DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Evergreen Post Acute LLC

DATE SURVEY COMPLETED: April 17, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from April 8, 2025 through April 17, 2025. The deficiencies in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred thirty-five (135). The survey sample totaled forty-three (43) residents. **3201 Regulations for Skilled and Intermediate Care Facilities** **3201.1.0 Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed April 17, 2025: F550, F578, F582, F583, F584, F603, F623, F637, F641, F656, F657, F660, F676, F677, F684, F689, F690, F760, F761, F808, F812, F880, F881 and F883.	cross reference epoc	

Provider's Signature A Rooth, Nha Title Administrator Date 5.13.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD SMYRNA, DE 19977

(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
E 000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from April 8, 2025 through April 17, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from April 8, 2025 through April 17, 2025. The deficiencies in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one-hundred thirty five (135). The survey sample totaled forty-three (43) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; ADLs - Activities of daily living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Amputation - the intentional surgical removal of a limb or body part; Antecubital - before or in front of the elbow; Anterior - front surface of the body; Antibiotic stewardship - is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients; BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaaluating	F 000		

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

Electronically Signed | 05/15/2025

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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F 000	Continued From page 1	F 000		

cognition in the elderly. BIMS score of 0-7 is relective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition;
BP - Blood pressure;
BOM - Business Office Manager;
C- Contractor
CDC - Center for Disease Control;
CMS - Centers for Medicare and Medicaid Services;
CNA - Certified Nurse's Aide;
CCS - Corporate Clinical Support;
Contact precautions - series of procedures used to minimize the transmission of infectious organisms by direct or indirect contact, such as wearing gloves and a gown;
Continence - control of bladder and bowel function;
DA - Dietary Aide;
DelVax- a confidential online computer system used in Delaware by doctors, nurses, schools and practices to keep track of their patients/students immunizations;
Dermatologist - a physician who treats skin conditions;
DO - Doctor of Osteopathy;
DON - Director of Nursing;
EBP - enhanced barrier precautions;
EMR - electronic medical record;
EMT - emergency medical technician;
ER - emergency room;
ESBL - extended spectrum beta-lactamase, a MDRO bacteria that required Enhanced barrier precautions;
Fahrenheit (F) - temperature scale;
Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period;
FSD - Food Service Director;

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HR - heart rate;
Incontinence - loss of control of bladder &/or bowel function;
Interdisciplinary Team (IDT)- a coordinated group of staff from several different fields who work together towards a common goal or project;
IV - intravenous;
LOC - level of consciousness;
LPN - Licensed Practical Nurse;
MAR - Medication Administration Record;
MDRO - multidrug-resistant organisms;
MDS - Minimum Data Set, a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/medicaid nursing homes that evaluates functional capabilities and health needs;
mg - milligrams;
MRSA - methicillin-resistant Staphylococcus aureus, a MDRO that required enhanced barrier precautions;
NP - Nurse Practitioner;
O2 - supplemental oxygen;
PICC - peripherally inserted central catheter;
Posterior - back surface of the body; the back or behind;
POA - power of attorney;
RN - Registered Nurse;
SBAR - physician's communication tool;
Scabies - a highly contagious skin infestation caused by a tiny, burrowing mite;
SNFABN - Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage - notification of services not covered by Medicare;
S/P - status post;
SW - Social worker;
Terminal cleaning - the cleaning procedures used to control the spread of infectious diseases in a healthcare environment;
Toileting program - A toileting program typically

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F 000	Continued From page 3 consist of a patient-specific assessment of incontinence followed by a program of prompted voiding, habit retraining, and/or timed voiding as part of an individualized care plan; UM - Unt Manager; Urinary incontinence- inability to prevent accidental leakage of urine from bladder; UTI - urianry tract infection; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days; VS - vital signs.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §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.	F 550		6/3/25

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F 550	Continued From page 4 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R14) out of forty-three (43) residents in the investigative sample, the facility failed to ensure R14 was treated with respect and dignity. Findings include: 1. Review of R14's clinical record revealed: 12/13/20 - R14 was admitted to the facility. 4/8/25 8:34 AM - During an observation, E45 (CNA) knocked on R14's room door and entered the room without waiting for R14's response/permission to enter the room. 4/8/25 8:45 AM - During an observation, E44 (Central Supply) knocked on R14's room door and entered the room without waiting for R14's response/permission to enter the room. 4/8/25 9:01 AM - During an interview E44 (Central Supply) confirmed that the expectation is to	F 550	a. R14 has no adverse effect related to the deficiency; E45 was educated on resident rights related to knocking on resident room door and awaiting response before entering. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow appropriate protocol related to knocking and waiting for response/permission to enter the residents room. Staff Educator/Designee will re-educate all facility staff on requirement to await response/permission to enter residents room after knocking. d. Observations will be conducted to ensure that staff are awaiting residents to respond with permission to enter their	

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F 550	Continued From page 5 knock and wait for a response to enter a resident's room. E44 confirmed that she did not wait for a response before entering R14's room. 4/8/25 9:49 AM - During an observation, E45 knocked on R14's room door and entered the room without waiting for R14's response/permission to enter the room. 4/11/25 2:16 PM - During an observation, E45 knocked on R14's room door and entered the room without waiting for R14's response/permission to enter room. 4/11/25 2:21 PM - During an interview E45 (CNA) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E45 confirmed she did not wait for a response before entering R14's room.	F 550	room after employees knock. 5 daily audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		6/3/25

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F 578	Continued From page 6 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R641) out of the seven residents reviewed for advanced directives, the facility failed to ensure that R641's' representative was included in the advanced directive acknowledgment as R641 had cognitive impairment. Findings include: Review of R641's clinical record revealed: 7/5/24 - R641 was admitted to the facility. 7/11/24 - R641's admission MDS documented a BIMS score of 11, which was reflective of	F 578	a. R641 has no adverse effect related to the deficiency b. All residents have the potential to be affected by this deficient practice. Future residents at risk due to having cognitive deficits will be protected by the Social Services Director ensuring that the resident representative is involved in completing Advance Directive Acknowledgement Forms for residents with a BIMS lower than 12. c. Root cause analysis was conducted,	

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F 578	Continued From page 7 moderate cognitive impairment. 4/11/25 10:05 AM - A review of R641's EMR revealed that R641's face sheet listed F4 (R641's daughter) as the emergency contact #1. The EMR also contained documentation of a signed and notarized POA with two witnesses dated from 2006 that named F4 as the sole POA for both durable medical and financial issues. 4/11/25 10:25 AM - A review of R641's admission paperwork revealed that E6 (SW) completed the Advance Directive Acknowledgment form with R641 on 7/5/24. A review of the form revealed that R641 printed her name on the signature line using a different first name and mispelling her last name, leaving a letter out of it. 4/11/25 11:04 AM - During an interview, E5 (SW Director) stated, "For new admissions, we try to do the BIMS section of the MDS right away. If they come in during the evening, we try to do it the next day. A BIMS score for a person with cognitive impairment is 6 or 7. If they have a score of 10-11, then it is a judgment decision. We don't really have a cutoff score for when residents cannot make decisions. It is more of a judgment thing. There really is not any formal training for the BIMS test. It is a piece of paper that we follow. When filling out the Advance Directive Acknowledgement form, if they want more information about advanced directives, we get the ombudsman involved." 4/11/25 11:47 AM - During an interview, E2 (DON) stated, "Normally, if the BIMS score is below 12, we get the family representative or POA involved in signing the paperwork."	F 578	and it was found that staff did not follow the requirement to have resident representative included in the completion of the Advance Directive Acknowledgement Form for a resident with moderate to severe cognitive impairment. Social Services Director will re-educate all Social Services / Admissions staff on requirement to have resident representative included in the Advance Directive Acknowledgement Form for anyone with a BIMS score lower than 12. d. Advance Directive Forms for new admissions will be reviewed to ensure that if a resident is determined to have cognitive impairment by scoring below a 12 on the BIMS test, the resident representative is contacted and involved in completion of Advance Directive Form. Daily audits will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 578	Continued From page 8 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §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.	F 582		6/3/25

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F 582	Continued From page 9 (iii) If a 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 record review and interview, it was determined that for one (R188) out of four residents reviewed for Beneficiary Notification Review, the facility failed to ensure the resident was informed in advance of a change that occurred to their bill. Findings include: Review of R188's clinical record revealed: 5/2/24 - R188 was admitted to the facility. 6/1/24 - An Eligibility Verification Notice was provided to the facility by R188's insurance that indicated the resident had "0" days remaining for nursing home stay. 6/3/24 11:15 AM - A SNFABN notice was read over the telephone to R188's Responsible Party (RP)(R188's daughter) that explained beginning on 6/4/25 R188 and RP would be responsible to	F 582	a. The facility cannot retroactively correct this issue. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis conducted, and it was found that staff did not inform resident in advance of a change that occurred to their bill. Facility provided SNFABN on 6/3/2024 and billed resident from last date of coverage beginning 5/26/2024. Administrator will re-educate Business Office Manager that 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,	

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F 582	Continued From page 10 pay out of pocket for the R188's facility stay. The notice was completed by E5 (SW) and witnessed by E6 (SW). 4/11/25 8:15 AM - During an interview, E4 (BOM) confirmed that R188 and RP were not made aware of the change in billing in advance. E4 explained that the facility was made aware of R188's change in coverage on 6/3/24 and provided the SNFABN notice that same day, then charged R188 from the last date of coverage 5/26/24. 4/11/25 9:00 AM - A statement of the same date was provided to the surveyor by E4 (BOM) that indicated R188 was billed from 5/26/24 - 5/31/24 $506.00/day = $3036.00. Then billed 6/1/24 -6/3/24 $506.00/day = $1518.00 for room and board. The statement contained a projected write off of the bill dated 4/30/25. E4 stated she contacted corporate that morning and that R188 and RP would no longer be responsible for the bill. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 582	ensuring that advanced notice of a change in residents bill is provided prior to charges incurring. d. SNFABN notices will be reconciled with Billing Office to ensure that residents are informed in advance of changes in coverage prior to being billed. Daily audits will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		6/3/25

