STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	48AM	A. BUILDING: _____ B. WING _____	02/13/2025

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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M 000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey and four (4) Complaint Investigations (CI) MS #27703, CI MS #27184, CI MS #27940, and CI MS #27952 at the facility from 2/10/25 through 2/13/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M500, M610, M655, M1015, M1210, and M1570. The SA identified non-compliance and cited M500 regarding resident rights for CI MS #27952. The SA identified non-compliance for CI MS#27703 and cited M1210 and M1015. The SA investigated CI MS #27184 and CI MS #27940 with no deficiencies cited. The census at the time of the survey was 114 and the facility was licensed for 152 beds	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem	M 500		3/14/25

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M 500	Continued From page 1 rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend	M 500		

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M 500	Continued From page 2 changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the	M 500		

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M 500	Continued From page 3 facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in	M 500		

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure a residents rights were honored to be free from physical restraints (Resident #88), receive mail on Saturdays (Resident #8, #14, #25, #38), have scheduled smoke breaks (Resident #60) and request beverages of choice with meal (Resident #13 and #303) for eight (8) of 23 sampled residents. Resident #8, #13, #14, #25, #38, #60, #303, and #88 Findings include: Review of the facility policy, titled "Residents' Rights Summary" unrevised, revealed, "9. Mail: The resident has the right to privacy in written communications, including the right to send and receive mail promptly and unopened and have access to stationary, postage, and writing implements at the resident's expense." Also revealed under, "Examples of Violations: ... 12. Restraining a resident without a physician's order for the convenience of staff, or as a disciplinary measure." Resident #88 Physical Restraint An observation on the Memory Care Unit on 2/11/25 at 3:49 PM revealed Resident #88 sitting in a wheelchair in the activity room and Certified Nurse Aide (CNA) #4 was standing in front of the resident with her right knee in between the residents' legs. The resident was anxious and asked the aide to take her to the bathroom. The resident tried to stand up from the wheelchair	M 500	1. On 2/11/2025, Certified Nurses Assistant CNA#4 was removed from resident care and suspended pending investigation as it is not the policy of Diversicare to use restraints. 1:1 education regarding resident rights and restraints was provided to this Certified Nurses Assistant (CNA) by the Director of Nursing (DNS) prior to the CNA leaving the center on 2/11/2025. Resident #88 was assessed by the DNS on 2/11/25 for unmet needs and emotional status with no negative outcomes identified. The Administrator met with residents #8, 14, 25, 38 on 2/28/25 to assure the timely delivery of mail including on weekends will be enforced. Education was provided 2/27/25 to Social Services to assure understanding of mail delivery to residents including weekends by the Director of Clinical Education. Residents #60, #65, A and B and other residents who smoke were offered and assisted to the smoking area on 2/13/25 by staff member. Education completed on 2/27/25 with staff on residents rights to include the smoking policy and smoking times to assure compliance by the Director of Clinical Education. On 2/18/2025, the Dietary Services Manager met with resident #13 to update dietary preferences regarding the desire to receive a larger serving of sweet tea with meals. On 2/18/2025, the Dietary Services Manager met with resident #303 to update dietary preferences regarding the desire to receive coffee with meals. Tray tickets	

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M 500	Continued From page 5 several times but was stopped. CNA #4 replied, "No, you've got to stay right here" while touching the resident's leg and instructing her to sit down because she had just went to the bathroom. The resident continued rocking forward in her wheelchair. An observation and interview with the Memory Care Unit Coordinator on 2/11/25 at 4:01 PM confirmed CNA #4 was standing over Resident #88 and restricting her from voluntarily standing up. She revealed CNA #4 was doing that to keep the resident from getting out of the chair and falling. She stated that the resident had just been toileted and was frequently asking to go to the bathroom. The Memory Care Coordinator revealed the resident was on a toileting program and should be toileted every two (2) hours and when needed. An interview with the Administrator (ADM) on 2/11/25 at 4:08 PM confirmed the aide's actions were not how the facility should be handling the residents. She stated that she had been made aware of the incident witnessed between CNA #4 and Resident #88. She revealed the resident's request to go to the bathroom could be a behavior or a urinary tract infection. An interview with the Director of Nursing (DON) on 2/11/25 at 4:13 PM confirmed that CNA #4's action was restraining Resident #88 from standing up from the wheelchair. An interview with CNA #4 on 2/11/25 at 4:18 PM revealed she was trying to prevent Resident #88 from getting up and falling. She explained the resident was a fall risk and always asking to go to the bathroom because she wanted to go and stay in her room.	M 500	were updated at that time. Education was provided 3/5/2025 to RN#4 by the Administrator to assure resident's choices and preferences were provided. 2. All residents have the potential to be affected by this practice. 3. A resident council meeting was conducted on 2/18/2025 to inquire as to whether residents feel safe at the center and all residents in attendance voiced no safety concerns. On 2/27/2025 education was provided to staff members on resident rights and restraints by the Director of Clinical Education (DCE). On 2/12/2025 education was provided to staff members by the DCE on Abuse and Neglect. A resident council meeting was conducted on 3/4/25 to discuss mail delivery on weekends by the Administrator. Education was conducted by the Director of Clinical Education on 2/27/25 with staff on residents rights to ensure mail is delivered six days per week (excluding holidays) to residents. Going forward, Manager on Duty (MOD) is to ensure this process is followed and mail is delivered on weekends. Notification of the smoking policy was provided to the residents who smoke on 3/4/25 by the Administrator. A resident council meeting was conducted by the Administrator on 3/4/25 to discuss the current smoking times and variances that may occur due to weather concerns. Education was provided by the Director of Clinical Education on 2/27/25 to staff to ensure residents that desire to smoke will be assisted by staff to the smoking area during scheduled smoking times when weather concerns are present based off the residents choice to attend. Beginning	

