review of current "Care Plan" for Resident #30, revised on 5/1/2025, revealed the focus, "...The resident is at risk for skin impairment related to hx (history) of wound to left heel which resolved...Resident frequently refused to wear heel protection boots..." Review of current "Care Plan" for Resident #30, revised on 6/2/2025, revealed, the focus, "...Resident requires enhanced barrier precautions related to pressure ulcer..." with no interventions. Review of "Skin & Wound Evaluation" dated 5/26/25, revealed, "...Pressure...Deep Tissue Injury...Left heel...In house acquired...length 0.3 CM x width 0.5 CM x depth < 0.1 CM...90% of wound covered...10% affected area covered with dermal tissue..." Review of "Skin Assessment" dated 6/3/25, revealed, "...Left heel...black/purple spot on heel..." During an observation on 06/03/25 at 08:56 AM, Resident #30 had a PPE bin and a sign on the wall outside of his room which indicated he was under EBP. This side was not present the		QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The NHA is responsible for achieving and sustaining compliance.	

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	previous day. In an interview on 06/03/25 at 11:53 AM, Registered Nurse (RN) "YY" reported Resident #30 had a wound on his heel and he had it prior to entry on 6/2/25. Resident #540 Review of an "Admission Record" revealed Resident #540 was a male with pertinent diagnoses which included right foot transmetarsal amputation (partial foot amputation where the bones of the forefoot (metatarsals) are removed while preserving the ankle joint and most of the foot's length: often performed as a limb saving procedure for conditions like infection, gangrene, or diabetic ulcers), cellulitis of right lower limb, foot drop-right foot, edema, and muscle weakness. Review of current "Care Plan" for Resident #540, revised on 5/22/25, revealed the focus, " ...Resident requires enhanced barrier precautions related to R (right) foot surgical incision..." with the interventions "...Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray...Utilize enhanced barrier precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis)...Review with visitors and family members how to follow the recommended precautions when visiting if prolonged physical contact is anticipated..." Review of current "Care Plan" for Resident #540, revised on 5/22/25, revealed the focus,			

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	"...Resident has impaired skin integrity as evidenced by (SPECIFY: wound type and location) related to..." with the interventions "...Administer treatment (s) per orders...Notify Nurse of any new areas of skin impairment noted during bathing or daily care...Notify physician/NP/PA of noted worsening skin condition or any new areas of skin impairment...Notify physician/NP/PA of signs/symptoms of infection..." Review of "Order" dated 5/7/25 for Resident #540, revealed, "...Use enhanced barrier while performing high-contact activity with the resident related to wounds. every shift..." Review of "Order" dated 5/12/25 for Resident #540, revealed, "...Patient to consult wound clinic due to worsening foot wound..." Review of "Order" dated 5/26/24 for Resident #540, revealed, "...TX: R (right) foot surgical site: Cleanse area with normal saline and blot dry. Apply Bacitracin Zinc Ointment to surgical site BID (twice a day). Leave open to air. Monitor area for any worsening s/sx (signs and symptoms) of skin integrity. Notify MD/NP of any s/sx of infection. every day and evening shift for RLE (right lower extremity) stump wound..." During an observation on 06/02/25 at 09:35 AM, a personal protective equipment (PPE) cart was observed placed along the wall outside Resident #540's room. There was no enhanced barrier precautions sign on the wall outside of the room to indicate enhanced barrier precautions were required when providing high contact resident care activities. During an observation on 06/02/25 at 10:16 AM, Resident #540 was seated on the side of his bed, he was dressed. Next to the recliner over on the			

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	far wall was placed a black trash bin traditional used for PPE when staff were finished providing high contact resident care activities. During an observation on 06/02/25 at 10:27 AM, Resident #540 was observed sitting on the side of his bed. Certified Nursing Assistant (CNA) "II" donned gloves and was observed entering Resident #540's room. CNA "II" went to his bed, grabbed the urinal hanging from the enabler bar on his bed, and went to the bathroom to empty it. CNA "II" did not don any other PPE prior to performing this care. CNA "II" doffed her gloves, grabbed the trash in his room, and performed hand sanitization as she exited the room. In an interview on 06/02/25 at 10:37 AM, Resident #540 reported he had to have his toes amputated, they were healing but "kinda slow." In an interview on 06/02/25 09:38 AM, Unit Manager (UM) "RR" reported for a resident who was on enhanced barrier precautions (EBP), the facility normally had a sign for EBP, and highlighted the resident's name which would indicate who had the precautions. UM "RR" reported it was a "team effort" for the placement of the EBP signs but the infection preventionist was the responsible person. When queried if staff had been providing high contact resident care activities for Resident #540 since his return from the hospital, she reported he had wounds and required hands on assistance, so it would be logical staff would have been providing care without PPE. UM "RR" reported the PPE carts were strategically placed and not necessarily for this room so if not the PPE bin wasn't present, staff and visitors would not know their were residents in the room under EBP. During an observation on 06/02/25 at 09:42 AM, observed UM "RR" place an Enhanced Barrier			