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F 583	Continued From page 11 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on a random observation and interview, it was determined that for four (R37, R69, R72, and R133) residents, the facility failed to protect personal privacy. Findings include: 4/10/25 11:08 AM - A random observation of the staff charting station on Sierra Unit with a monitor displaying resident's protected health information: - R37's admission date, admitting diagnoses, and birthdate. - R69's admission date, admitting diagnoses, and birthdate. - R72's admission date, admitting diagnoses, and	F 583	a. The facility cannot retroactively correct the issue. b. All residents PHI have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow requirement to close and lock computer screens at charting station to prevent residents personal protected health information from being visible to others. Staff Educator/Designee will re-educate	

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F 583	Continued From page 12 birthdate. - R133's admission date, admitting diagnoses, and birthdate. 4/10/25 11:10 AM - During an interview with E3 (ADON), it was confirmed that a charting station monitor was left open, displaying R37's, R69's, R72's and R133's personal protected health information (PHI). The information was visible to anyone passing by the monitor. E3 took immediate action to close the screen and secure the PHI. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 583	all facility staff on requirement to close and lock computer screens at charting stations when not in use that can be visible to others. d. DON/Designee will conduct random observational rounds of charting stations in building once daily to ensure PHI is not visible when not in use. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/3/25

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F 584	Continued From page 13 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two out of three resident units the facility failed to provide a clean and homelike environment. Findings include: 4/15/25 10:23 AM - During an observation in room 316 Seaside Unit, the bathroom door frame had multiple areas of chipped paint. The wall to the right of the bathroom had several scrapes and an exposed metal plate was observed on the left corner of the bathroom wall. 4/15/25 10:32 AM - During an observation in room 317 Seaside Unit, the wall to the right of the bathroom had multiple scrapes and black marks.	F 584	a. Chipped paint and exposed metal in Room 316 have been repaired. Wall to the right of bathroom in room 317 has been repaired. Wall in room 318 facing the toilet has been repaired. Room 104 bathroom door frame and wall to the right of bathroom has been repaired. Room 108 bathroom door frame and wall to the right of the bathroom has been repaired. Tiles missing in Sierra unit tub room have been replaced and grout on floor has been cleaned to remove dark black substance. E7 was educated to report any areas of environmental concerns to appropriate party. E8 was educated on following up timely on any environmental	

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F 584	Continued From page 14 4/15/25 10:41 AM - During an observation in room 318 Seaside Unit, the bathroom wall facing the toilet had two areas of missing plaster just above the baseboard. 4/15/25 10:52 AM - During an interview, E7 (CNA) stated she has worked on the unit for five years and was aware of the rooms in question the needed repairs. When asked how long the rooms have been in a state of disrepair? E7 responded "way over six months close to a year." 4/15/25 11:05 AM - During an interview, E8 (Maintenance Director) confirmed the repairs in rooms 316, 317, and 318. E8 revealed they did the hallway repairs first. When asked how long he had been aware of the repairs in resident rooms, E8 responded "it's been a long time, close to a year." 4/16/25 2:50 PM - During an observation in room 104 Sierra Unit, the bathroom door frame had multiple areas of chipped paint.The wall to the right of the bathroom had several areas of missing plaster and multiple scrape marks. 4/16/25 2:55 PM - During an observation in room 108 Sierra Unit, the bathroom door frame had multiple areas of chipped paint.The wall to the right of the bathroom had several areas of missing plaster and multiple scrape marks. 4/16/25 3:02 PM - During an interview, E8 demonstrated how to retrieve work orders. E8 stated that any staff member can place a work order online. E8 also maintains a worklog on his cell phone and confirmed there are no current orders for painting or repairs to resident rooms.	F 584	repairs required. b. All residents have the potential to be affected by this practice. c. Root cause analysis was conducted, and it was found that timely identification and repair of damage to walls and to bathroom tile was not completed. Maintenance staff will conduct environmental rounds weekly to identify and address any walls or bathroom tile in need of painting or repair. Work orders will be reviewed by Director of Maintenance to assure any repairs needed are addressed. d. Maintenance Director will round weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for a minimum of 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	

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F 584	Continued From page 15 4/10/25 2:20 PM - An observation of the Sierra unit tub room noted tiles missing on shower floor approximately 3"L x 4"W, a dark black substance noted in the grout of tile on the floor, and dirt and debris noted all over floor close to entrance. 4/11/25 10:04 AM - An observation of the Sierra unit tub room noted tiles missing on shower floor approximately 3"L x 4"W and a dark black substance noted in the grout between the tiles on the floor. 4/14/25 11:45 AM - An observation of the Sierra unit tub room noted tiles missing on shower floor approximately 3"L x 4"W and a dark black substance noted in the grout between the tiles on the floor. 4/15/25 1:45 PM - An observation of the Sierra unit tub room noted tiles missing on shower floor approximately 3"L x 4"W and a dark black substance noted in the grout between the tiles on the floor. 4/16/25 9:43 AM - In an interview with E43 (Housekeeping) confirmed that the tub room is cleaned daily and sometimes twice daily. E43 confirmed the tiles have been broken and maintenance has been notified. Additionally, E43 confirmed the dark substance noted in the grout of the tiles on the floor. 4/16/25 9:49 AM - In an interview with E42 (Maintenance) confirmed that no work order was in the system regarding the missing tiles to be replaced in the Sierra Unit tub room. E42 stated he will take care of it today. 4/17/25 1:45 PM - Findings were reviewed with	F 584		

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F 584	Continued From page 16 E1 (NHA) and E2 (DON).	F 584		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews, for one (R112) out of five sampled for abuse, it was determined that R112 was not free from involuntary seclusion. Findings include: Cross refer F684 and F880. Review of R112's clinical record revealed: 7/30/24 - R112 was admitted to the facility. 8/18/24 - A SBAR (physician's communication tool) documented that R112 had a rash on both arms and upper thighs. 8/18/24 3:15 PM - A nursing skin observation tool documented R112 had the following skin conditions noted: right antecubital rash, left	F 603	a. R112 is no longer at facility. b. All residents have the potential to be affected by this deficient practice. At the time of review all residents were free from involuntary seclusion as evidenced by no residents having orders for contact isolation. Future residents at risk, due to being on isolation, will be protected from involuntary seclusion by the facility ensuring that isolation precaution timeframes align with CDC recommendations. c. Root cause analysis was conducted, and it was found that resident R112 was placed on contact isolation precautions for scabies due to clinical presentation longer	6/3/25

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F 603	Continued From page 17 antecubital rash, bilateral thighs front. 8/27/24 - A care plan documented that R112 "was placed on isolation precautions related to scabies". 8/27/24 3:12 PM - A physician's order documented that R112 was on "contact isolation" due to scabies for fourteen days. R112's 8/24 MAR documented that Ivermectin oral tablets and Permethrin external cream for scabies were started on 8/29/24. 9/3/24 - A physician (C5 NP) progress note documented that R112 was seen and examined for a scabies. C5 documented for R112 to continue on Permethrin external cream to skin at bedtime for seven days, then for two days a week, and to continue isolation precautions. 9/16/24 - A physician (C5 NP) progress note documented that R112 requested to be seen and wanted to be taken off isolation precautions. The progress note documented that the rash to upper extremities had resolved and that the rash was now on lower extremeties and inner thighs. E21 documented for R112 to continue on Permethrin external cream and added benadryl and hydrocortisone creams regimen for itching. R112 was to continue on contact isolation precautions. 10/4/24 - A physicians (C5) progress note documented R112 was seen for a follow up for scabies and that a new linear rash was noted on his abdomen. It was noted that the rash had improved with the applications of Permethrin cream. R112 was to continue on isolation precautions.	F 603	than CDC guidelines recommend. DON/designee will educate Infection Preventionist on requirement to review all residents on isolation and collaborate with the physician to ensure that isolation are based on CDC recommendations. d. Isolation orders will be reviewed daily by DON/designee for clinical indication and adheres to CDC recommendations. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 603	Continued From page 18 11/9/24 - A physicians order was written for R112 to have a consult with dermatology related to scabies. 11/13/24 - A physician progress note documented that R112 was seen for a follow up post dermatology consult, and dermatology diagnosed R112 with atopic dermatitis (generalized rash). Per dermatology, R112's rash was unrelated to scabies and contact isolation discontinued per order. 4/8/25 6:48 AM - An interview with R112 revealed that R112 was on contact isolation for 78 days related to "a misdiagnosed scabies outbreak." R112 stated "I felt like a prisoner being confined to this room all that time and no one would listen to me until I saw the dermatologist." R112 stated that he did not receive showers until sometime in October. 4/14/25 10:48 AM - An interview with E38 (CNA) confirmed that R112 was on isolation precautions and unable to shower from August 27, 2024 to October 16, 2024. 4/15/25 10:30 AM - During an interview with C2 (NP) and C5 (NP), C2 stated that the providers do not determine how long a resident is on isolation precautions, that the facility mandates the timeframe. C2 and C5 confirmed that they did not refer to the CDC guidelines for the treatment of scabies for R112. Additionally, C2 stated that R112 had requested a meeting with the providers to discuss why he was still on isolation precautions, and C2 confirmed that once R112 was seen by dermatology, that R112's isolation precautions were removed.	F 603		

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F 603	Continued From page 19 4/15/25 11:12 AM - An interview with E1 (NHA) confirmed that the process of determining isolation precautions is a collaborative effort between the IDT team which includes input from the physician's, management, and the infection control preventionist. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 603		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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. 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-	F 623		6/3/25

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F 623	Continued From page 20 (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 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	F 623		