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M 500	Continued From page 6 An interview with the Nurse Practitioner (NP) on 2/12/25 at 10:08 AM revealed Resident #88 had declined over the past three (3) months with an increase in behavior and restlessness. She explained that the resident had been up walking but recently required a wheelchair because she was unsteady. She revealed frequent bathroom requests had started around the same time and the resident was currently on an antibiotic for a urinary tract infection (UTI) which could be increasing her behavior. An interview with Registered Nurse (RN) #3 on 2/13/25 at 8:38 AM revealed the Memory Care Unit had a fall risk area where the residents that were at risk stayed, so they were overseen closely by the staff. She revealed the aides were to watch over the residents and oversee but never prevent a resident from getting up. Record review of CNA #4 "Education Transcript" revealed she was trained on preventing falls (8/15/24), dementia care (8/16/24), and dementia with challenging behaviors (1/21/25). Record review of the "Admission Record" revealed the facility admitted Resident #88 on 3/19/24 with a diagnosis that included Alzheimer's Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/24 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #88 was severely cognitively impaired. Resident Council Concerns	M 500	2/18/2025 and completed by 2/20/2025, Dietary staff interviewed all residents to determine preferences. All resident tray tickets was updated at that time. On 2/27/2025, the Administrator began education with direct care staff regarding resident choice to assure resident's choices and preferences are provided when requested. 4. On 2/24/2025, the Administrator and DNS began an audit of a minimum of five Memory Care residents to ensure no use of restraints. This audit will be weekly x four weeks, then monthly for an additional two months. On 2/21/25 the Administrator began an audit of a minimum of five residents weekly x four weeks then monthly x two months to ensure compliance of mail delivery including the weekends. On 2/28/25, the Administrator began an audit of three residents weekly x four weeks then monthly x two months to ensure compliance with the smoking schedule. Beginning 2/24/2025, the Administrator or team member will conduct resident interviews of ten residents weekly x four weeks then monthly x two to assure resident preferences are acknowledged and provided. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M 500	Continued From page 7 During a Resident Council meeting on 2/11/25 at 11:00 AM, Resident's #8, #14, #25 and #38 voiced that they have not been getting mail delivered to them on Saturday. The residents revealed they could not recall the last time they did. Resident #25 stated that the facility did not have anyone available to distribute the mail on Saturdays, so it just stayed in the mailbox until the social worker was back during the week. She explained that if anyone was waiting for a card or letter, they would have to wait for it. An interview with Social Services (SS) #1 on 2/11/25 at 12:05 PM, confirmed the residents were not getting mail on Saturdays. She explained the mail was always left for her to pass out. SS #1 revealed it was important for the residents to receive their mail and stated, "I would want mine." An interview with the Administrator (ADM) on 2/12/25 at 2:18 PM revealed the facility had a manager on duty Saturdays that was responsible for passing out the mail. She revealed she was not aware it was not being done. The ADM confirmed the mail should be passed out to the residents on days the mail ran. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 7/25/12. Record review of Resident #8's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/25 revealed under, section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	M 500		

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M 500	Continued From page 8 Record review of the "Admission Record" revealed the facility admitted Resident #14 on 11/27/12. Record review of Resident #14's MDS with an ARD of 11/11/24 revealed under, section C, a BIMS score of 15, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #25 on 9/15/20. Record review of the MDS with an ARD of 12/17/24 revealed under section C, a BIMS summary score of 15, which indicated Resident #25 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #38 on 12/29/17. Record review of the Quarterly MDS with an ARD of 12/12/24 revealed under, section C, a BIMS summary score of 15, which indicated Resident #38 was cognitively intact. Smoking - Resident #60, Resident A & B Review of the facility policy titled, "Resident Rights & Quality of Life Policy" with an effective date of 3/13/20, revealed, "It is the policy of "proper name" that all patients and residents have the right to a dignified existence, self-determination...A patient or resident has the right: To be fully informed of his or her rights and all rules and regulations governing patient and resident conduct and responsibilities during the stay in the center."	M 500		

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M 500	Continued From page 9 Review of "Proper name Smoke Schedule" undated, revealed ** Staff members are not allowed to take residents out to smoke during inclement weather, such as: Rain, Sleet, Snow, Hail, Storms, Heat index of 100+ and freezing temp of 32 degrees and below. ** In an interview on 2/12/25 at 8:35 AM, Resident #60 revealed that she wanted to go out and smoke, but they won't take anyone because it is raining outside. She stated she would really like to have a cigarette, plus we didn't get to go out yesterday and smoke all day because it was raining. During an interview on 2/12/25 at 8:45, Certified Nurse Aide (CNA) #8, with Resident #60 present, confirmed that the residents aren't allowed to go out today and smoke because it is raining. She revealed they aren't allowed to go out if it's raining, snowing, bad weather, or cold. During an observation and interview on 2/12/25 at 11:05 AM, Resident #60 was sitting in her doorway in her wheelchair and stated that she really wanted to go out and smoke, but we still can't because it's still raining. In an interview on 2/12/25 at 11:15 AM, Central Supply revealed that the person that is assigned to take the smokers out at 11 AM is the Minimum Data Set (MDS) #1, but she probably won't do it because it's raining. She then confirmed that the residents don't go out to smoke if it's raining, so they did not get to go yesterday either. An observation and interview on 2/12/25 at 11:25 AM revealed several residents sitting by the smoking door waiting for the 11 AM smoke break.	M 500		

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Resident A and Resident #60 both revealed they hoped they would let them, especially since they missed yesterday because it rained all day.