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	Precautions (EBP)sign on the wall outside the door for Resident #540's room. During an observation on 06/02/25 10:24 AM hoyer was observed outside of Room 303 in the the hallway, purple wipes, plastic bag. The blue grasp cover for residents had dried soiled material which was tan in color and appeared to be soiled with dried food and dirt. Resident #37 During an observation on 6/2/25 no signage was noted outside or around Resident #37's room indicating to staff that resident was in enhanced barrier precautions (EBP), and that personal protective equipment should been work during high contact care activities. Review of "Order Summary" for Resident #37 revealed " ...Use enhanced barrier precautions while performing high-contact activity with the resident every shift for wound care" with a start date of 3/31/2025. Review of "Care plan" for Resident #37 revealed no indication of enhanced barrier precautions use. Review of "Skin and Wound Evaluation" for Resident #37 dated 6/2/25 revealed "pressure ...stage 2- partial thickness skin loss with exposed dermis ...location-coccyx ...exact stated it began was 5/19/2025 ..." During an observation and interview on 6/3/25 at 4:20 pm "Licensed Practical Nurse" (LPN) "V" visualized Resident #37's wound dressing to be dry and intact, and repositioned Resident #37 in bed and adjusted her bed linens. LPN "V" was not wearing an PPE while providing care with Resident #37. LPN "V" reported she was assisting Resident #37 to reposition in bed, and she wanted			

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	to make sure Resident #37's dressing was still intact. LPN "V" reported she did not think that Resident #37 was in EBP. In an interview on 6/4/25 at 11:15 am "Unit Manger" (UM) "RR" reported Resident #37's wound was resolved, and she was not in EBP. In an interview on 6/4/25 at 11:21 am, "Registered Nurse" (RN) "BB" reported she was the wound nurse, and Resident #37 did have a wound on her coccyx. RN "BB" reported Resident #37 should be in EBP and that she should fix that. RN "BB" reported she was responsible for updating care plans, and confirmed Resident #37's care plan did not include EBP and that she would need to fix that too. Resident #33 During an observation of medication administration on 06/03/25 at 08:32 AM Registered Nurse (RN) "EE" prepared an insulin (used to manage blood sugar levels) injection (when a needle is used to administer medication) for Resident #33. The medication was labeled Lantus (a long acting insulin). Observed RN "EE" inject 10 units of the Lantus into Resident #33's right abdomen. RN "EE" did not use hand sanitizer prior to entering the room and did not wear gloves during the injection. In a subsequent interview on 6/3/25 at 8:35 AM, RN "EE" reported that she did not normally wear gloves with injections, nor did the person that trained her. Review of "Centers for Disease Control and Prevention" (CDC) dated March 20,2024, revealed, "...Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed			

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	to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities...EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing...EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO...Effective Date: April 1, 2024..." Review of Centers for Disease Control (CDC) poster for Enhanced Barrier Precautions, revealed, "...Enhanced Barrier Precautions: Everyone Must...Clean Their Hands, including before entering and when leaving a room...Providers and Staff Must Also...Wear Gown and Gloves for the following High Contact Resident Care Activities...Dressing...Bathing/Showering...Transferring...Changing linens...Providing hygiene...Changing briefs or assisting with toileting...Device care or use: central line, urinary catheter, feeding tube, tracheostomy...Wound Care: any skin opening requiring a dressing..."			
F0921 SS= E	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:	F0921	Element 1 Dish Machine area grout worn or missing grout fixed. Garbage disposal tiles secured with grout to eliminate moisture accumulation. In house maintenance treated area around dish machine to exterminate gnats near	6/23/2025