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F 623	Continued From page 21 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(k). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R79) out of five residents reviewed for hospitalizations, the facility failed to notify R79's responsible party in writing of the reason for transfer to the hospital. Findings include: Review of R79's clinical record revealed:	F 623	a. Hospital transfer was reviewed with responsible party for R79 and a copy of the notification form was mailed. b. All residents have the potential to be affected by this deficient practice. Transfer forms will be reviewed verbally, and a copy will be provided to residents or mailed to resident representative if the	

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F 623	Continued From page 22 11/6/20 - R79 was admitted to the facility, with diagnoses including but not limited to, dementia. 4/1/25 - R79's quarterly MDS documented a BIMS score as three, which reflected severe cognitive impairment. 4/5/25 9:38 PM (Saturday) - E9 (LPN) documented in R79's EMR progress note, "...Resident vomited again a large amount of brown colored vomit. Resident with change in LOC ...order to send to ER via 911...Emergency contact [F1] notified." 4/14/25 1:32 PM - A review of R79's EMR revealed F1 (R79's responsible party) was listed as the "Emergency Contact #1." 4/15/25 10:14 AM - A review of R79's transfer notice, dated 4/7/25 (Monday) and signed by E10 (Admissions Director), failed to document to whom the notice of transfer was presented. 4/15/25 12:03 PM - During an interview, E10 stated, "The bed hold and transfer/discharge notification form is housed in the social work department. They fill in the form and print it out. I then call the family member and make sure they know the resident has left the facility. I go over the bed hold policy based on their insurance. I date and time the notification and it gets scanned I to the resident's EMR ... No, I don't mail the notification form to the family member." The facility failed to notify in writing R79's transfer to the hospital. Additionally, E10 confirmed that a copy of the notification form was not mailed to R79's responsible person. Additionally, the notification scanned into R79's EMR stated	F 623	resident has a cognitive impairment. The Admission Director will verbally review and notate on the transfer notice the detailed, specific reason for transfer. The Admission Director will notate on the transfer notice the name of whom the notice of transfer was presented to. c. Root cause analysis was conducted, and it was found that staff did not follow policy and indicate on the notice of transfer who it was presented to and notify the residents responsible party in writing of transfer to the hospital. Staff Educator/Designee will re-educate the Admission Department of requirement to notify responsible person in writing when residents are transferred to the hospital. Transfer notice has been updated to require documentation of whom the notice of transfer was reviewed with and how written copy was provided, if in person or by mail. d. Transfer notices will be reviewed daily by Admissions Director to ensure that the responsible party is notified in writing and that the name of the person who the form is reviewed with it is documented. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 623	Continued From page 23 "reason for transfer/discharge: ER". R79 was transferred to the hospital 4/5/25 for change in LOC and vomiting large amounts of brown secretions. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R136) out of forty-three sampled residents, the facility failed to complete a comprehensive assessment after R136 had a significant change in status. Findings include: Review of R136's clinical record revealed: 11/7/24 - R136 was admitted to the facility. 12/6/24 - R136 was admitted to hospice care. 1/2/25 - C2 (consultant NP) entered an order into	F 637	a. The facility cannot retroactively correct the issue. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that lack of communication amongst interdisciplinary team led MDS staff to not follow policy and complete a comprehensive assessment after R136 was admitted to hospice care.	6/3/25

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F 637	Continued From page 24 R136's EMR, "Hospice [local hospice service] every shift." This was twenty-seven days after R136 was admitted to a hospice service. 4/9/25 1:44 PM - A review of R136's EMR MDS schedule revealed there was no significant change MDS completed within fourteen days of R136's hospice admission. 4/10/25 11:02 AM - In a telephone interview, C1 (hospice office staff) confirmed. [R136] was admitted to our hospice service on 12/6/2024." 4/10/25 11:27 AM - During an interview, E4 (Business Office Manager) confirmed, "[R136] went on hospice care on 12/6/24." 4/10/25 1:23 PM - During an interview, E11 (RNAC) confirmed that R136's MDS for a significant change was completed on 1/3/25, as soon as the MDS office became aware that R136 was placed on hospice services. "We were not aware of the change. We did the mandatory MDS assessment as soon as we were notified." 4/11/25 9:36 AM - Review of the Ombudsman Transfer/Discharge list for December 2024 revealed R136 was listed as converting to hospice on 12/6/24. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 637	Residents admitted to hospice services will be reviewed during daily morning meeting to assure IDT is aware of services so that a comprehensive MDS assessment can be completed timely as per requirement. d. Residents admitted to hospice services will be reviewed by RNAC to ensure that comprehensive assessment is completed within 14 days of hospice admission. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		6/3/25

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F 641	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined for two (R40 and R50) out of forty-three sampled residents, the facility failed to ensure the MDS was accurate. Findings include: 1. Review of R40's clinical record revealed: 12/15/15 - R40 was admitted to the facility. 9/10/24 - A quarterly MDS assessment documented R40 was experiencing verbal behavioral symptoms directed towards others for one to three days during the review period. 9/2024 - A CNA behavioral flow sheet documented R40 had behaviors for five days from 9/3/24 to 9/10/24. 12/10/24 - A quarterly MDS assessment documented R40 was experiencing verbal behavioral symptoms directed towards others for one to three days during the review period. 12/2024 - A CNA behavioral flow sheet documented R40 had behaviors for five days from 12/3/24 to 12/10/24. 4/17/25 10:15 AM - During an interview, E46 (RN) confirmed that R40 had an increase in verbal behaviors specifically during shift change prior to R40 moving to a different unit. 4/17/25 10:30 AM - During an interview, E5 (SW) confirmed that the MDS data was not accurate for R40 during the September 2024 and December 2024 review.	F 641	1. a. MDS was modified for R40 to accurately reflect behavioral documentation. b. All residents with behaviors have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that documentation on behavioral flow sheet was not accurately reflected on MDS assessment. Staff Development/Designee will conduct training for SW staff on importance of accurately transferring information from behavioral flow sheet onto the MDS. d. All new quarterly MDS assessments will be reviewed by SW to ensure that behaviors documented on CNA behavioral flow sheet are accurately documented on MDS. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. MDS was modified for R50 to accurately reflect behaviors documented. b. All residents with behaviors have the potential to be affected by this deficient	

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F 641	Continued From page 26 2. Review of R50's clinical record revealed: 7/25/23 - R50 was admitted to the facility. 10/15/24 - A quarterly MDS assessment documented that R50 was experiencing physical behavioral symptoms towards others and other behavioral symptoms not directed at others for one to three days during the review period. 10/2024 - A CNA behavioral flow sheet documented R50 had behaviors for five days from 10/8/24 to 10/15/24. 1/15/25 - A quarterly MDS assessment documented that R50 was experiencing behaviors on zero days during the review period. 1/2025 - A CNA behavioral flow sheet documented R50 had behaviors for four days from 1/8/25 to 1/15/25. 4/17/25 10:30 AM - An interview with E5 (SW) confirmed that the MDS data was not accurate for R50 during the October 2024 and January 2025 review. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 641	practice. c. Root cause analysis was conducted, and it was found that documentation on behavioral flow sheet was not accurately reflected on MDS assessment. Staff Development/Designee will conduct training for SW staff on importance of accurately transferring information from behavioral flow sheet onto the MDS. d. All new quarterly MDS assessments will be reviewed by SW to ensure that behaviors documented on CNA behavioral flow sheet are accurately documented in MDS. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		6/3/25

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F 656	Continued From page 27 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

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F 656	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record reviewed and interview it was determined that for one (R196) out of forty-three residents sampled, the facility failed to ensure the person centered care plan included necessary interventions. Findings include: The facility policy on dialysis care last updated, January 2025 indicated, "The nurse will monitor and document the status of the resident's access site." Review of R196's clinical record revealed: 2/15/25 - R196 was admitted to the facility with multiple diagnoses including kidney disease. 2/16/25 - A task was added to R196's physicians orders for blood pressure medications for staff not to obtain blood pressures on the resident's right arm. 2/18/25 - A care plan was created for R196's renal disease. Interventions for the care plan included dialysis twice a week, monitor lab and report abnormal results, observe for and report any signs of infection/leaking/dislodgement of dialysis catheter and record weights and report changes. There was no evidence that the care plan included an intervention to avoid blood pressures to the right arm due to the dialysis catheter. 2/21/25 - An admission MDS assessment documented that R196 received dialysis. 4/17/25 4:26 PM - During an interview E2 (DON) confirmed the finding.	F 656	a. R196 no longer resides at the facility. b. All care plans for residents currently receiving dialysis have been reviewed to ensure that any precautions required for obtaining blood pressure are care planned appropriately. c. Root cause analysis was conducted, and it was found that staff did not update the care plan to reflect physician order and task to not obtain blood pressure from residents right arm. Staff Development/Designee will conduct training for nurse managers on the importance of accurately care planning precautions required for obtaining blood pressure for dialysis patients. d. All care plans for residents receiving dialysis will be reviewed by DON/Designee to ensure precautions required for obtaining blood pressure are care planned. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 656	Continued From page 29 4/17/25 5:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five residents (R91, R119, R120, R130, and R440) out of forty three	F 657	1. a. The care plan for R440 has been updated to reflect that he does not comply	6/3/25

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F 657	Continued From page 30 sampled residents, it was determined that for R440 and R130 the facility failed to implement care plan interventions. For R12, the facility failed to hold a quarterly care plan meeting. For R91, R119, and R120 the facility failted to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: 1. Review of R440's clinical record revealed: 4/1/25 - R440 was admitted to the facility with the diagnosis of syndrome of inappropriate antidiuretic hormone secretion (a condition in which high levels of a hormone cause the body to retain water). 4/2/25 3:00 PM - A physician's was order written for R440 that documented "Fluid restriction 1200 milliters a day." 4/2/25 - R440's care plan that was initiated on 4/2/25 documented "potential/alteration in nutritional status r/t (sic) need for mechanically altered, fluid restricted diet." The care plan lacked evidence the resident was resistive to the physician's order for a fluid restrictive diet. 4/8/25 10:09 AM - An observation revealed that R440 had a water pitcher sitting on the nightstand next to the bed filled with ice water, and a large drinking mug sitting on the over bed table next to R440's bed filled with liquid. [R440] stated, "oh that has Gatorade in it." 4/9/25 8:53 AM - A second observation revealed that R440 had a water pitcher and two other large drinking mugs at the bedside.	F 657	with fluid restrictions. b. All care plans for residents on fluid restrictions have been reviewed by dietician and updated as needed to accurately reflect residents known compliance. c. Root cause analysis was conducted, and it was found that nurse management failed to care plan R440s noncompliance with fluid restriction order. Staff Development/Designee will conduct training for nurse management staff on importance of care plan accurately reflecting noncompliance when residents chose to not adhere to fluid restriction orders. d. All new orders for fluid restriction will be reviewed by dietician, if resident is identified as not willing to comply with fluid restriction order, care plan will be reviewed to ensure non compliance with fluid restriction is documented. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. The care plan for R130 has been updated to show that she does not comply with allowing staff to provide nail care.	

