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	255273	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 3/11/25-3/13/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F580, F604, F641, F656, F677, F688, F692, F699, F761, F812, F851, and F880. The census at the time of the survey was 79 and the facility is licensed for 87 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		4/18/25

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

Electronically Signed | 03/27/2025

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on dialysis staff and facility staff interview, record review, and facility policy review, the facility failed to promptly notify the physician of a resident change in both nutrition and hydration status for one (1) of four (4) residents reviewed for nutrition. Resident #12 Cross Reference F692 Findings Include: Review of the facility policy titled "Change in a Resident's Condition or Status" with a revision	F 580	* On 3-13-25, the Director of Nursing(DON) contacted the dialysis clinic, that Resident #12 receives services at, to inquire about a recommendation that was faxed to facility in the month of February 2025. The dialysis clinic faxed the recommendation dated for February 20,2025. On 3-13-25, the Assistant Director of Nursing (ADON) notified the primary physician and the consulting Registered Dietician (RD) to notify them of the omission to implement the recommendation made on February 18,	

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F 580	Continued From page 2 date of May 2017, revealed, "Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status..." Record review of Resident #12's MAR revealed an order dated 1/09/25, "Dialysis Fluid Restriction 1,500cc (cubic centimeters). Record review of the "Registered Dietician Note" dated 2/18/25 for Resident #12 revealed, "RD (Registered Dietician) spoke with RD from dialysis regarding resident having issues with fluid overload. RD suggests changing TF (tube feeding) to Nutren 2.0 in order to meet needs for weight gain/wound healing without having excess fluids to prevent overload. Dialysis RD agrees and will monitor dialysis labs for elevated phosphorous. Dialysis RD states that fluid restriction for resident is 1000 ml (milliliters) H20 (water), however online orders (facility physician orders) show 1500 ml (milliliters) H20 (water)." Additionally revealed under, "Interventions: 1. Consult MD (physician) for fluid restriction clarification. 2. Change TF (tube feeding) to Nutren 2.0 (1) can five (5) times per day. Flush with 50 ml (milliliters) H20 (water) after each feeding. TF (tube feeding) will provide 2500 calories, 100 grams protein, 1125 milliliters free H20 (water) 1500 milliliters total H20 (water). 3. Change med flushes to 15 ml (milliliters) H20 (water) before and after meds. Med flushes will provide 60-90 milliliters H20 (water). Goal: WG (weight gain) to IBW (ideal body weight), TF (tube feeding) to meet needs for dialysis and desired WG (weight gain)." Record review of Resident #12's Medication	F 580	2025 to decrease Resident #12 fluid intake. On 3-13-25, the ADON received an order approving the recommendation of decreasing Resident #12 fluid intake. On 3-13-25, the order was implemented by the ADON. On 3-14-25, the DON completed 100% audits of all consultant recommendations for the month of February 2025 to ensure the primary physician was notified of any recommendations made. No other omissions were identified. * All residents are followed by outside consultants monthly; therefore, all residents could have been affected by an omission. * On 3-25-25, the DON began an in-service with the nursing staff, with the guidance of the policy titled, "Change in a Resident's Condition or Status". On 3-25-25, the Quality Assurance (QA) Committee reviewed said policy and it was determined that the policy needs no changes or updates. On 3-26-25, the Nurse Consultant in-serviced the DON, ADON, Registered Nurse Supervisor and the Treatment nurse on ensuring recommendations are followed up on according to policy. Following the policy, physicians will be notified within twenty-four (24) hours of recommendations; unless an emergency and requiring significant change to resident's plan of care; the RN Supervisor and the ADON will be responsible to fax or email recommendations within 2 hours for significant changes to plan of care.	