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	Based on observation, interview, and record review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living, affecting the following areas: Findings Include During a tour of the kitchen, at 8:48 AM on 6/3/25, observation of the dish machine area found worn and missing grout along portions of the back left floor juncture underneath the dish machine. Further review found multiple tiles pushed up from the floor underneath the garbage disposal allowing moisture to accumulate and create an environment conducing for the growth of insects and bacteria. Multiple gnats were found under the dish machine at this time. Mainly grouping around the unused floor drain and sections of the floor where grout is worn low, and water can accumulate and stagnate. An interview with Dietitian "SS", at 8:50 AM on 6/3/25, found that the exhaust for the dish machine has been down for some time and the facility is looking to replace it, but she's not sure where the repair is at this point. The surveyor noted the moisture accumulation in and around the dish machine area is being exacerbated by the fact there is no exhaust for the high temperature dish machine, which creates a large amount of steam and humidity. During a tour of the B hall shower room, at 11:11 AM on 6/3/25, with Maintenance Director (MD) "UU" and Housekeeping General Manager (HGM) "TT", it was found that a crusted white powder debris was found on the back top of the commode seat and further observation of the room found that no paper towels or holder was		kitchen drain. Contacted contracted pest control to add area to next service. Exhaust for the dish machine motor was replaced and functioning. B hall shower room debris on the back top of commode seat was cleaned, paper towel holder and paper towels were added to the shower room. D hall Shower bed was cleaned to remove trash, debris and dirt. Boxes of briefs in central supply were removed from the floor. Shelving in central supply room was removed and replaced with shelving with smooth, cleanable surface. C hall soiled utility room vinyl coving was secured with backing. D hall soiled utility room exhaust fan was repaired and functioning. Room 301 dried liquid on the tile floor and brown dried material on the wall was cleaned. Room 303 cobwebs in the corner of the window sills, corners of window and blinds were removed and window sill dusted. Cobwebs in the upper corner of the bathroom were removed. Room 303 scraps along the walls and baseboard repaired and threshold to the room stripped. Room 305 cobwebs on window sill and blind	

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	available in the shower room. An interview with MD "UU" found that there was a large renovation project in the shower room awhile back and they must not have installed a new paper towel holder when they were done. Observation of the shower bed found an accumulation of trash, debris, and white and brown staining underneath the shower mat stuck into the crevices and holes of the netting underneath. When asked who would typically take care of this area. HGM "TT" stated that care staff should be cleaning this area between residents. During a tour of the central supply room, off the service hall, at 11:28 AM on 6/3/25, it was observed that numerous boxes of briefs were found stored on the floor of the room. Further observation found that two newer shelving units were found with press-board racks that are not smooth and easily cleanable. During a tour of the C Hall Soiled Utility room, at 1:57 PM on 6/3/25, it was found that vinyl coving had fallen and was observed sunk back into the wall for portions of the perimeter of the room. Further observation found that coving was placed over areas with little to no backing to give structure or support to the coving. During a tour of the D Hall Soiled Utility room, at 2:11 PM on 6/3/25, it was found that no exhaust fan was working in the room. When asked if the whole hall would be out if this one exhaust was not working, MD "UU" stated the whole hall is connected to this one, so yes. During an observation on 06/02/25 at 10:37 AM, Room 301, bed 1 this writer observed on the floor along the side of the head of the bed, running over to the recliner was dried liquid on the tile floor, and it had brown outline to it. The wall next to the side of the bed had brown dried material		cleaned. Dirt and debris on the window sill cleaned. Cobwebs in the upper right corner of wall by head of the bed cleaned. Room 306 wall bead strip and screws secured to the wall, paint chips on the heater repaired and sides of heater repaired and cracks on the wall repaired. Element 2 All residents that reside in the facility have the potential to be effected. Kitchen was audited to ensure no missing grout. Concerns will be repaired. Kitchen tiles will be audited to ensure secured to eliminate moisture accumulation. Concerns will be repaired. Kitchen audit will be completed to ensure no other gnats. Concerns will be addressed. Exhaust in the kitchen audited to ensure functioning. Concerns will be addressed. 2nd shower room will be audited to ensure commode seats are clean, paper towel holder and power towels in place. Concerns will be addressed. Shower beds will be audited to ensure clean of trash, debris and dirt. Concerns will be addressed. Storage rooms will be audited to ensure no boxes on the floor. Shelving units in central supply will be audited to ensure shelving is a smooth and cleanable	