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F 657	Continued From page 31 4/9/25 9:15 AM - An interview with E16 (RN, UM) confirmed that R440 does not comply with fluid restrictions. E16 stated, "[R440's] wife brings in additional fluids for him, we have educated them we are keeping a close eye on it and I'm going to check to see if the care plan was updated to reflect this problem, if not I'm updating it now, we are going to stay on top of that." 4/9/25 - R440's care plan, revised 4/9/25, documented "resistive/noncompliant with treatment/care related to disbelief in value of treatment (resident and family has been educated numerous times on risks associated with not following fluid restrictions) interventions included "provide education about risks of not complying with therapeutic regimen, provide education to patient/family." Cross Refer, F677 example 1 2. Review of R130's clincial record revealed: 3/7/25 - R130 was admitted to the facility. 3/10/25 - A review of R130's care plan for ADL self-care deficit documented "[R440's] will be clean, dressed and well-groomed daily to promote dignity and psychosocial wellbeing for ninety days. R440's interventions included assist with daily hygiene, grooming, dressing, oral care, and eating as needed." 3/13/25 - R130's admission MDS assessment documented the resident was severely cognitively impaired and required substantial maximum assistance for personal hygiene and grooming. 4/8/25 9:26 AM and 4/11/25 11:07 AM -	F 657	b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that nurse management failed to care plan R130s noncompliance with allowing staff to provide nail care. Staff Development/Designee will conduct training for Licensed nursing staff on the importance of addressing on care plan noncompliance with allowing staff to provide nail care. d. Random audits of care plans for residents refusing nail care will be done by DON/designee. Audits will be completed on 5 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 3. a. The facility cannot retroactively correct the issue. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy for care conference attendance or input to include physician, RN, CNA and dietary staff. Staff Development/Designee will conduct training for Social Services department to	

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F 657	Continued From page 32 Observations confirmed that R130's nails on both hands were long, with dark encrusted debris underneath each nail. E16 (RN UM) confirmed that R130 needed nail care. 4/11/25 11:07 AM - E16 (RN UM) stated "Well last week the CNA was trying to do [R130's] nail care and she ecame combative so it couldn't get done." E16 also confirmed R130's ADL care plan had not been revised to reflect refusal of nail care. E16 stated, "No she has not been care planned for refusing nail care." 3. Review of R119's clinical record revealed: 5/13/24 - R119 was admitted to the facility. 5/20/24 - An admission MDS was completed. 5/22/24 - The admission Resident Care Conference Attendance Sheet for R119's post admission care plan meeting lacked evidence of attendance or input from a physician, a registered nurse, a CNA, or dietary staff. 4/17/25 8:34 AM - In an email communication, the surveyor notified E1 (NHA) and E2 (DON) that there was a lack of evidence of input by all IDT members at the initial care plan meeting. E1 responded that the facility will "ensure participation from these parties immediately and ongoing in all care plan meetings, including the initial meetings. " 4. Review of R120's clinical record revealed: 5/14/24 - R120 was admitted to the facility. 5/20/24 - An admission MDS was completed.	F 657	ensure that care plan meetings include attendance or input from a physician, RN, CNA and dietary staff. d. Social Services Director will review all Care conference Attendance Sheets to ensure that care plan meeting includes input from a physician, RN, CNA and dietary staff. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 4. a. The facility cannot retroactively correct the issue. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy for care conference attendance or input to include physician, RN, CNA and dietary staff. Staff Development/Designee will conduct training for Social Services department to ensure that care plan meetings include attendance or input from a physician, RN, CNA and dietary staff. d. Social Services Director will review all Care conference Attendance Sheets to ensure that care plan meeting includes input from a physician, RN, CNA and	

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F 657	Continued From page 33 5/20/24 - The admission Resident Care Conference Attendance Sheet for R120's post admission care plan meeting lacked evidence of attendance or input from a physician, a registered nurse, a CNA, or dietary staff. 4/17/25 8:34 AM - In an email communication, the surveyor notified E1 (NHA) and E2 (DON) that there was a lack of evidence of input by all IDT members at the initial care plan meeting. E1 responded that the facility will "ensure participation from these parties immediately and ongoing in all care plan meetings, including the initial meetings. " 5. Review of R91's clinical record revealed: 2/27/25 - R91 was admitted to the facility. 3/5/25 - An admission MDS was completed for R91. 3/7/25 10:00 AM - The admission Resident Care Conference Attendance Sheet for R91's post admission care plan meeting lacked evidence of attendance or input from a physician, a CNA, or dietary staff. 4/14/25 11:57 AM - An interview with E5 (SW) confirmed that all members of the interdisciplinary team were not present or provided input on 3/7/25 for R91's care plan meeting. E5 confirmed input from the physician, CNA, and dietary was not provided. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 657	dietary staff. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 5. a. The facility cannot retroactively correct the issue. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy for care conference attendance or input to include physician, CNA and dietary staff. Staff Development/Designee will conduct training for Social Services department to ensure that care plan meetings include attendance or input from a physician, CNA and dietary staff. d. Social Services Director will review all Care conference Attendance Sheets to ensure that care plan meeting includes input from a physician, CNA and dietary staff. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any	F 660		6/3/25

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F 660	Continued From page 35 referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R188) out of three residents reviewed for discharge the facility failed	F 660	a. The facility cannot retroactively correct the issue.	

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F 660	Continued From page 36 implement a discharge planning process that prepared the resident/RP to effectively transition to post-discharge care. Findings include: The facility policy on transfer and discharge undated indicated, "Anticipated transfers or discharges - A post discharge plan of care that is developed with the participation of the resident and the residents representative which will assist the resident to adjust to his or her new living environment." Review of R188's clinical record revealed: 5/2/24 - R188 was admitted to the facility. 5/3/24 - A care plan for discharge documented that R188 expressed wish for discharge to home. 5/3/24 12:34 PM - A social work progress note written by E6 (SW) in R188's clinical record documented, "Resident is short term care at our facility. Resident will be discharged back to prior living arrangement once therapy is completed." The note did not document R188's actual discharge date. 5/9/24 - An admission MDS assesment documented that R188 was admitted with plans to discharge to the the community. 6/1/24 - An Eligibility Verification Notice was provided to the facility by R188's insurance that indicated the resident had "0" days remaining for nursing home stay as of 5/26/24.. 6/3/24 11:15 AM - A SNFABN notice was read over the telephone to R188's RP.	F 660	b. All residents being discharged have the potential to be affected by this deficient practice. c. Root cause analysis conducted, and it was found that staff notified resident and family member on 6/3/24 of scheduled discharge for 6/4/24, allowing only 24 hours to prepare for anticipated transfer home. Administrator will re-educate Social Services Staff that 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, ensuring that for anticipated discharges home a discharge plan of care is developed with participation of the resident and their representative to assist with adjusting to new living environment. d. SNFABN notices will be reviewed by Social Services Director to ensure that residents are informed in advance of changes in coverage and a discharge plan of care is developed with resident and resident representative for anticipated discharges. Daily audits will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 660	Continued From page 37 6/3/24 11:52 AM - A social work progress note in R188's clinical record written by E5(SW) documented, "[R188] had his discharge plan meeting today with the interdisciplinary team along with [responsible party]. E5 (SW) informed resident and family member of 100th day 5/26/24... SW also inform resident and family member the facility just notified of discharge to home on 6/4/24 for the resident. SW also informed resident and family member of private pay cost of $506.00. Family member and resident have refused to pay private rate. SW did inform resident and family once bill has been received call the number to file a dispute." 6/4/24 - A discharge return not anticipated MDS assessment was completed for R188 that documented the discharge was planned. 4/10/25 2:38 PM - During an interview E5 (SW) confirmed that R188 and their RP were notified of their discharge date on 6/3/24 giving one day to prepare for R188's transfer home. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 660		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		6/3/25

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F 676	Continued From page 38 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record reviews it was determined that for one (R132) out of one resident reviewed for communication the facility failed to provide assistive devices to support communication for R132 who was fluent only in Spanish. 3/8/25 - R132 was admitted to facility for rehabilitation.	F 676	a. R132 has been provided with a communication board at bedside and her direct care staff have been educated on how to use the language line. b. All residents with communication deficit due to language have been identified and communication boards and instructions for language line have been placed at their bedside.	