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F 580	Continued From page 3 Administration Record (MAR) revealed the RD recommendations dated 2/18/25 were not implemented. Record review of Resident #12's MAR revealed an order dated 2/12/25, "Enteral Feed Order ... Nepro 1 can six (6) times per day via bolus. Flush with 30 ml (milliliters) H20 (water) after each feeding. Tube feeding will provide: 2560 calories, 115 grams protein, 1394 cc (cubic centimeter) free H20 (water), 1782 cc (cubic centimeter) total H20 (water)." Also revealed an order dated 3/7/25, "Enteral Feed Order every shift: Flush peg tube (Percutaneous Endoscopic Gastrostomy) with 15cc (cubic centimeters) of water before and after administration of medication and 5cc (cubic centimeters) in between each medication. A telephone interview with the facility RD on 3/12/25 at 10:40 AM revealed she last saw Resident #12 in the facility on 2/18/25. She revealed she called and spoke with the dialysis RD. The RD revealed that after speaking with the Dialysis RD, she was made aware that the resident should be on a 1200 ml fluid restriction. The RD explained that she made recommendations that day to change the enteral feedings to Nutren 1 can bolus 5 times daily and to change up the flushes. She revealed she also recommended contacting the MD for a clarification on the fluid restriction. She revealed she gave the recommendation to the Director of Nursing or the Assistant Director of Nursing while she was at the facility. An interview with the Director of Nursing (DON) on 3/12/25 at 10:53 AM confirmed the RD recommendations should have been put into place for Resident #12. She explained that she	F 580	* Beginning on 3-14-25, the DON began doing audits on 100% of recommendations made within 7 days of receiving to ensure proper and timely notification to physicians; this will continue as an on-going basis. The QA Committee will receive an update on all non-compliance concerns on a weekly basis for six (6) weeks, beginning at the scheduled meeting for 3-26-25, or a special called QA meeting for major concerns identified; then monthly for two (2) months to ensure compliance is maintained.	

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F 580	Continued From page 4	F 580		

remembered talking to the RD and then going back and forth about his changes. The DON revealed the RD recommendation must have been misplaced because she was unable to locate it. She revealed once the RD makes a recommendation, it was given to her, and she placed it in the physician's folder for him or the nurse practitioner to review.

A telephone interview with "Proper Name of Dialysis Company" RD on 3/12/25 at 1:18 PM revealed the facility had the resident on a 1500 ml (milliliter) fluid restriction, which was not what the dialysis physician had ordered. The RD revealed that she faxed a 1200 ml (milliliter) fluid restriction physician order to the facility on 2/20/25.

A follow up interview with the DON on 3/12/25 at 2:48 PM confirmed that the physician was not made aware of Resident #12's new RD recommendations via telephone because she thought the nurse practitioner intended to come to the facility a couple of days later and could have reviewed it then. She acknowledged the physician should have been made aware as the resident had had a delay getting the care.

Record review of the "Dialysis Orders Log" for Resident #12 revealed an order dated 2/20/25, "Patient to follow a fluid restricted diet, limiting fluid intake to 1200 ml (milliliters) per day. Monitor fluid closely and report any concerns to dialysis unit."

Record review of the "Admission Record" revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure with Stage 5 Chronic Kidney

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F 580	Continued From page 5 Disease and End Stage Renal Disease.	F 580		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy, the	F 604	* On 3-13-25, the Director of Nursing (DON), removed the bed and chair alarm	4/18/25

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F 604	Continued From page 6 facility failed to ensure a resident's right to be free from physical restraints when a bed alarm pad and a wheelchair alarm pad were used that restricted the resident's movements. The alarms caused the resident to stop moving to avoid triggering the alarm sounds, demonstrating a restrictive effect for one (1) of two (2) residents reviewed for restraints. (Resident #67) Findings include: Review of the facility policy titled "Use of Restraints," revised April 2017, revealed "Policy Interpretation and Implementation: 'Physical Restraints' are defined as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body..." An observation and interview with Resident #67 on 3/11/25 at 10:15 AM revealed a bed alarm pad attached to the resident's bed. During the interview, Resident #67 stated that the bed alarm went off frequently and voiced, "I hate it." He reported that when the alarm sounds, he stops moving so it will stop alarming. During an interview with Certified Nurse Assistant (CNA) #6 on 3/13/25 at 8:16 AM, she confirmed that Resident #67 had a bed alarm pad in place due to a history of frequent falls. When asked if the resident had ever complained about the alarm pad, CNA #6 stated that she had observed the resident stop moving or attempting to get up when the alarm sounded, as he did not want it to continue. When asked if she reported this behavior, she stated that she believed she did.	F 604	from Resident #67 room. On 3-13-25, the DON, removed all bed and chair alarms from the general supply room to ensure they could not be accessed without the proper order, care plan and consent being in place before application. * Seven (7) residents had the potential to be affected by having a bed or chair alarm placed. * On 3-25-25, the DON reviewed the care plans for each resident that has an order for a bed or chair alarm to ensure it was updated with interventions to prevent resident being "restrained" by the sound of the alarm. On 3-25-25, the DON began meeting with each resident with an order for bed or chair alarm to see if the alarm made them not "move" or if it is a reminder for them to call for help when needed. No further adverse effects were identified. On 3-26-25, the DON did an in-service for all staff that performs room rounds to inquire with the resident how they feel about the alarms and to report that in the morning staff meeting on a weekly basis; this will be on-going. On 4-2-26, the DON began an in-service with all nursing staff on the use of restraints and when an alarm becomes a restraint. * The RN Supervisor will be responsible to audit each resident weekly to determine if a bed or chair alarm stops them from moving; the DON began the audits on 3-25-25 and reported to the QA Committee on 3-26-25 at the already scheduled meeting.	