An observation and interview on 2/12/25 at 11:30 AM, MDS #1 arrived at the door to the smoking area with the residents still waiting and stated that they do not usually take them out to smoke when it's raining or inclement weather.

An interview on 2/12/25 at 11:35 AM with Resident A, B and #65. Resident A stated, "I don't understand why we can't come out to smoke, because we have a pavilion to sit under and it helps my nerves. Resident B revealed he wishes they would let them go out and smoke regardless of the weather when it is their smoke break time. Resident #65 stated, "I didn't get a cigarette all day yesterday because it was raining."

During an interview on 2/12/25 at 2:35 PM with the Admission Liaison she revealed it is her responsibility to complete admission paperwork with the residents and their families. She stated that the admission paperwork does not address smoking. She revealed that if they ask, she does tell them that they allow smoking, but they do not sign anything.

An interview on 2/12/25 at 3:37 PM, the Administrator (ADM) confirmed that the residents do not have to sign anything regarding smoking rules. She revealed that they discuss smoking rules during the 72-hour report after admitting the residents and confirmed that she understands that residents have their rights.

Record review of Resident #60's "Admission Record" revealed the facility admitted the resident on 6/28/2023 with diagnoses that included Major

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M 500	Continued From page 11	M 500		

Depressive Disorder, and Nicotine Dependence, Cigarettes.

Record review of Resident #60's MDS with an Assessment Reference Date (ARD) of 11/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

A record review of Resident #65's "Admission Record" revealed the facility admitted the resident on 10/14/2023 with diagnoses that included Heart Failure, Major Depressive Disorder, and Nicotine Dependence on Cigarettes.

A record review of Resident #65's MDS with an ARD of 12/9/24 revealed, under section C, a BIMS score of 15, which indicated that Resident #65 is cognitively intact.

Record review of Resident A's "Admission Record" revealed the facility admitted the resident on 1/9/2025 with diagnoses that included Displaced Trimalleolar Fracture of the Left Lower Leg, Encounter for Closed Fracture with Routine Healing, Weakness, and Bipolar Disorder.

A record review of Resident A's MDS with an ARD of 1/16/25 revealed, under section C, a BIMS score of 15, which indicated the resident is cognitively intact.

A record review of Resident B's "Admission Record" revealed the facility admitted the resident on 11/27/2023 with diagnoses that included Anxiety Disorder and Major Depressive Disorder.

A record review of Resident B's MDS with an ARD of 11/14/24 revealed, under section C, a BIMS score of 13, which indicated that the

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M 500	Continued From page 12	M 500		

resident is cognitively intact.

Beverage of choice Resident #13 and #303

Review of the facility policy titled "Dining and Food Preferences" with a revision date of 9/17, revealed "Policy Statement: Individual dining, food, and beverage preferences are identified for all residents/patients."

An observation of Resident #13 on 2/10/25 at 11:44 AM, revealed she was lying in bed. Registered Nurse (RN) #4 entered the resident's room with her meal tray. The resident voiced she wanted to eat in the dining room and wanted a large glass of tea. RN #4 explained to the resident she could only have a small glass of tea because of the caffeine and stated, "You can have a small glass of tea and some water, or you'll be climbing the wall." A large glass of tea was not provided.

An observation of Resident #13 during the lunch meal on 2/11/25 at 11:52 AM, revealed the resident was eating in the dining area and had a small 120 milliliter (ML) glass of tea and water.

An observation of Resident #303 during the lunch meal on 2/11/25 at 11:55 AM revealed the resident was sitting at the dining table and requested a cup of coffee. Registered Nurse (RN) #4 replied, "We only get coffee with breakfast." The coffee was not provided.

An interview with Resident #303 on 2/11/25 at 1:24 PM, revealed he liked coffee in the morning, and voiced he could drink it all day.

An interview with the Memory Care Coordinator

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M 500	Continued From page 13 on 2/11/25 at 1:29 PM, confirmed the residents should have their preferences honored. She revealed that if a resident requested something and if possible, the staff should provide it. She confirmed she overheard Resident #303 request coffee at lunchtime and revealed the nurse should have gone to get the coffee. An interview with RN #4 on 2/11/25 at 1:42 PM, revealed she did not give Resident #13 a large glass of tea because her family did not want her to have it due to the caffeine. She confirmed the resident had the right to request the things in life that she liked. She confirmed Resident #303 should have been given coffee when he requested it at lunch, as this was his preference. An interview with the Administrator on 2/12/25 at 2:18 PM, confirmed the residents have a right to their preference. She explained the kitchen has coffee available throughout the day for the residents and stated the staff should get the things the residents request. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 11/02/23 with medical diagnoses that included Schizophrenia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #13 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #303 on 1/30/25 with a medical diagnosis that included Acute Kidney Failure.	M 500		