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F 676	Continued From page 39 3/8/25 - The care plan documented that R132's participation in activities was limited due to a language barrier, as the resident was fluent only in Spanish. R132 had difficulty communicating, as evidenced by a limited understanding and use of English. The care plan goal was to facilitate communication through alternative methods, such as a communication board, to express needs and wants. Interventions included teaching R132 how to use a communication book/board or electronic device and utilizing a Spanish interpreter as needed. 3/10/25 - A baseline care plan documented Spanish as the primary language for R132. 3/10/25 - A physician's order for speech therapy evaluation and treatment 1-3x per week for 41 days for dysphagia therapy and group therapy as indicated. 3/17/25 - An admission MDS documented that R132 has the ability to understand others and be understood by others adequately. 4/8/25 10:01 AM - An observation of R132 interacting with E49 (LPN) revealed R132 can speak very little and broken English using hand gestures to communicate her needs. 4/8/25 10:05 AM - During an interview with E49 (LPN) when asked how staff communicates with R132, E49 stated that staff sometimes use a translation app on their personal cell phones to attempt communication with R132 or call the resident's representative, (F7), to assist with translation when needed. E49 was unaware of whether the facility had a language line available for staff to use when communicating with	F 676	c. Root cause analysis conducted; it was determined that the interventions care planned for communication for resident who was fluent only in Spanish were not used consistently. Staff educator will conduct training for direct care staff on importance of using assistive communication devices and language line for residents with language barriers. d. DON/designee will conduct random audit of residents with language barriers to assure that communication devices or language line is utilized by staff. Daily audits will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 676	Continued From page 40 residents who do not speak English. 4/9/25 3:15 PM - An observation of R132's room with no communication board and an activities calendar printed in English hung on her wall. 4/9/25 3:28 PM: During an interview, E33 (Guest Services) stated that a daily bulletin is delivered to the bedside each morning listing available food options and daily activities. E33 also showed the surveyor a binder kept in the bedside table drawer that lists food choices residents can select from. The binder provided to R132 was in English. 4/11/25 10:11 AM - During an interview, C9 (Speech Therapist Contractor) reported that a phone interpreter service was used to conduct the assessments. The printed swallow study instructions provided to the patient were in Spanish, and a communication board (pictures, spanish and english) was also given to assist with understanding. C9 noted that she collaborated with dietary services for R132's. 4/11/25 10:56 AM - During an interview, C10 (contractor Rehab Director) revealed that therapy uses the language line to communicate with R132 and that a communication board had previously been provided for R132 to keep in her room. 4/11/25 - During an observation immediately following the above interview, no communication board was found in R132's room. Therapy staff provided the surveyor with a communication board at that time and it was placed on the residents bedside table. 4/16/25 - During an interview E1 (NHA) stated	F 676		

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F 676	Continued From page 41 that language line information with phone number and instructions on use are posted at R132's bedside as well as each nurse station and medication carts. E1 further stated that the facility also has a Spanish speaking employee that will help to interpret everyday conversations/daily living conversations when needed. 4/16/25 12:16 PM - An observation of R132 in the hallway, smiling and engaging with the surveyor and staff. E34 (LPN) spoke to R132 in English, asking if she had any current needs and if she would like to wait in the lobby for her lunch delivery from outside the facility. E34 repeated the questions multiple times. R132 appeared confused, lifted her hands, and shrugged her shoulders, indicating she did not understand what was being asked. 4/16/25 12:49 PM - During an interview with R132 with the use of an interpreter line, R132 confirmed that she does not like the food provided by the facility and further stated that she is not able to read the daily bulletin that lists food options and activities for the day as she is not able to read written language at all. Additionally, R132 confirmed that Nursing and CNA staff do not use the language line when trying to communicate with her. R132 further expressed feeling lonely, hopeless and frustrated as she does not understand what staff is saying and staff does not understand her. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		6/3/25

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F 677	Continued From page 42 §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 it was determined that for four (R130, R73 and R114) out of fourteen residents reviewed for ADL (Activities of Daily Living) the facility failed to provide ADL care for dependent residents. Findings include: Cross Refer, F657 example 1 1. Review of R130's clinical record revealed: 3/7/25 - R130 was admitted to the facility. 3/10/25 - A review of R130's care plan for ADL self-care deficit documented "[R440] will be clean, dressed and well groomed daily to promote dignity and psychosocial wellbeing for ninety days." R440's interventions included" assist with daily hygiene, grooming, dressing, oral are, and eating as needed." 3/13/25 - R130's admission MDS assessment documented the resident was severely cognitively impaired and required "substantial maximum assistance" for personal hygiene and grooming. 4/8/25 9:26 AM - An observation of R130's hands revealed encrusted dark debris underneath each fingernail on the right and left hands. Additionally, R130's fingernails were long and needed to be trimmed. 4/11/25 10:48 AM - During a phone interview RP2	F 677	1. a. Nail care for R130 has been provided. b. All residents have the potential to be affected by this deficient practice. A facility sweep has been conducted for all dependent residents requiring assistance with nail care to ensure nails are clean and trimmed. c. Root cause analysis was conducted, and it was found that staff failed to provide nail care for dependent resident R130. Staff Development/Designee will conduct training for nursing staff on the importance of ensuring nail care is provided to dependent residents to ensure nails are clean and trimmed. d. Random audits of dependent residents nails will be conducted by DON/designee to ensure they are clean and trimmed. Audits will be completed on 3 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. Oral care for R73 has been provided. E45 was educated on documenting appropriately when services are rendered. b. All residents have the potential to be	

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F 677	Continued From page 43 (Responsible Party) stated, "I noticed that her nails are dirty and long, so I was planning on bringing in a nail clipper and a file to do her nails today." 4/11/25 11:01 AM - Another observation confirmed that R130 still had not been provided nail care. R130's nails on both hands still had dark encrusted debris underneath the resident's fingernails. 4/11/25 11:07 AM - During an interview E16 (RN, UM) checked R130's fingernails on both hands. E16 confirmed R130 had not been provided nail care. E16 stated, "Yes they do need to be cleaned and cut." E16 then stated, "Well last week the CNA was trying to do [R130's] nails and she became combative so it couldn't get done." 4/11/25 11:20 AM - E2 (DON) confirmed R130 needed nail care and then stated, "Ok this will be taken care of right away." 4/11/25 11:45 AM - E2 confirmed and stated, "[R130] had been provided nail care." 2. Review of R73's clinical record revealed: 1/2/20 - R73 was admitted to the facility. 1/4/20 - A care plan documented that R73 required assitance with all ADL's with the following interventions: assist with daily hygiene, grooming, oral care, and eating as needed; encourage to participate in self care; praise all efforts; report any changes or decline to provider. 2/25/25 - A quaterly MDS documented R73 required set up or clean up assistance of one	F 677	affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff failed to provide assistance with oral care for resident R73 who required assistance with this task. Staff Development/Designee will conduct training for nursing staff on the importance of ensuring assistance with oral care is provided to residents who are care planned for needing assistance with oral care. d. Random audits of residents requiring assistance with oral care will be conducted by DON/designee to ensure compliance with this task. Audits will be completed on 3 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 3. a. Nail care for R114 has been provided. b. All residents have the potential to be affected by this deficient practice. A facility sweep has been conducted for all dependent residents requiring assistance with nail care to ensure nails are clean and trimmed. c. Root cause analysis was conducted, and it was found that care staff failed to provide nail care for resident R114 who required assistance with this task. Staff Development/Designee will conduct training for direct care staff on the importance of ensuring nail care is	

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F 677	Continued From page 44 staff member for oral hygiene. Additionally the MDS documented R73had a BIMS score of 15 meaning he was cognitively intact. 4/8/25 8:21 AM - An interview with R73 revealed the need for assistance with ADL's and he feels that staff is not attentive to his needs. 4/10/25 9:37 AM - An interview with R73 confirmed that he brushes his teeth after staff set up breakfast. Also, R73 confirmed he had not been set up at this time to bursh his teeth. 4/10/25 11:26 AM - An observation of R73 had not brushed his teeth and R73's toothbrush was sitting in cup in bathroom dry. 4/10/25 11:34 AM - An interview with E45 (CNA) confirmed that she did not assist R73 with oral care this morning. Additionally E45 confirmed documenting the oral care was completed in EMR. The facility failed to assist R73 with ADL's. 3. Review of R114 clinical record revealed: 10/1/24 - R114's was admitted to the facility. 2/20/25 - A quarterly MDS documented that R114 was dependent on staff for personal hygiene. 2/26/25 - R114's care plan included that the resident required assist of one person for ADL care. R144's care plan did not include refusal of nail care. 4/8/25 8:17 AM - An observation revealed that R114 had black debris underneath all his fingernails.	F 677	provided to dependent residents to ensure nails are clean and trimmed. d. Random audits of dependent residents nails will be conducted by DON/designee to ensure they are clean and trimmed. Audits will be completed on 3 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 677	Continued From page 45 4/8/25 1:15 PM - An observation revealed that R114 had black debris underneath all his fingernails. 4/9/25 8:50 AM - An observation revealed that R114 had black debris underneath all his fingernails. 4/10/25 9:00 AM - During an interview E36 (CNA) stated when she gives a bath she washes residents entire body, provides nail care, and the resident bath days are two times a week unless there are special instructions on task list. 4/10/25 9:05 AM - During an interview, E37 (CNA) confirmed R114 received a bath on 4/5/25 and 4/9/25 during the 7:00 AM to 3:00 PM shift. E37 also acknowledged the nail care was her responsibility and stated she would complete it at this time. 4/10/25 9:07 AM - During a confirming interview E12 (LPN) confirmed black debris underneath all his nails . 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/3/25

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F 684	Continued From page 46 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R112 and R644) out of forty three residents reviewed in the investigative sample, the facility failed to ensure received treatment and care in accordance with professional standards of practice and physician orders. Findings include: 1. Review of R112's clinical record revealed: Cross refer F603 and F880 7/30/24 - R112 was admitted to the facility. 8/27/24 3:12 PM - A physician's order documented that R112 was on contact isolation due to scabies for fourteen days. 11/9/24 - A physicians order was written for R112 consult to dermatology related to scabies. 11/13/24 - A specialist physician's (dermatologist) progress note documented that R112 was not contagious and to remove isolation precautions. 4/15/25 10:30 AM - An interview with C2 (NP) and C5 (NP) confirmed that R112 was on contact precautions from 8/27/24 to 11/13/24. There was a ten week delay in consulting the dermatologist resulting in R112 being in isolation for 78 days. 2. R644's clinical record revealed:	F 684	1. a. Resident R 112 is no longer at facility. b. All residents have the potential to be affected by this deficient practice. At the time of review all residents were free from involuntary seclusion as evidenced by no residents having orders for contact isolation. c. Root cause analysis was conducted, and it was found that resident R112 was placed on isolation precautions for scabies longer than CDC guidelines recommend. DON/designee will educate Infection Preventionist on requirement to review all residents on contact isolation and collaborate with the physician to ensure that isolation is clinically indicated and that orders for isolation are discontinued based on CDC guidelines. d. Isolation orders will be reviewed daily by DON/designee to assure isolation is indicated based on CDC guidelines. Audits for residents with isolation orders will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. Resident R644 is no longer at facility.	