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F 604	Continued From page 7 A record review of the Order Summary report for Resident #67 revealed no physician order for a bed alarm pad. Further review revealed an order dated 10/15/24 for a wheelchair/chair alarm pad to alert staff of attempts to get up unassisted. An interview with the Medicare Nurse on 3/12/25 at 8:35 AM confirmed that if Resident #67 stated he stops moving to make the alarm stop and staff reported observing the resident stopping movement in response to the alarm, the alarms would be considered a restraint. She confirmed that no restraint assessments had been completed for either alarm devices because she was unaware that the alarm was restricting the resident's movement. She also revealed the resident only had an alarm pad ordered for the wheelchair and was not aware that he had an alarm pad to the bed. During an interview with the Director of Nursing (DON) on 3/13/25 at 8:50 AM revealed that she was unaware that Resident #67 had voiced his dislike for the alarm or that it caused him to stop moving. She confirmed that while the resident had an order for an alarm pad on the wheelchair, there was no order for an alarm pad on the bed. The DON stated she did not know when or by whom the bed alarm pad was placed. She confirmed that if the resident expressed distress about the alarm and staff verified his behavior of stopping movement to silence it, both alarm devices would be considered restraints. During an interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 3/13/25 at 3:34 PM revealed concerns about the use of restraints, stating that they could lead to	F 604	The Quality Assurance Committee will be notified, by the identifying staff member, of any adverse reactions to an alarm within 2 hours of the complaint, as an on-going basis, to determine the risk and the benefits. The QA committee will monitor the results of said findings weekly for six (6) weeks; then monthly for two (2) monthly.	

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F 604	Continued From page 8 anxiety or depression and hinder residents from performing daily activities independently. Record review of the "Admission Record" revealed Resident #67 was admitted on 1/19/2024, with a diagnoses which included Repeated Falls. A record review of Resident #67's Minimum Data Set (MDS), Section C with an Assessment Reference Date (ARD) of 2/12/2025, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was severely cognitively impaired.	F 604		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete section N of the Minimum Data Set (MDS) for a resident taking an antiplatelet medication for one (1) of 23 MDS assessments reviewed. Resident #42 Findings Include: Review of the facility policy titled "Resident Assessment Instrument" with a revision date of September 2010 revealed under, "Policy Statement: A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission." Additionally revealed, "4. Information derived from	F 641	* On 3-17-25, the Director of Nursing (DON) in-serviced the assessment nurses, using the MDS 3.0 User's Manual section N0415, on when to code a medication as an anticoagulant. On 3-26-25, the Minimum Date Set (MDS) Coordinator modified the assessment with the Assessment Reference Date (ARD) of 12/3/24, to reflect the medication as an antiplatelet. * The DON completed a review of all residents that are prescribed an antiplatelet, with 23 being identified; therefore, 23 residents had the potential to be affected by this encoding error.	4/18/25