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M 500	Continued From page 14 Record review of the 5-day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/06/25 revealed under section C, a BIMS summary score of 3, which indicated Resident #303 was severely cognitively impaired.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene for three (3) of 23 residents reviewed for Activities of Daily Living (ADL) care. Resident #62, #74 and #253. Findings include: Review of the facility policy titled, "ADL's (activities of daily living)," dated August 2021, revealed, "Policy: Ensure ADLs are provided in accordance with accepted standards of practice. ... ADLs-(hygiene-grooming)..."	M 610	1. Fingernails were trimmed, filed, and cleaned for resident #62 on 2/11/2025 by the Nurse Practitioner and residents #253, and #74 by the Certified Nursing Assistant (CNA) on 2/14/2025. Resident #253 was shaved on 2/14/2025 by the CNA. Resident #74 was provided hair trimming extending from his ears on 2/11/2025 by CNA. The nurse assessed resident #62 on 2/11/2025 and assured the nails were trimmed and cleaned. Care plans were reviewed by Registered Nurse Assessment Coordinator (RNAC) on 2/12/2025 for all three residents and updated as needed. 2. All residents requiring assistance nail	3/14/25

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M 610	Continued From page 15 Resident #62 An observation and interview on 2/11/25 at 11:00 AM, revealed Resident #62's fingernails to be approximately 1/2 (one-half) inch long past the tips of the fingers, dirty in appearance with a dark brown substance under the nail beds. Resident #62 stated he would like to have them trimmed and confirmed he did not like them long. An observation on 2/12/25 at 1:30 PM, with Certified Nurse Assistant (CNA)#3 confirmed that Resident #62's nails were very long and dirty with a dried dark brown substance under the nail beds. She stated it appeared that the resident had not had nail care in a very long time. In an interview with the Director of Nursing (DON) on 2/12/25 at 2:09 PM, she revealed that if the residents were not getting personal hygiene it could lead to the spread of bacteria and skin concerns. She confirmed that Resident #62's nails should have already been cleaned and trimmed. Review of the "Admission Record" revealed the facility admitted Resident #62 on 8/23/23 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction. Record review of Resident #62's Section C of the Annual Minimum Data Set (MDS) dated 11/21/24 revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section: GG0130- I.) Personal hygiene-was coded setup or clean-up assistance. Resident #253	M 610	care and facial hair have the potential to be affected by this practice. 3. On 2/17/2025, The Director of Nursing (DNS) assured nursing staff completed a 100% audit on all residents to assess for dirty, jagged, or long nails and facial hair. Any residents identified with long/jagged or dirty nails were immediately addressed. Any resident refusing nail care or facial hair removal was care planned and charted as such. Any resident with personal choice for long nails or facial hair was care planned. Systemic changes implemented on 2/17/2025 to avoid this nail care and facial concerns included implementing daily environmental rounds check list to include observation of nails. Any resident with long/jagged or dirty nails or unkempt facial hair should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the administrator on 3/6/2025 with team members regarding updated environmental rounds along with implementation. Education completed on 2/28/2025 with staff on Activities of Daily Living (ADL) to assure understanding and importance of checking resident appearance, nails, hair, and overall grooming needs by the Director of Clinical Education. 4. On 2/17/2025, the Director of Nursing began an audit of a minimum of five residents weekly x four weeks then monthly for an additional two months to assure that nails are clean and trimmed and facial hair trimmed in accordance with the resident's wishes. The results of the audits will be addressed in the Quality Assurance and Performance Improvement	

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M 610	Continued From page 16 An observation on 2/10/25 at 10:10 AM, revealed Resident #253's fingernail beds to have a dark brown substance underneath them, and they were jagged in appearance. His facial hair was also observed to be unkept. An observation on 2/11/25 at 1:30 PM, revealed Resident# 253 to have a brown substance under his fingernail beds, and the fingernails remained jagged in appearance. An observation of Resident #253 on 2/11/25 at 1:53 PM, with CNA #2 confirmed the resident's nails were jagged and had a brown substance under the nail beds. In an interview with the Certified Occupational Therapist (COTA) on 2/11/25 at 1:55 PM, she stated that she has Resident #253 on caseload for upper body therapy and confirmed his fingernails were dirty last week and his facial hair was also unkept. In an interview with the DON on 2/11/25 at 2:05 PM, she confirmed that Resident #253 should have had nail care and that staff failing to provide personal hygiene care for any resident could lead to skin concerns and spread of bacteria. Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage. Record review of Resident #253's Section C of the Admission MDS dated 2/05/25 revealed the BIMS score was 9, indicating the resident was moderately cognitively impaired. Section: GG0130- I.) Personal hygiene-was coded partial/moderate assistance.	M 610	(QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M 610	Continued From page 17 Resident #74 An observation on 2/10/25 at 10:45 AM, revealed Resident #74 sitting in his wheelchair in the hallway with long gray hairs extending from both of his ears, approximately one-half (1/2) inch in length. His fingernails on both hands measured approximately one-fourth (1/4) inch in length and jagged with a brown substance underneath. An interview with the Memory Care Unit Coordinator on 2/10/25 at 1:29 PM, confirmed Resident #74 had long, jagged nails. She revealed the aides were responsible for cutting, cleaning, and filling them with showers. She revealed the resident could scratch himself and cause a skin injury. She stated the barber was responsible for trimming the resident's ear hair and explained he trimmed it when he had time but had not been there recently. Record review revealed the facility admitted Resident #74 on 11/30/23 with a medical diagnosis that included Cerebral Infarction.	M 610		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Pattern	M 655	1. Thrombo-embolic deterrent (TED) hose were applied to bilateral lower	3/14/25