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F 684	Continued From page 47 Cross refer F760 9/12/24 - R644 admitted to the facility with diagnoses including but not limited to, heart failure and chronic obstructive pulmonary disease. 10/2/24 - C2 (contractor NP) entered order in R644's EMR stating, "DC (discontinue) PICC (peripherally inserted central catheter) RUE (right upper extremity) ...". 10/3/24 - R644's Resident Care Conference Attendance Record documented that E23 (RN) and F3 (R644's daughter) participated in this discharge planning conference. The paperwork stated, "PICC will be pulled by nursing ...". 10/5/24 - R644 was discharged home on hospice services. 4/11/25 2:08 PM - During a telephone interview, F3 (R644's daughter) stated, " ...When my mom [R644] arrived home after discharge from Evergreen, her PICC line was still in. It was supposed to be taken out at Evergreen prior to discharge."	F 684	b. Residents who have a peripherally inserted central catheter being discharged have the potential to be affected. c. Root cause analysis was conducted, and it was found that staff did not properly follow order to discontinue peripherally inserted central catheter. Staff educator will conduct training for licensed nurses on the importance of following orders to discontinue peripherally inserted central catheters. d. Residents with peripherally inserted central catheter (PICC) will be reviewed by DON/designee for clinical indication for use and removal when discharged. Audits will be completed for all residents with PICC orders daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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.	F 689		6/3/25

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F 689	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R35) out of 11 resiedents reviewed for accidents the facility failed to implement a care planned fall intervention. Findings include: Review of R35's clinical record revealed: 6/27/24 - R35 was admitted to the facility. 6/27/24 - An admission MDS documented the resident required extensive to total assistance with most ADLs, including transfers and mobility. The resident was dependent for bed mobility, toileting, and dressing. 9/25/24 - R35 was readmitted to the facility from the hospital with diagnoses including a right broken leg from a fall at the facility. A care plan revised on 10/2/24 included a new intervention for fall mats to be placed at the bedside when R35 is in bed. 10/3/24 - A fall risk assessment scored R35 at 17, indicating a high risk. On the following dates, no fall mats were observed at the bedside while R35 was in bed: 4/8/25 at 7:46 AM 4/11/25 at 2:27 PM 4/15/25 at 10:25 AM On 4/15/25 from approximately 10:55 AM to	F 689	a. R35 has no adverse effect related to the deficiency. b. All residents with a task to have fall mats when in bed, have been confirmed to have fall mats in room and care team has been made aware that they are to be used when resident is in bed. c. Root cause analysis was conducted, and it was found that staff did not follow the task to place fall mats at bedside . Staff educator will provide education to direct care staff that if a resident has a task for fall mats at bedside they are to ensure that this is in place. Education will include that if fall mats are not available in the room, staff are to notify supervisor immediately and supervisor is responsible for locating and placing fall mats at residents bedside. d. Observational rounds will be conducted by DON/designee to ensure that residents with a task to have fall mats while in bed will be in place. Audits will be conducted daily for 5 residents tasked for fall mats and will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 689	Continued From page 49 11:00 AM, during an interview and observation with E15 (CNA) and E16 (CNA) it was confirmed there were no fall mats at the bedside or in the room. 4/15/25 11:10 AM - An interview with E16 (Unit Manager) and E2 (Director of Nursing) it was revealed that the intervention for fall mats was listed on the task list. E2 confirmed that fall mats should have been placed at the bedside while R35 was in bed and stated the issue would be addressed immediately. On 4/16/25 at 8:23 AM, during a final observation, R35 was in bed with fall mats appropriately in place. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 689		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R644) out of eleven residents, the facility failed to ensure that R644 was free of medication error. On 9/13/24, R644 was inadvertently given the incorrect medications (amlodopine 10mg, benzapril 40mg, Coreg 25 mg and selevamer 800mg). This medication error resulted in harm as R644's blood pressure significantly dropped and she was sent emergently to the hospital for evaluation and treatment. This harm is being cited as past	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 50 non-compliance. Findings include: Facility's "Medication Administration policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Procedure: 3. Identify resident by photo in the MAR (medication administration record) ... 10. Compare medication source with MAR to verify resident name, medication name, form, dose, route and time ...". Rev. 1/2025 Review of R644's clinical record revealed: 9/12/24 - R644 admitted to the facility with diagnoses including but not limited to, heart failure and chronic obstructive pulmonary disease. 9/13/24 9:30 AM - E23 (staff RN) documented in R644's EMR progress notes, "Resident's vital signs checked and resident noted to be hypotensive 65/26 in LUE (left upper extremity) ...". 9/13/24 9:37 AM - C6 (EMT) documented in R644's prehospital care report, " ... The staff relayed the patient [R644] was given amlodipine 10 mg, benzaprine 40 mg, Coreg 25 mg and sevelamer 800 mg this morning at 8:20 AM. The staff relayed that those medications are not prescribed for the patient and the patient was suppose to be given amlodipine 5 mg, clonidine 0.1mg, furosemide 40 mg and losaratan 100 mg. The staff relayed that they checked the patient's blood pressure an hour after the medication mix-up and found the patient to be hypotensive	F 760		

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F 760	Continued From page 51 and 911 was activated ...". 9/13/24 9:48 AM - R644's blood pressure (BP) documented on the prehospital care report as 50/20. 9/13/24 9:53 AM - R644's blood pressure (BP) documented on the prehospital care report as 50/26. 9/13/24 3:25 PM - C7 (hospital ER DO) documented on R644's ER visit summary, " ...Reason for visit: drug overdose, Diagnosis: hypotension ...You were seen here in the emergency room for your low blood pressure after taking the wrong medication. We did an evaluation that included blood work and gave you IV fluids ...Blood pressure 110/51 ...". 9/14/24 1:31 AM -E27 (LPN) documented in R644's EMR progress notes, " ...Resident returned from [hospital] via stretcher accompanied by 2 EMTs ... VS 132/78 (BP), 72 (HR), 18 (Respirations), 97.9 (temperature), 98 (pulse oximetry) on O2 (oxygen) ...". R644 spent approximately 16 hours in the hospital ER receiving IV fluids and having her vital signs monitored. R644 returned to the facility on 9/14/25 at 1:31 AM. 9/18/24 - R644's admission MDS documented a BIMS score of 14, which was reflective of normal cognition. 4/11/25 2:03 PM -During a telephone interview, C6 confirmed that E27 (LPN) admitted to accidentally giving R644 her roommate's medications.	F 760		

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F 760	Continued From page 52 4/11/25 3:12 PM - A review of the facility's incident investigation provided a typed and signed statement from E27 (staff LPN) stating,"Around 8:15 AM, I pulled R644 roommate's medications. I was looking at the name in the room, there was only one name in there. I took her blood pressure, and it was normal. I called her [R644's roommate's name]. I said to R644, 'I have your medication' and she said I need my medication in pudding. I did not know she [R644] was hard of hearing. I gave medication and then I went to the roommate in B bed and that's when I realized I gave A bed, B bed's medication. I looked at the arm bands after I realized I made a mistake. At 8:20 AM the unit manager contacted the provider and provider stated to recheck the vital signs in a n hour. I re-checked her in about an hour later. Her blood pressure was 74/55 automatic blood pressure machine and then re-checked again still low. At 9:21 AM the unit manager contacted the provider and received orders to send to the ER for evaluation." 4/14/25 11:30 AM - An attempt to contact E27 for an interview was unsuccessful. 4/16/25 3:30 PM - A review of all the documentation of the corrective action plan completed by the facility included: -Timely reporting to the state Agency -Additional education regarding medication administration for E27 -Additional monitoring of E27 including a "3-person med pass" with the Pharmacist to verify her knowledge of med administration and shadowing during all med passes until she was cleared for normal duty. E27 was terminated on 1/1/25 for failing to perform the requirements of	F 760		

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F 760	Continued From page 53 the job. -Notification of the family informing them of the medication error It was verified by the surveyor that the corrections were completed as of 9/18/24 through document review and interview. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 760		
F 761 SS=B	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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.	F 761		6/3/25