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F 641	Continued From page 9 the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practical level of functioning." Record review of the Annual MDS with an Assessment Reference Date (ARD) of 12/3/24 revealed, under Section N, Resident #42 was coded as receiving an anticoagulant (blood thinner) medication during the 7-day look back period. Record review of the Medication Administration Record (MAR) for November and December 2024 revealed Resident #42 did not receive an anticoagulant (blood thinner) medication. Additionally, the resident did receive the antiplatelet medication Plavix. An interview with the Medicare Nurse on 3/12/25 at 9:40 AM confirmed Resident #42 did not receive an anticoagulant medication and revealed that Section N was coded wrong. She explained that the antiplatelet box should have been marked. The Medicare Nurse revealed they follow the Resident Assessment Instrument (RAI) manual for guidance in completing the assessments, and acknowledged Resident #42's MDS should be accurate to reflect the resident's status. Record review of the "Admission Record" revealed the facility admitted Resident #42 on 1/04/23 with a medical diagnosis that included Alzheimer's Disease.	F 641	* On 3-17-25, the DON in-serviced the MDS Coordinator and the MDS nurse on accurate coding of medications. The policy titled, Resident Assessment Instrument, was reviewed on 3-26-25 along with the Resident Assessment Critical Element Pathway by the QA Committee. No changes in policy nor any changes in procedure is needed. However, it is determined the additional training that was completed on 3-17-25 was appropriate. * On 3-25-25, the DON began audits of all MDS assessments completed each week for six (6) weeks to ensure proper classification of medications on the MDS. On 3-26-25, the Quality Assurance (QA)Committee reviewed the current encoding error and determined that encoding of medications should be reviewed for twelve (12) weeks; and the QA Committee would receive an update for any non-compliance during the weekly scheduled QA meetings on Wednesday for six (6) weeks; then monthly for two(2) months. Next scheduled QA meeting scheduled for 4-2-25.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		4/18/25

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F 656	Continued From page 10	F 656		

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required 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

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F 656	Continued From page 11 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to develop and/or implement care plans related to Activities of Daily Living (ADL) care for Residents #1, #34, #61 and #67, failed to develop a care plan related to Post-Traumatic Stress Disorder (PTSD) for Resident #41, and failed to develop a care plan related to activities for Resident #68. Additionally, the facility failed to implement a care plan intervention for a contracture device for Resident #12 for seven (7) of 23 resident care plans reviewed. The scope/severity of this deficiency was increased to "E" Pattern due to prior citation on the last Annual Recertification Survey. Findings include: Record review of the policy titled, "Care Plans, Comprehensive Person-Centered", revised December 2016, revealed its Policy Statement: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident # 1 Record review of Resident #1's ADL care plan	F 656	* On 3-13-25, the care plans for Resident #1, #34,#61, #67, #68, #41, and #12 were reviewed by the Director of Nursing (DON). Through this review it was determined what interventions were not implemented for each resident; interventions were then implemented as follows; Resident#1 had a hair cut and was shaved on 3-13-25 by the barber, Resident #34 had a hair cut and a shave on 3-13-25 by the barber; Resident #61 had a hair cut and a shave by the barber, on 3-13-25; Resident #67 had a hair cut and a shave by the barber, on 3-13-25; Resident #68 had an activity care plan developed by the Activity Director on 3-28-25; Resident #41 had his Trauma Informed Care care plan updated to include identified triggers, by the Social Worker on 3-14-25 and Resident #12 had his splint placed on his wrist by the Assistant Director of Nursing on 3-13-25. * All residents have the potential to be affected by failure to follow the interventions per the care plan. * The Quality Assurance Committee met on 3-26-25 to determine if there were any systems that needed to be revised or if the policy on care plans needed revision. It was determined during this meeting that	

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F 656	Continued From page 12 revealed, "Focus: Resident requires supervision-total assistance with ADL's r/t (related to) impaired mobility urostomy and colostomy status right aka above knee amputation) left bka (below knee amputation), DM... Interventions ...Shave resident prn (as needed) ...Shower three (3) times a week sponge bath on other days. On 3/11/25 at 9:34 AM, an observation and interview revealed Resident #1's facial hair was approximately ¾ inch long on his chin, sides of his face, and neck area. His hair was unkempt and thick. Resident #1 revealed the barber hadn't been here in quite some time; and stated "I would like to have a haircut and be shaved." He revealed no one had asked him if he wanted to be shaved or have a haircut, and it's been a very long time. On 3/12/25 at 9:35 AM, during an observation and interview the Director of Nurses (DON) confirmed that Resident #1 needed to be shaven, and his hair needed to be cut. The DON confirmed that Resident #1 had a care plan to shave the resident prn, and his plan of care was not being followed. A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 03/07/2022 with diagnoses that included Type 2 Diabetes Mellitus with Hypoglycemia without Coma, and Functional Quadriplegia. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/25 revealed, in Section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.	F 656	the policy did not need any revision; however, training and auditing did need to completed. On 3-26-25, the DON in-serviced the Interdisciplinary Team on the policy titled, "Care Plans, Comprehensive Person-Centered". * Audits began on 3-13-25 by the ADON by observing residents to ensure they had been shaved and a hair cut. The Interdisciplinary Team (IDT) began auditing and revising, as needed, care plans on 3-20-25. The IDT will audit and revise care plans with each care plan meeting that is scheduled for each resident on a quarterly basis. The QA Committee will receive an update on all non-compliance concerns regarding failure to implement an intervention or care plan. This will be done weekly for six(6) weeks and then monthly for two(2) months.	