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M 655	Continued From page 18 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for treating skin concerns (Resident #303) and application of TED (thromboembolic deterrent) compression hose for two (2) of 23 sampled residents. Resident #253 and #303 Findings include: Review of the facility policy titled "Skin Care Guideline" unrevised, revealed under, "Purpose: To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity." A review of a statement on facility letterhead titled, "Standards of Practice," revealed, "The expectation set forth by (Proper Name) management is that nurses comply with current standards of practice in terms of following physician's orders. This includes following orders for application of medical devices such as TED hose." Resident #253 Record review of a physician's order dated 1/30/25 for Resident #253 revealed, "TED hose - apply every am (morning) and remove every pm (night) due to orthostatic blood pressures." An observation on 2/10/25 at 10:10 AM, revealed Resident #253 lying in the bed with regular socks on his feet. An observation on 2/11/25 at 1:30 PM revealed no TED hose on Resident #253's legs and none	M 655	extremities of resident #253 by the nurse on 2/13/2025. Resident #303 was assessed by the nurse and a treatment order was obtained for the skin tear on 2/13/2025. This resident's careplan was updated to reflect the new plan of treatment. Resident #303 and #253 were assessed by the Director of Nursing (DNS) on 2/13/2025. There were no negative outcomes. 2. All residents have the potential to be affected by the deficient practice. 3. Nursing staff conducted 100% skin audit completed on 2/21/2025 of all residents to assess for any skin integrity concerns. There were no other residents identified with new skin concerns. On 2/21/2025 the DNS audited residents with physician orders for TED hose and verified placement. There were no other residents identified. Education was conducted by the Director of Clinical Education (DCE)on 2/28/2025 with the nursing department regarding standards of care and following physician orders to include application of TED hose. Education completed on 2/28/2025 with nurses on identification and obtaining orders from medical providers for addressing skin impairment concerns by the DCE. 4. Going forward, beginning on 2/17/2025 the DNS or team member will review daily for residents with identified skin impairment concerns to assure for presence of a treatment order. Beginning 2/17/2025, the Director of Nursing will audit residents with orders for TED hose and ensure application. This audit will occur five times weekly for four weeks, then monthly for two months. The results	

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M 655	Continued From page 19 in the resident's room. An observation of Resident # 253 on 2/11/25 at 1:53 PM with Certified Nurse Assistant (CNA) #2 revealed she was unaware of any TED hose and had not seen them on the resident. In an observation and interview with Licensed Practical Nurse (LPN) #3 on 2/11/25 at 2:10 PM, she revealed after review of Resident # 253's physician's orders, she confirmed the resident had an order for TED hose. An observation of Resident # 253 at this time with LPN #3 she confirmed the resident was not wearing TED hose and that if the resident did not wear the hose as ordered it could lead to increased episodes of orthostatic hypotension. An interview Physical Therapy Assistant (PTA) on 2/12/25 at 2:08 PM she revealed she has seen Resident # 253 several times over the past two weeks for physical therapy of the lower body and confirmed she had not seen the resident wearing TED hose until today. Review of the "Admission Record" revealed the facility admitted Resident # 253 on 1/29/25 with a diagnosis of Traumatic Subdural Hemorrhage. Record review of Resident #253's Section C of the MDS dated 2/05/25 revealed the BIMS score was 9, indicating the resident was moderately cognitively impaired. Section: GG0130- H.) putting on/taking off socks and shoes was coded as dependent (helper does all the effort). Resident #303 An observation on 2/10/25 at 10:50 AM, revealed Resident #303 sitting in a recliner in the activity	M 655	of the audits will addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M 655	Continued From page 20	M 655		

room. Two beige foam dressings observed on his left elbow with a moderate amount of brown drainage the size of 2 quarters. There was no date on the bandage.

Record review of Resident #303's "Order Summary Report" revealed there were no orders for any skin concerns.

An observation of Resident #303 on 2/13/25 at 8:56 AM, revealed two brown foam bandages observed to the left elbow with no date.

An observation and interview with Registered Nurse (RN) #3 on 2/13/25 at 9:02 AM, after removal of the two dressings on Resident #303's left arm revealed, a skin tear to the left upper arm above the elbow with intact skin and a skin tear to the elbow with no intact skin that was circular in appearance. A moderate amount of whitish drainage was present. RN #3 revealed she was not aware that the resident had skin tears. She revealed the resident did have a fall after admission and could have gotten a skin tear then. She confirmed the resident did not have an order for treatment and explained she had no idea how long the bandage had been there. RN #3 confirmed Resident #303 could get an infection or a delay in healing due to lack of treatment and monitoring.

Record review of the "Progress Notes" dated 2/1/25 for Resident #303 revealed, "Resident rolled out of bed and hit head on garbage can and cut above eyebrow, skin tear on left hand and left elbow." Also revealed, "The areas were cleaned and steri strips put on them."