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F 761	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for three out of three medication carts observed the facility failed to ensure that opened medications were labeled with an open date. Findings include: 1. 4/8/25 6:25 AM - An observation and inspection of the Sierra Unit "B" cart revealed four liquid medications that were opened and undated. The finding was immediately confirmed by E18 (LPN). 2. 4/8/25 6:33 AM - An observation and inspection of the Sierra Unit "A" cart revealed two liquid medications that were opened and undated. The finding was immediately confirmed by E18 (LPN). 3. 4/8/25 6:53 AM - An observation and inspection of the Seaside Unit "A" cart revealed four liquid medications that were opened and undated. The finding was immediately confirmed by E19 (LPN). 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 761	a. The facility cannot retroactively correct this issue. b. All residents have the potential to be affected by this deficient practice. Upon being made aware of observations by surveyor. DON audited all med carts to ensure that opened medications were labeled with an open date. c. Root cause analysis was conducted, and it was found that nurses administering medication did not follow policy and date liquid medications immediately upon opening them. All med carts were checked and it was confirmed that pens are available on all the med carts for nurses to label liquid medication bottles. Staff educator will provide education to licensed nursing staff that immediately upon opening liquid medications they are to be labeled with the open date. d. DON/designee will conduct random audit of medication carts to ensure than any opened bottles of liquid medication are labeled with open date. Audits will be conducted daily for all medication carts and will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R3) out of ten residents sampled for dining, the facility failed to provide the therapeutic diet that was prescribed by the physician. The facility failed to provide R3 large portions. Findings include: Review of R3's clinical record revealed: 5/24/24 - R3 was admitted to the facility. 1/23/25 - A physician's order for R3 documented low concentrated sweets diet, regular texture, thin liquid consistency: give large portions for all three meals. 4/14/25 12:10 PM - An observation of R3's meal tray that contained one piece of chicken, mashed potatoes, string beans, fruit cup and drinks on tray. The mashed potatoes and vegetables were one serving and not large portions. 4/14/25 12:26 PM - An interview with E40 (CNA) confirmed that R3 was on large portions and if R3 wants them she will ask staff for more. E40 confirmed that the mashed potatoes and green	F 808	a. The facility cannot retroactively correct this issue. Resident R3 is now being given large portions with meals. b. All residents have the potential to be affected by this deficient practice. All residents with orders for large portions have been confirmed by dietician to be receiving large portions. c. Root cause analysis was conducted, and it was found that while tray ticket did indicate R3 should be receiving large portions, kitchen staff were not plating the meal portions correctly, and staff were not confirming accuracy of large portions on tray prior to serving meal tray. Food Service Director will conduct education with kitchen staff on how to properly plate large portions when preparing meal trays. Staff Educator will conduct education for all staff that serve resident meal trays on how to check meal ticket for indication of large portions and how to visually confirm compliance with order prior to serving	6/3/25

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F 808	Continued From page 56 beans were not large portion. 4/14/25 12:29 PM - An interview with E41 (FSD) confirmed that large portions refers to the sides and double portions refers to the entrees. 4/15/25 12:15 PM - An observation of R3's meal tray that contained chicken broccoli casserole, side of rice, banana, and a fresh fruit cup. The casserole and side of rice were regular portions. 4/15/25 12:19 PM - An interview with E39 (CNA) and E40 (CNA) confirmed that R3's portions were not large portions. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 808	meal tray to resident. d. Residents with orders for large portions will be reviewed daily by Food Service Director to ensure meal trays are being prepared properly. Audits will be conducted daily for 5 residents with orders for large portions and will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/3/25

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F 812	Continued From page 57 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in manner that prevents food borne illness to the residents. Findings include: 1. 4/8/25 8:20 AM - Observation and inspection of the Sierra Unit nourishment refridgerator revealed that it contained a sandwich, container of pickles and a container of sliced tomatoes that were undated and unlabeled. The finding was immediately confirmed by E20 (LPN) unit manager. 2. 4/8/25 11:28 AM - During a dining observation in the main dining room, E21 (DA) was observed wearing gloves and holding a paper meal ticket in the right hand. At 11:33 AM, E21 left the dining room and entered the kitchen to communicate with kitchen staff. E21 then returned to the dining room at the food service counter still holding the same meal ticket paper in right hand, touched her nose, adjusted her face mask with the left hand then reached into the bag of bread with the same left hand to prepare a sandwich. The surveyor intervened, and E21 put down the meal ticket, and discarded both gloves and donned a new pair of gloves with out performing any hand hygiene. E21 immediately confirmed the findings and discarded the slice of bread. 3. 4/10/25 11:36 AM - 11:48 AM - During a follow up visit to inspect the facility kitchen the following was observed: - Eight plates removed from plating area contained food debris.	F 812	1. a. Unlabeled and undated items in the sierra unit nourishment refrigerator was discarded. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that dietary staff did not label or indicate open date on 3 items in the nourishment refrigerator on the Sierra Unit. Food service director will ensure markers are available to all kitchen staff as needed to label food items and containers. Food service director will conduct education for nursing and dietary on the requirement to label and date all individual food items placed in the nourishment refrigerators. d. Nourishment refrigerators will be checked daily to ensure all items are properly labeled and dated by Food Service Director/designee. Audits will be conducted daily a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. E21 was provided education on infection control related to hand hygiene. b. All residents have the potential to be affected by this deficient practice.	

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F 812	Continued From page 58 - Two dessert cups removed from dish rack contained food debris. - Meat stored on the top most shelf in the refrigerator thawing over vegetables. - Visible dust on the fan in the dish area. E22 (FSD) immediately confirmed the findings. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 812	c. Root cause analysis was conducted, and it was found that E21 did not follow required food handling practices or hand hygiene when changing gloves. Food Services Director will provide training to dietary staff on proper food handling practices. Staff educator will provide hand hygiene training to dietary staff. d. Food Service Director/designee will conduct random observational round of dietary staff for safe food handling. Audits will be conducted daily on 3 dietary staff members for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly on 5 dietary staff members for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 3. a. Dishes with food debris were removed from dish rack and plating area and rewashed. Vegetables found under thawing meat were discarded, meat was relocated to the lowest rack. Fan in the dish area was cleaned. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that: 1. Dishes were not inspected after washing to ensure all debris was cleaned off plate, Food Services Director will provide training to all dietary staff on expectation that dishware is inspected after washing and if not properly cleaned	

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F 812	Continued From page 59	F 812	are rewashed. 2. Appropriate protocol for thawing meat was not followed, Food services director will provide training to all dietary staff on proper protocol to safely thaw meat. 3. Process not in place for frequent cleaning of fan in dish area, Food Services Director will create a schedule to ensure fan in dish area is cleaned regularly to prevent dust build up. d. 1. Food Service Director/designee will audit dish racks and plating areas to ensure dishware is clean and free of debris. Audits will be conducted daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. Food Service Director/designee will audit refrigerator to ensure meat is properly placed for thawing. Audits will be conducted daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 3. Food Service Director/designee will audit fan in dish area to ensure it is dust free. Audits will be conducted daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4	

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F 812	Continued From page 60	F 812	weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		6/3/25

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F 880	Continued From page 61 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 record review and interview, it was determined that for two (R14 and R639) out of twelve residents reviewed for infection control, the facility failed to initiate and maintain appropriate precautions per CDC guidelines.	F 880	1. a. The facility cannot retroactively correct this issue. R14 is now on Enhanced Barrier Precautions. b. All residents have the potential to be	

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F 880	Continued From page 62 Additionally the facility failed to follow standard precautions. Findings include: CDC's "Infection Control Appendix A: Type and duration of Precautions Recommended for Selected Infections and Conditions...Multidrug-resistant organisms, infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant S.pneumoniae) Contact + Standard...". February 7, 2025 Facility's "Infection Prevention and control Program Policy: ...Policy Explanation and Compliance Guidelines: ...5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines." Rev 1/2025 Facility's "Enhanced Barrier Precaution Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced Barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). 1.Review of R14's clinical record revealed: 12/13/20 - R14 was admitted to the facility with diagnoses including but not limited to, multiple sclerosis, seizures and S/P colostomy. 10/5/23 - 10:23 AM - C3 (consultant medical	F 880	affected by this deficient practice. All residents who have a colostomy were reviewed to ensure they have orders for EBP. c. Root cause analysis was conducted, and it was found that staff did not follow policy to obtain physician order timely to initiate EBP for resident with colostomy. Staff Educator/Designee will re-educate facility licensed nursing staff on policy that any resident who admits to facility with a colostomy must have orders for Enhanced Barrier Precautions initiated upon admission. d. DON/Designee will audit newly admitted residents with order for colostomy to ensure there is an order for Enhanced Barrier Precautions. Audits will be completed for all new admissions daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. The facility cannot retroactively correct this issue. R639 has discharged from the facility. b. All residents have the potential to be affected by this deficient practice. No residents in house are currently has diagnosis of MRSA pneumonia that would require contact precautions. c. Root cause analysis was conducted, and it was found that staff did not follow policy to obtain physician order timely to	

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F 880	Continued From page 63 director) documented in R14's progress note, " ...History of present illness: Patient is a 64 year old male with past medical history significant for HTN (hypertension) ... colostomy ..." 4/1/24 - New EBP guidelines from CMS were effective in long term care facilities. 11/22/24 - C2 (consultant NP) initiated an order in R14's EMR, "Enhanced Barrier precautions related to history of ESBL urine, colostomy. Every shift for monitoring." The facility failed to initiate EBP for R14 until eight months (from 4/1/24 to 11/22/24) after the new guidelines were mandated. 4/16/25 - 12:01 PM - During an interview, E2 (DON) confirmed that R14 "has had a colostomy since he has been in the facility". 2. Review of R639's clinical record revealed: 6/21/24 - R639 was admitted to the facility with diagnoses including but not limited to, chronic obstructive pulmonary disease. 10/3/24 - 5:37 PM - C4 (hospital MD) documented in R639's discharge summary, "Principal diagnosis: MRSA pneumonia ... due to positive MRSA swab ... discharge medications: ...linezolid 600 mg (milligram) tablet- take 1 tablet by mouth 2 times a day for 20 days ...". 10/3/24 - C2 (NP) entered order in R639's EMR stating, "linezolid tablet 600 mg - give 1 tablet by mouth every 12 hours for infection of lungs for 20 days."	F 880	initiate contact precautions for resident with diagnosis of MRSA pneumonia. Staff Educator/Designee will re-educate facility licensed nursing staff on policy that any resident who is being treated for MRSA pneumonia must have orders for contact isolation precautions for duration of treatment. d. DON/Designee will audit residents being treated for MRSA pneumonia to ensure there is an order for contact isolation precautions. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 3. a. E26 was educated on infection control practices when handling soiled items and disposing of them properly. b. All staff have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy to doff gloves prior to leaving resident room with trash and to take trash directly to biohazard room. Staff Educator/Designee will re-educate facility direct care staff on protocol to doff gloves prior to leaving residents room, wash hands and then immediately take trash to biohazard room. d. DON/Designee will complete observational rounds to ensure staff	