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Resident #61

Record review of Resident #61's ADL care plan revealed, "Focus: Resident requires assistance with ADLs 's d/t (due to) decreased mobility, colostomy status, incontinence of bladder, schizophrenia and depression...Interventions. Shower 3 times a week sponge bath on other days.

On 3/11/25 at 9:55 AM, an observation and interview revealed Resident #61 had facial hair approximately one and a half inches long to his cheeks, chin, and neck and hair that was unkempt, long, and greasy. Resident #61 stated it's been a long time since he had been shaved and had a haircut.

During an interview on 3/12/25 at 3:05 PM, the DON confirmed that the staff is responsible for addressing the residents' grooming needs daily and ensuring they are adequately groomed, which includes shaving and hair care.

During an interview on 3/12/25 at 1:30 PM, the Medicare Nurse revealed she and the MDS nurse are responsible for developing the residents' nursing care plans. She revealed that the purpose of the care plan is to paint a thorough picture of the resident's individualized needs, and anyone can look at their care plan and know exactly their needs. She confirmed that the care plan for Resident #61 was not developed to reflect his shaving and that it should have been. After reviewing the care plans for Resident #1 and Resident #61, she revealed they were very vague about the interventions needed for their hygiene and grooming needs.

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A record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 08/17/2022 with diagnoses that included Paranoid Schizophrenia and Depression.

A record review of the MDS with an ARD of 01/06/25 revealed, in Section C, a BIMS score of 15, which indicated Resident #61 was cognitively intact.

Resident #41

Record review of Resident #41's Admission Record" revealed the resident was re-admitted to the facility on 12/02/2024 with medical diagnoses that included Post Traumatic Stress Disorder (PTSD), and Bipolar Disorder.

Record review of Resident #41's "Care Plan Detail" revealed under, "Focus: Resident has a dx (diagnosis) of PTSD related to killing other humans with a machine gun in combat. Resident has experienced other trauma such as death of close family, being assaulted in lifetime. "Under, Interventions/Tasks, the care plan was not developed for triggers or trigger-specific interventions.

On 3/12/25 at 8:35 AM, during an interview, Resident #41 confirmed that he does have PTSD that stems from when he came home from Vietnam and the treatment that he received during the war.

In an interview on 3/12/25 at 8:50 AM, CNA #5 revealed Resident #41 doesn't have behaviors now, but he use to have a lot of behaviors. She

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stated that she wasn't sure if the resident had PTSD or not.

On 3/12/25 at 9:40 AM, in an interview the Social Worker (SW) stated that she didn't know what Resident #41's triggers were. She revealed she had never discussed his PTSD or triggers with the him and confirmed he did not have a PTSD care plan that addressed any triggers.

On 3/12/25 at 10:00 AM, during an interview the DON confirmed that Resident #41 has PTSD. She revealed his trigger were being awakened in the middle of the night by staff knocking on the door and entering the room. She confirmed that the resident did not have a PTSD care plan that addressed trigger-specific interventions, so therefore the staff were not made aware so that they could try and prevent re-traumatization.

Record review of Resident #41's MDS with an ARD of 1/15/2025 revealed in Section C, a BIMS score of 15, which indicated the resident is cognitively intact.

Resident #12

Review of Resident #12's "Care Plan" revealed, "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) decreased mobility and function, incontinent of bowel and bladder, HTN (hypertension), PVD (peripheral vascular disease), GERD (gastroesophageal reflux disease), Pain, ESRD (end stage renal disease), multi contractures, Hx (history) dysphagia". Additionally revealed under, "Interventions/task: Resident will wear resting hand splint on LUE (left upper extremity) x (times) 4-6 hours daily, report to OT (occupational

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therapy) any complications".