An interview with Registered Nurse (RN) #1 on 2/13/25 at 11:02 AM, revealed without proper

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M 655	Continued From page 21 monitoring and treatment of Resident #303's skin tears, they could worsen and deteriorate and become infected. Record review of the "Admission Record" revealed the facility admitted Resident #303 on 1/30/25 with a diagnosis that included Acute Kidney Injury.	M 655		
M1015	45.35.2 Bathtubs, Showers, and Lavatories Bathtubs, Showers, and Lavatories. Bathtubs, showers, and lavatories shall be kept clean and in proper working order. They shall not be used for laundering or for storage of soiled materials. Neither shall these facilities be used for cleaning mops, brooms, etc. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a safe, clean environment as evidenced by an unsanitary toilet in room C-7 for one (1) of seventy-three resident occupied rooms observed. Findings Include: Review of the facility policy titled, "Resident Rights and Quality of Life Policy", dated 3/13/20, revealed, "A patient or resident has the right: ... to receive services in a center environment that is safe, clean, and comfortable ..." Findings include: An observation 2/10/25 at 10:45 AM of the bathroom in room C-7 revealed a raised toilet	M1015	1. The raised toilet seat in the bathroom of C7 was replaced by the Maintenance Director on 2/12/25. 2. All residents who have raised toilet seats have the potential to be affected by this deficient practice. 3. Facility staff were in-serviced 2/27/2025, on reporting damages to Maintenance for a safe, clean, comfortable and homelike environment. Nursing staff were educated on providing cleaning of soiled resident equipment. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator and the Director or Nursing will make rounds to ensure cleanliness of the environment one x week x four weeks beginning 3/4/2025 then monthly x two months. The results of the audits will be addressed in the Quality	3/14/25

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M1015	Continued From page 22 seat that had a large dark brown dried substance on the back of the toilet seat rim, and a smeared dark brown substance was also on the metal bar at the top of the back of the raised toilet seat. An observation of the bathroom of room C-7 with Certified Nurse Assistant #3 on 2/11/25 at 1:25 PM, she confirmed there was a large dried dark brown substance on the back of the toilet seat rim and a smeared dark brown substance on the metal bar at the top of the back of the raised toilet seat that appeared to be stool. She stated concerns about the toilet not being clean is that it is not sanitary and could lead to the spread of infection. She then stated the nursing staff are responsible for cleaning the toilets or any equipment or surface that is contaminated with bodily secretions. An interview with the Director of Nursing on 2/11/25 at 2:05 PM, she confirmed that nursing staff are responsible for cleaning equipment that is soiled with bodily fluids, she stated concerns from not sanitizing the toilet it is an infection control concern and sanitation issue and could lead to infections. In an interview with housekeeper #2 on 2/12/25 at 2:00 PM, she revealed housekeeping should notify their supervisor and nursing staff if they find a room that has surfaces or equipment soiled with bodily fluids. She then stated that the housekeeping staff clean the contaminated surfaces after nursing has cleaned the surfaces.	M1015	Assurance and Performance improvement (QAPI) meeting on 3/13/25 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	
M1210	45.40.7 Walls and Ceilings Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface	M1210		3/14/25

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M1210	Continued From page 23 and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a safe, clean environment as evidenced by a wall in disrepair for one (1) resident in the seventy-three resident occupied rooms observed. Resident #99 Findings Include: Review of the facility policy titled, "Resident Rights and Quality of Life Policy", dated 3/13/20, revealed, "A patient or resident has the right: ... to receive services in a center environment that is safe, clean, and comfortable ..." Resident #99 During the initial tour on 2/10/25 at 11:40 AM, an observation revealed a large section of paint, measuring approximately two feet wide by one and a half feet high, missing from the wall behind Resident #99's headboard. During an interview, Resident #99 stated he would like to have the paint repaired. During an observation of Resident #99's room with the DON and interview on 2/11/25 at 3:25 PM, the DON confirmed the wall needed repair. She stated the maintenance department is responsible for the repair of damaged walls and it was the staff's responsibility to report these concerns so they could be addressed. She confirmed each resident should have a room that is clean, comfortable and homelike and the facility	M1210	1. The Maintenance Director painted the section of wall in room of Resident #99 on 2/28/2025. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance Director was in-serviced on room inspection and reviewing work orders and timely completion by the Director of Clinical Education on 2/27/2025. Facility staff were in-serviced 2/27/2025, on reporting damages to Maintenance for a safe, clean, comfortable and homelike environment. 4. To monitor the performance of our corrective action and ensure sustainability, the Administrator and Maintenance Director will make rounds one x week x four weeks beginning 2/27/2025, then monthly x two months to ensure a safe, clean, comfortable environment. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI)meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M1210	Continued From page 24 failed to provide this for Resident #99. An interview on 2/12/25 at 8:50 AM, with the Administrator confirmed that the maintenance staff was responsible for painting and repairing damage. She stated the paint concern had been noted on the room rounds previously but had not been repaired. She confirmed each resident has the right to a safe, comfortable, home-like environment and the facility failed to provide this for Resident #99. Record review of Resident #99's "Admission Record" revealed the facility admitted the resident on 1/23/25 with medical diagnoses that included Traumatic Subdural Hemorrhage, Dysphagia, and Epilepsy. Record review of Resident #99's Admission MDS with an ARD of 1/30/25 revealed a Brief Interview for BIMS score of 9 which indicated the resident had a moderate cognitive impairment.	M1210		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a	M1570		3/14/25