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	smeared on the wall. During an observation on 06/03/25 at 11:44 AM, this writer observed the floor in Room 301, bed 1 and it still had the dried spilled liquid on the floor by the side of the bed, and then flowing over to the recliner. The wall next to the side of the bed had brown dried material smeared on the wall. During an observation on 06/02/25 at 01:39 PM, Room 303 this writer observed the window in the room had cobwebs in the corner of the sills attached to his blinds, the window sill had not been dusted. There were cobwebs noted to be in the upper corner of the wall by the bathroom. During an observation on 06/03/25 11:45 AM, Room 303 still had cobwebs in the corners of the window. far right left corner of the window. The wall in the room had scraps along the walls and baseboard areas. The threshold to the room was dirty appearing and appeared to need to be stripped. During an observation on 06/02/25 at 02:00 PM, Room 305 this writer observed several cobwebs on his window sill which were attached to the blinds. There was dirt and debris on the window sill. As well as cobwebs in the upper right corner of his wall by the head of the bed. During an observation on 06/03/25 09:03 AM, Room 306 the wall bead strip came off and was leaning against the wall in the corner of the room by the window, the heater had chips of paint missing from the sides of the box, cracks on the wall. The front of the heater had paint missing scrapped off, and there were nails/screws in the wall where the strip was supposed to go. In an interview on 06/04/25 at 09:31 AM, Housekeeper "ZZ" reported when she entered a		surface. Concerns will be addressed. Coving in the utility rooms will be audited to ensure secured with backing. Concerns will be addressed. Exhaust fans will be audited to ensure functioning. Concerns will addressed. Resident rooms will be audited to ensure floors and walls are cleaned. Concerns will be addressed Resident rooms and bathrooms will be audited for cobwebs, dusty window sills, dirt and debris to window sills. Concerns will be addressed. Resident rooms will be audited to ensure wall bead strips are secured, heaters for paint chips and cracks on the wall. Concerns will be addressed. Element 3 The Administrator and DON reviewed the safe and homelike environment policy and deemed it appropriate. Policy reviewed at QAPI. Housekeeping staff was re-educated on the 5 and 7 step cleaning process. Staff educated on TELS system to enter facility maintenance needs that have been identified. Housekeeping staff will be re- educated on Resident/Patient Room Cleaning Policy, Restroom cleaning Policy, Linen Quality, Deep Cleaning Checklist, QCI Maintenance staff will be educated on TELS system, auditing kitchen grout/flooring,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394160	A. BUILDING _____ B. WING _____	**6/4/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	**2575 N DRAKE ROAD KALAMAZOO, MI 49006**

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	room she would do all the trash first, wipe all surfaces, such as the table, light and dust too the window sills and everything else, then she would sweep all the floors and mop. She reported when she dusted she would dust the light fixtures, tv, and the upper areas in the room. Housekeeper "ZZ" reported she would ensure the room was stocked with needed toiletry items as well. Housekeeper "ZZ" reported the housekeepers followed a 5 or 7 step procedure when they cleaned the rooms. She reported she had worked for the facility for several years as when she originally started she was trained to follow the steps she reported during the interview. She reported if the resident was in the room, the housekeepers would ask if they could clean the room and it would be noted on the checklist they were unable to clean the room. In an interview on 06/04/25 at 02:13 PM, Registered Nurse (RN) "KK" reported there was an electronic system for maintenance work orders so they would be assigned by maintenance for completion. If staff noticed a need for maintenance, they would complete an online work order for maintenance.		monthly pest control, exhaust fan checks and functioning, vinyl coving secured, timely repair of walls and paint. During daily rounds staff will report concerns. Element 4 The administrator/ designee will perform facility audits weekly x 4 weeks then monthly until sustained compliance of gnats, damaged tiles, grout, exhaust function, missing wall strip, cove base not secured chipped paint and damage to walls. The administrator/ designee will perform facility audits weekly x 4 weeks then monthly until sustained compliance of Shower bed cleanliness, debris on toilets, paper towel holder and paper towels available, resident rooms and bathrooms to ensure walls clean, lack of cobwebs to window sills, blinds and corners, blinds clean and dusted and debris removed from walls. The administrator/ designee will perform facility audits weekly x 4 weeks then monthly until sustained compliance of central supply for briefs on the floor, and smooth cleanable shelving. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The administrator is responsible for compliance.	