On 3/11/25 at 9:37 AM, an observation of Resident #12 revealed he was lying in bed with a left upper extremity contracture without a device in place.

On 3/12/25 at 8:08 AM and again at 9:30 AM, an observation of Resident #12 revealed he was lying in bed without a contracture device in place on the left extremity.

On 3/12/25 at 9:45 AM, an observation and interview with the Assistant Director of Nursing (ADON) confirmed Resident #12 was not wearing the ordered splint.

An interview with the Medicare Nurse on 3/13/25 at 8:02 AM confirmed the staff did not follow the care plan for Resident #12's splinting device.

Record review of the "Admission Record" revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 5 Chronic Kidney Disease and End Stage Renal Disease.

Resident #68

Record review of Resident #68's "Care Plans" revealed a care plan was not developed for activities.

An interview with the Medicare Nurse on 3/13/25 at 8:05 AM confirmed an activity care plan was not developed for Resident #68 and should have been. She revealed the Activity Director is

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responsible for developing the activity care plans.

An interview with the Activity Director (AD) on 3/13/25 at 8:20 AM revealed she had been working at the facility for one year. She revealed Resident #68 did participate in activities but was more of a sit and watch person due to her poor attention span even though she did like to talk. The AD admitted that when the facility changed charting systems in August 2024 she did not develop an activity care plan for the resident and confirmed that it should have been done to determine the resident's functional abilities and preferences.

Record review revealed the facility admitted Resident #68 on 3/07/23 with a medical diagnosis that included Dementia.

Resident #34

Record review of Resident #34's care plan related to ADLs, last revised on 10/11/2024, revealed the focus area indicated that he required extensive assistance with personal hygiene related to muscle weakness, decreased mobility, pain, and history of falls. Interventions/tasks revealed resident requires extensive assistance with personal hygiene.

On 3/11/25 at 10:30 AM, an observation and interview revealed Resident #34 to be unshaven and his hair appeared oily with visible white flakes around the scalp edges. He expressed a desire to be shaved and have his hair washed but was unable to recall the last time he received such care.

Record review of Resident #34's MDS Kardex

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Report also noted that he required extensive assistance with personal hygiene.

An interview on 3/12/25 at 8:31 AM, with the Medicare Nurse confirmed, after reviewing the ADL care plan for Resident #34, that staff had not implemented the required personal hygiene interventions outlined in the ADL care plan.

Record review of Resident #34's "Admission Record" revealed he was admitted to the facility on 9/11/2024, with diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 1 through Stage 4 Chronic Kidney Disease, and Malignant Neoplasm of Bladder.

Record review of Resident #34's MDS Section C, with an ARD of 12/16/2024, revealed a BIMS score of 14, indicating the resident was cognitively intact ...Section GG 0130 Self Care was coded dependent.
Resident #67

A review of Resident #67's Care Plan titled, "Resident requires assistance with ADLs r/t incontinence, dementia, and muscle weakness," last revised on 2/16/25, revealed no interventions related to personal hygiene assistance.

On 3/11/25 at 10:00 AM, during an observation and interview with Resident #67 the resident was noted to be unshaven with unkempt facial hair and his face and hair appeared oily. When asked about his personal care routine, the resident stated he had not been shaved in a while and could not recall when his hair was last washed.

An interview with the Medicare Nurse on 3/13/25

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F 656	Continued From page 19 at 8:35 AM confirmed that after reviewing Resident #67's ADL care plan, it was not developed to include personal hygiene interventions. She stated that comprehensive care plans should accurately reflect a resident's needs and guide staff in providing necessary care. An interview with the DON on 3/13/25 at 8:50 AM acknowledged that if care plans related to ADL's do not include personal hygiene interventions, staff may not provide essential hygiene assistance, leading to unmet care needs. A review of Resident #67's Admission Record revealed that he was admitted on 1/19/2024, with a diagnosis of Infrarenal Abdominal Aortic Aneurysm. A review of the MDS Section C with an ARD of 2/12/25, revealed a BIMS score of 7, indicating severe cognitive impairment. Section GG ADL was coded as Item 01301 Personal Hygiene dependent.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for residents that require assistance for four (4) of seventy-nine (79)	F 677	* On 3-13-25, the barber at the facility cut and shaved the residents #1, #34, #61 and #67. On 3-13-25, other residents also received a hair cut according to their wishes.	4/18/25