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M1570	Continued From page 25 mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Widespread Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by: 1) not having procedures in place to monitor and test the water source for Legionella's Disease which had the potential to affect all residents in the facility; 2) storing of respiratory equipment on the floor for Resident #82, and 3) not using required Enhanced Barrier Precautions (EBP) Resident #11 and Resident #157 for three (3) of 23 sampled residents. Findings include: Record review of facility policy titled, "Infection Control Guide", dated 2022, revealed, " ...In order to accomplish the primary goal of infection control, which includes preventing or reducing the risk of healthcare associated infections, an epidemiology plan needs to be designed to include the following oversight operations and responsibilities: ... cleaning and disinfecting equipment ... prevention of infections ...Enhanced	M1570	1. Education was completed on 2/12/2025 by the Director of Clinical Education with Licensed Practical Nurse LPN#1 and Certified Nurses Assistant CNA#7 on enhanced barrier precautions (EBP) to assure use of appropriate personal protective equipment while performing care needs for residents. Resident #11 was assessed 2/11/2025 by the nurse and no negative outcome was noted. Education was completed by the Director of Clinical Operations on 2/11/2025 with RN#1 on enhanced barrier precautions to assure use of appropriate personal protective equipment while intravenous medications via a peripherally inserted central catheter. The resident was assessed by the Assistant Director of Nursing (ADNS) with no negative outcomes. On 2/11/2025 the Director of Nursing (DNS) cleaned the nebulizer, replaced the nebulizer tubing and ensured the nebulizer and tubing was stored appropriately from the floor for resident #82. This resident's care plan was updated on 2/12/2025 by the Director of	

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M1570	Continued From page 26 Barrier Precautions recommendations is to consider expanding the use of PPE (Personal Protective Equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug resistant organism) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, from nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infections or colonization..." Record review of facility policy titled, "Policies and Practices - Infection Control", dated 11/1/17, revealed, "This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. ... The objectives of our infection control policies and practices are to: a. prevent, identify, detect, investigate, report and control infections in the center; b. maintain a safe, sanitary, and comfortable environment for team members, residents, volunteers, visitors, and the general public..." Record review of facility policy titled, "Legionnaires' Disease: Detection, Response, Prevention" with revision date of 2/2/17, revealed, "The Center will utilize sound clinical and infection control practices to quickly identify and treat any	M1570	Clinical Education (DCE) to include that the resident will be encouraged to place nebulizer on bedside table and not on the floor. An audit of all residents was completed on 2/11/2025 to determine appropriate signage needed for residents requiring enhanced barrier precautions by the DCE. Appropriate signage was immediately placed to the resident doors. Procedures will be put into place by 3/12/2025 to monitor and test the water source for Legionnaires disease that includes the adherence to CMS QSO-17-30 and consideration of the CDC tool kit, a water management plan that includes a facility risk assessment for legionella that identifies areas of the water system where Legionella could grow and spread, control measures to mitigate or eliminate the risk of Legionella development, recording and monitoring of the control measures and a testing protocol on water cultures for the presence of Legionella. 2. All residents have the potential to be affected by this practice. No additional residents were observed to be impacted as of 2/12/2025. 3. Education was completed by the DCE on 2/12/2025 to assure staff understanding and implementation of EBP and storage of nebulizers and nebulizer tubing. Going forward, the facility will conduct environmental rounds daily for observation of required EBP signage. Any missing signage will be immediately addressed and corrected. An in-service was conducted by the DCE on 2/27/2025 with team members regarding updated environmental rounds along with	

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M1570	Continued From page 27 potential Legionnaires" related illnesses. ... This water management program will consist of the following... decide where 'control measures' should be applied and set limits, such as, temperature levels, disinfectant levels, acceptable ranges, etc., establish ways to intervene when control limits are not met (corrective actions), verify that your program is running as designed and is effective, document and communicate all activities of your Water Management Program." During an interview with Maintenance #1 on 2/13/25 at 10:15 AM, he revealed that they changed shower heads in the facility monthly, flushed unused water sources, and flushed eye wash stations to prevent Legionella. He stated he did not keep logs on the measures he had in place, and he did not monitor them to ensure the measures used were effective. An interview with the Administrator on 2/13/25 at 10:30 AM revealed Legionella and other water borne illnesses were serious and could cause major health complications. She stated the water system should be checked and monitored to ensure the residents were safe from any potential illness and to ensure this and thinks the water should be tested to be certain the measures in place were effective. She confirmed that the facility failed to have documented monitoring of the preventative measures testing to ensure they maintain the water system safely. Resident #11 During an interview on 2/11/25 at 9:30 AM, Resident #11 stated she had a sore on her bottom and her feet and she was receiving treatment on them.	M1570	implementation. All new admits and readmits will be reviewed for need for EBP signage by the DNS and DCE or team member. Control measures will be added 3/12/2025 to the centers computerized maintenance management system (TELS) so they can be recorded and monitored. In service on water management plan including control measures will be provided to the Water Management Team by the Senior Director of Plant Operations and the Senior Director of Risk Management on 3/12/2025. 4. On 2/12/2025, the Director of Nursing began an audit of a minimum of five residents weekly x four weeks then monthly x two months of residents to ensure implementation of EBP and appropriate storage of nebulizers and nebulizer tubing. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately. The Administrator will monitor control measures in TELS monthly x three months beginning on 3/12/2025. The results of the monitoring will addressed in the QAPI meeting on 3/13/2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M1570	Continued From page 28 An observation on 2/12/25 at 2:45 PM of wound care provided by Licensed Practical Nurse (LPN) #1 and assisted by Certified Nursing Assistant (CNA) #7 revealed revealed neither staff member donned a gown prior to beginning the care. During an interview on 2/12/25 at 2:47 PM with CNA #7 she stated she had been in-serviced on EBP but was nervous and forgot to put the gown on. LPN#1 revealed that this was his second day back after not working at the facility for over a year, and when he previously worked at the facility, EBP were not used. He stated he had been instructed on this new process, but did not have a good understanding of what was required. An interview with the Administrator on 2/12/25 at 2:55 PM, revealed EBP were required to reduce the spread of infection and should be used during care on a resident with a chronic wound. She confirmed the facility failed to use EBPs during wound care for this resident. During an interview on 2/12/25 at 3:15 PM, the Director of Nursing (DON) revealed EBP were required to reduce the likelihood of the spread of infection to a vulnerable resident with a wound. She confirmed the facility failed to ensure EBP was used as required for a resident receiving pressure wound care, which increased the risk of an infection to the resident. Record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 4/28/21 with medical diagnoses that included Protein Calorie Malnutrition, Polyneuropathy, History of Falling, and Chronic Pain. Record review of Resident #11's Significant Change in Status "Minimum Data Set" (MDS)	M1570		