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F 880	Continued From page 64 4/16/25 - 10:35 AM - A review of R639's EMR revealed that there was not a contact precautions order in effect while R639 was being treated for MRSA pneumonia with linezolid (antibiotic to treat MRSA pneumonia). The facility failed to initiate contact precautions for R639 while he was being treated for MRSA pneumonia from 10/3/24 to 10/24/24. 4/8/25 6:16 AM - A random observation revealed a clear plastic trash bag with dirty briefs and gloves was sitting on the floor in front of room 200 which had signage on the door that indicated EBP (Enhanced Barrier Precautions). 4/8/25 6:20 AM - E26 (CNA) was observed leaving room 200 wearing disposable gloves. E26 picked up the trashbag and proceeded to walk across the hallway to room 201 another room with EBP signage on the door, placed the trash bag on the floor and entered the room wearing the contaminated gloves on both hands. 4/8/25 6:41 AM - During an interview E2 (DON) observed the trash bag was sitting on the floor in the doorway of room 201. E2 stated, "No this should not be it should go directly to the biohazard room." E2 picked the trash bag up off the floor, E26 opened the door to leave room 201 wearing gloves, E2 stopped E26 in the hallway and educated the CNA on wearing gloves, hand washing and that trash should not go from room to room and is to be taken to the biohazard room for disposal. The trash was disposed off by E2. 4/8/25 8:31 AM - An additional observation of room 200 with EBP signage revealed a clear	F 880	properly doff gloves and wash hands before leaving a residents room. DON/Designee will complete observational rounds audit to ensure that trash bags are taken directly from residents room to biohazard room. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 880	Continued From page 65 plastic bag with dirty linen and a bag with briefs and other trash were sitting on the floor inside of room 200. E16 (RN, UM) entered room 200 and picked the bags up off the floor. E16 confirmed and stated, "Yes I know the trash bags being left on the floor is an infection control concern." E16 proceeded to take the bags to the biohazard room for disposal. 4/17/25 1:45 PM -Findings were reviewed with E1 (NHA) and E2 (DON).	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R18 & R33) out of five residents reviewed for antibiotic usage, the facility failed to monitor antibiotic usage. Findings include: Facility's "Antibiotic Stewardship program Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of this program is to optimize the treatment of infections while reducing adverse events associated with	F 881	1. a. R18 was not adversely affected by this deficient practice. b. All residents who have orders for antibiotic usage are have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy to monitor antibiotic usage for R18. DON will re-educate facility Infection Preventionist on Antibiotic Stewardship Program policy and requirement to update infection control line listing with all	6/3/25

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F 881	Continued From page 66 antibiotic use ...". Rev. 12/2024 1. Review of R18's clinical record revealed: 9/9/21 - R18 was admitted to the facility. 12/10/24 - C5 (consultant NP) entered an order in R18's EMR stating, "Metronidazole (antibiotic) oral tablet 500 mg- give 1 tablet by mouth two times a day for cellulitis of penis for 5 days." 12/12/24 - C3 (consultant MD) documented in R18's re-admission history and physical note, " ...Admitted to [hospital] for penis necrosis, and underwent debridement of penis on 12/7/24 ...Physical exam: Skin- see wound care note ...Plan: Penis Necrosis: ... continue on metronidazole 500 mg 1 tab every 12 hours for 5 days and cefpodoxime 200 mg 2 tabs 2 times a day for 5 days ...". 12/13/24 - C3 (consultant MD) entered order in R18's EMR, "Cefpodoxime proxetil (antibiotic) oral tablet 200 mg- give 2 tablets by mouth two times a day for cellulitis of penis X 5 days." 4/14/25 12:31 PM - A review of the facility's infection control line listing for December 2024 revealed that R18's cefpodoxime and metronidazole antibiotic courses were not listed on the document. A review of R18's hospitalization discharge summary dated 12/10/24 revealed R18 was being treated with cefpodoxime post-operatively after having a necrotic mass removed from his penis. The facility failed to implement their protocol to monitor antibiotic usage with regard to R18's cefpodoxime and metronidazole.	F 881	antibiotic courses. d. DON/Designee will audit infection control line listing to ensure antibiotic courses are accurately reflected on line listing. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. R33 was not adversely affected by this deficient practice. b. All residents who have orders for antibiotic usage have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not follow policy to monitor antibiotic usage for R33. DON will re-educate facility Infection Preventionist on Antibiotic Stewardship Program policy and requirement to update infection control line listing with all antibiotic courses. d. DON/Designee will audit infection control line listing to ensure all antibiotic courses are accurately reflected on listing. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	

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F 881	Continued From page 67 2. Review of R33's clinical record revealed: 12/25/24 - R33 was admitted to the facility. 12/25/24 - C2 (consultant NP) initiated an order in R33's EMR stating, "Vancomycin HCl (antibiotic) 25 mg/ml solution- give 125 mg by mouth two times a day for c-diff for 5 days." 2/8/25 - C5 (consultant NP) initiated an order in R33's EMR stating, "Bactrim DS (antibiotic) oral tablet 800-160 mg- give 1 tablet by mouth two times a day for UTI (urinary tract infection)." 4/14/25 12:31 PM - A review of the facility's December 2024 infection control line listing revealed that R33's vancomycin antibiotic course and C-difficile infection was not documented. A review of the facility's February 2025 infection control line listing revealed that R33's Bactrim antibiotic course and UTI infection were not documented. The facility failed to implement their protocol to monitor antibiotic usage with regard to R33's vancomycin and Bactrim. 4/16/25 1:55 PM - During an interview, E12 (LPN/IP) stated that the monthly infection control line listing was the method that the facility used to track infections and antibiotic usage in the facility. 4/17/25 1:45 PM -Findings were reviewed with E1 (NHA) and E2 (DON).	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		6/3/25

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F 883	Continued From page 68 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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F 883	Continued From page 69 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R33 and R96) out of twelve residents reviewed for pneumococcal vaccines, the facility failed to accurately assess the residents' pneumococcal vaccine status. Findings include: Facility's Pneumococcal Vaccine (Series) Policy: "It is our policy to offer our residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations ... Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission ...6. A pneumococcal vaccination is recommended for all adults 65 years and older and based on the following recommendations: ... b. For adults 65 years or older who have only received a PPSV23: Give 1 dose PVC15 or PCV20. 1. The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination ...". Rev 1/2025	F 883	1. a. R33 was not adversely affected by this deficient practice. b. All residents have the potential to be affected by this deficient practice. c. Root cause analysis was conducted, and it was found that staff did not review Delvax prior to administering PCV20 to R33. DON/designee will re-educate facility Infection Preventionist to ensure vaccine information is obtained from DelVax be used as a source to obtain vaccination status prior to vaccine administration. d. DON/Designee will review Delvax and audit pneumococcal pneumonia vaccine administration form to ensure proper protocol was followed prior pneumococcal pneumonia vaccine administration. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until	

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F 883	Continued From page 70 1. Review of R33's clinical record revealed: 12/25/24 - R33, aged 69 years, was admitted to the facility. 12/25/24 - R33 signed Attachment D Pneumococcal Pneumonia and Influenza Vaccinations/Tuberculosis Testing form from the admission packet and consented to receive the pneumococcal pneumonia vaccine. 12/29/24 - R33's admission MDS assessment documented R33 as having a BIMS score of 14, which reflected normal cognition. 1/15/25 - R33 was administered the PCV20 vaccine by the facility. 4/10/25 3:45 PM - A review of the DelVax (vaccine registry) website revealed R33 had been administered PPV23 on 9/5/13 and PCV20 vaccine on 8/19/24, just five months prior. 4/14/25 10:49 AM - During an interview, E12 (staff LPN/ Infection Preventionist) confirmed that she had access to the DelVax website. E12 stated, " ...[nurse] used to put the vaccines in Delvax but she does not work here anymore. Now we do it sometimes. When the resident comes in, we ask them about their vaccines. We look on the hospital records and the historic records. If they are not up-to-date, we offer it to them ...We only give the pneumococcal 20 vaccine here now ...". 2. Review of R96's clinical record revealed: 10/1/24 - R96 was admitted to the facility.	F 883	100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee. 2. a. R96 was not adversely affected by this deficient practice. b. All residents have the potential to be affected by this deficient practice. Vaccine consent is now being obtained after the BIMS is obtained to ensure that appropriate parties are giving consent for vaccination. c. Root cause analysis was conducted, and it was found that staff did not obtain consent from resident representative to administer vaccines to a resident who was cognitively impaired. Staff Educator/Designee will conduct training for licensed nurses Including IP that residents who are cognitively impaired cannot sign the consent form for pneumovax and influenza. Staff must obtain consent from resident representative prior to administering vaccines. d. DON/Designee will audit Pneumococcal pneumonia vaccine and influenza administration to ensure that if a resident is cognitively impaired that the resident representative completed the consent form for vaccine. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI	

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F 883	Continued From page 71 10/7/24 - R96's admission MDS assessment documented a BIMS score of 9, which was reflective of moderate cognitive impairment. 4/11/25 10:35 AM - A review of R96's face sheet revealed that F5 (R96's daughter) was R96's Power of Attorney (POA). The EMR contained documentation of Attachment D Pneumococcal Pneumonia and Influenza Vaccinations/Tuberculosis testing form that was signed by R96. This document was not dated and granted consent for R96 to be vaccinated with the pneumovax and influenza vaccines. 4/11/25 11:04 AM - During an interview, E5 (SW Director) stated, "For new admissions, we try to do the BIMS section of the MDS right away. If they come in during the evening, we try to do it the next day. A BIMS score for a person with cognitive impairment is 6 or 7. If they have a score of 10 -11, then it is a judgment decision. We don't really have a cutoff score for when residents cannot make decisions. It is more of a judgment thing. There really is not any formal training for the BIMS test. It is a piece of paper that we follow." The facility failed to involve R96's known POA in obtaining consents for vaccinations. 4/17/25 1:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 883	Committee.	