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F 677	Continued From page 20 residents observed during the initial tour. Resident's #1, #34, #61 and #67 The scope/severity of this deficiency was increased to "E" - Pattern due to prior citation on the last Annual Recertification Survey. Findings include: Review of the facility policy titled, "Quality of Life," revised August 2009, revealed Policy Interpretation and Statement: 3.) "Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc. (et cetera). Resident #1 An observation and interview on 3/11/25 at 9:34 AM revealed Resident #1's facial hair was approximately ¾ inch long on his chin, sides of his face, and neck area. His hair was unkempt and thick. Resident #1 stated, "The barber has not been here in quite some time. I would like to have a haircut and be shaved." He admitted that no one had asked him if he wanted to be shaved or have a haircut, and it's been a very long time. An observation on 3/12/25 at 8:20 AM revealed Resident #1 with no change in appearance from the previous day. During an interview and observation on 03/12/25 at 9:25 AM, Certified Nurse Aide (CNA) #1 revealed she was assigned to Resident #1 and confirmed he had long facial hair and needed a haircut. She admitted she was not sure if the resident wanted to be shaved because she had not asked and confirmed that she should have put him down on the barber list for a haircut.	F 677	* The majority of the residents at facility use the in-house barber; therefore, all residents could have been affected by staff not asking residents if they want a hair cut or shave. * The Quality Assurance (QA) Committee held a meeting on 3-26-25 to determine if current system of having residents hair cut was in need of any modifications. The QA Committee determined on 3-26-25 that a new system needed to be implemented to ensure each resident has the opportunity to have their hair cut monthly. The QA Committee agreed to have a "Barber Shop List" binder which would include every residents name and the date of any trips to barber shop or the refusal to have hair cut, the binder was started on 3-26-25. The social worker will be responsible to ask each resident during the first part of the month if they would like a hair cut for that month. The social worker will then make a list and follow up to ensure the hair cut was received. * Beginning on 3-13-24, the Social Worker will be responsible to ensure each resident has a hair cut or offered and declined a hair cut monthly. The Social Worker will ensure there is proper documentation made to clarify when and if the resident received a hair cut; this will be an on-going process. The QA committee will have a report provided at each weekly meeting scheduled for Wednesdays for the next 4 weeks; then	

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During an observation and interview on 3/12/25 at 9:35 AM, the Director of Nurses (DON) confirmed that Resident #1 needed to be shaven, and his hair needed to be cut. She stated, "He's able to tell the staff when he wants it to be done." Resident #1 replied, "But I don't know when the man comes to cut our hair." He stated to the DON that he had his haircut last year, and the barber also shaved him at that time, but that was the last time he was shaven. Resident #1 then confirmed that he would like to be shaved and have his hair cut.

A record review of the "Daily Barber Shop Charges" revealed Resident #1's last haircut was on 10/8/24.

A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 3/07/2022 with diagnoses that included Type 2 Diabetes Mellitus with Hypoglycemia without Coma, Tachycardia, and Functional Quadriplegia.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Jan 20, 2025 revealed, in Section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.

Resident #61

An observation and interview on 3/11/25 at 9:55 AM revealed Resident #61 had facial hair approximately 1.5 (one and one-half) inches long to his cheeks, chin, and neck and his hair was long, and greasy. Resident #61 admitted that it had been a long time since he had been shaved

monthly for two (2) months. The next scheduled QA meeting will be held 4-2-25.

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and had a haircut, and he wanted to have those things taken care of.

An observation on 3/12/25 at 8:20 AM revealed Resident #61 with no change in appearance from the previous day.

In an interview and observation on 3/12/25 at 8:55 AM, CNA #5 confirmed that Resident #61 needed to be shaved and have his hair washed and cut. She revealed that she was assigned to Resident #61 today and stated that he was "looking rough." She then stated that she wasn't sure how long it had been since the resident had a haircut or had been shaved.

A record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 8/17/2022 with diagnoses that included Hypokalemia and Depression.

A record review of the MDS with an ARD of 1/6/25 revealed, in Section C, a BIMS score of 15, which indicated Resident #61 was cognitively intact.