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M1570	Continued From page 29	M1570		

with an Assessment Reference Date (ARD) or 1/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

Resident #82

During the initial tour on 2/10/25 at 11:05 AM, Resident #82's respiratory treatment nebulizer was noted on the floor next to the resident's bed. The tubing and mask were in a bag on top of the nebulizer. The resident stated he had lung issues and received treatments several times a day. He stated that he had asked staff about this being on the floor, but nothing was done differently.

An observation on 2/11/25 at 9:05 AM revealed the respiratory nebulizer on the floor by the resident's bed with tubing and mask lying on the floor next to nebulizer.

During an observation and interview on 2/11/25 at 1:30 PM, Resident #82 stated he had been at a doctor's appointment and received breathing treatment and pain medicine when he returned. Observation of nebulizer, tubing, and mask still on floor by bed.

During an observation in Resident #82's room and interview on 2/11/25 at 3:10 PM, the Director of Nursing (DON) verified that the resident's respiratory nebulizer, tubing, and mask were on the floor and was unacceptable. She stated this was a concern for infection control and the resident could "breathe bacteria into his lungs and become sick". She confirmed the nebulizer should be off the floor and the tubing and mask should be stored in a bag to ensure they remained clean. She confirmed the facility failed to ensure a resident's respiratory equipment was

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M1570	Continued From page 30	M1570		

clean and stored properly to assist in the prevention of a respiratory infection.

Record review of Resident #82's "Order Summary Report" revealed an order dated 1/28/25 for "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligrams)/3 ml (milliliters) inhale orally three times a day for COPD (Chronic Obstructive Pulmonary Disease).

Record review of Resident #82's "Admission Record" revealed the facility most recently admitted the resident on 1/23/25 with medical diagnoses that included Wedge Compression Fracture of Fourth and Fifth Lumbar Vertebra, Malignant Neoplasm of Bronchus or Lung, Emphysema, and Chronic Obstructive Pulmonary Disease.

Record review of Resident #82's admission MDS with an ARD of 1/30/25 revealed a BIMS of 12 which indicated the resident had a moderate cognitive impairment.

Resident #157

During a medication administration observation for Resident #157 on 2/11/25 at 2:50 PM revealed, Registered Nurse (RN)#1 administered intravenous (IV) antibiotics via a Peripherally Inserted Central Catheter (PICC) to the right upper arm, with no observation of staff wearing a gown as part of EBP. A continued observation revealed no signage was visible to alert staff that the resident was on EBP.

In an interview with RN #1 on 2/11/25 at 2:55 PM, she confirmed she forgot to wear a gown for EBP and confirmed she knew that EBP should have been used because the resident has a PICC line.

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M1570	Continued From page 31 She then revealed EBP is used for all residents with indwelling devices to add a layer of protection to reduce the risk of spreading infection. She also confirmed there was no signage on the door or in the residents' room alerting staff that EBP should be used. In an interview with CNA #1 on 2/11/25 at 3:00 PM, she confirmed she was assigned to Resident # 157 and then revealed she was not aware that the resident was on EBP. She confirmed she had not been using the precautions. She stated she knew the resident had a PICC line, but there was no sign on the door, so she did not think he was on any precautions. Record review of the "Order Summary Report" for Resident #157 revealed Cefazoline Fosamil 600 mg (milligrams) intravenously three times a day for septic discitis of the lumbar region until 3/10/25 with a start date of 2/5/25. ... In an interview with the Director of Nursing (DON) on 2/13/25 8:13 AM, she confirmed that RN #1 should have used EBP to protect the residents from increased risk of transfer of bacteria. She also confirmed that an EBP sign should have been on the door to alert staff that the resident was on EBP. Review of the "Admission Record" revealed the facility admitted Resident # 157 on 2/5/25 with a diagnosis that included Discitis of the Lumbar Region. Record review of Resident #157s Section C of the Admission MDS with an ARD of 2/12/25 revealed the BIMS score was 15, indicating the resident was cognitively intact.	M1570		