Resident #34

An observation and interview on 3/11/25 at 10:30 AM, revealed Resident #34's hair was greasy with white flakes around the scalp edges and his face had visible facial hair. He stated he could not remember the last time his hair was washed, or he was shaved but he wanted it done.

An observation on 3/12/25 at 8:25 AM, with CNA #4, confirmed that Resident #34 appeared to have gone without a shower or hair wash for an extended period.

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F 677	Continued From page 23	F 677		

An observation on 3/12/2025 at 8:27 AM, with Registered Nurse (RN) #3, she confirmed Resident # 34 looked "scruffy and unkempt."

Record review of Resident #34's "Admission Record" revealed he was admitted to the facility on 9/11/2024, with diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Stage 1 through Stage 4 Chronic Kidney Disease, and Malignant Neoplasm of Bladder.

Record review of Resident #34's MDS Section C, with an ARD of 12/16/2024, revealed a BIMS score of 14, indicating the resident was cognitively intact. Section GG 0130 Self Care was coded dependent.
Resident #67

During an observation and interview with Resident #67 on 3/11/25 at 10:00 AM, the resident's face and hair appeared oily with long unkempt facial hair. The resident stated he had not been shaved in a while and could not remember when his hair was last washed.

An observation with CNA #6 on 3/12/25 at 8:16 AM confirmed that Resident #67's facial hair was unkempt, needed to be shaved, and his face and hair were oily and needed washing.

During an interview with the DON on 3/13/25 at 8:50 AM, she confirmed that all residents should receive personal hygiene daily and as needed. She acknowledged that a lack of personal hygiene could lead to potential skin issues.

Review of the ADL documentation for Resident #67 from 2/27/25-3/12/25 revealed only two days

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F 677	Continued From page 24 of documentation for personal hygiene. A review of Resident #67's Admission Record revealed that he was admitted on 1/19/2024, with a diagnosis of Infrarenal Abdominal Aortic Aneurysm. A review of the MDS, Section C, dated 2/12/25, revealed a BIMS score of 7, indicating severe cognitive impairment. A review of the MDS-Nursing (7) Seven-Day Look Back Report dated 3/12/25 documented that Resident #67 was coded as dependent for Section GG: 01301 - Personal Hygiene.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		4/18/25

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F 688	Continued From page 25 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a splint was applied for a resident with contractures for one (1) of 35 residents with limited range of motion (ROM) residing in the facility. Resident #12 The scope/severity of this deficiency was increased to "E" Pattern due to prior citation on the last Annual Recertification Survey. Findings Include: Review of the facility policy titled "Resident Mobility and Range of Motion" with a revision date of July 2017, revealed under, "Policy Statement: 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable..." An observation of Resident #12 on 3/11/25 at 9:37 AM revealed he had a left upper extremity contracture with no contracture device in place. An observation of Resident #12 on 3/12/25 at 8:08 AM and again at 9:30 AM revealed the resident continued to have no device in place for the left extremity contracture. Record review of Resident #12's March 2025 Medication Administration Record (MAR) revealed an order dated 6/11/24, "Resident to wear resting hand splint to LUE (left upper	F 688	* On 3-13-25, the Assistant Director of Nursing(ADON) applied the splint to the Resident #12. * Four(4) residents have orders to apply splints; therefore, four(4) residents had the potential to be affected by not having their splints applied. * A review completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Director of Rehab (DOR) on 3-26-25 revealed that Resident #12 needed to be re-screened from previous recommendations to determine the most appropriate device for him; therefore, a new screening will be completed. During the review, it was determined that the responsibility of applying the splints would be assigned to the assigned nurse for each day. The ADON began in-servicing staff on 3-26-25, regarding the application of splints per physician orders, using the policy titled "Resident Mobility and Range of Motion". * On 3-17-25, the DON began audits to include 100% of the residents with splint orders at various times and various days, per week for six (6) weeks; then monthly for two (2) months. The Quality Assurance Committee reviewed plan of correction (POC) during the 3-26-24 QA meeting and approved said POC. The QA Committee will receive an update on any non-compliance concerns during the weekly QA meeting scheduled for each Wednesday for six (6) weeks, then	

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extremity) daily. Put on at 8:00 AM. Leave on resident 4-6 hours as resident will allow. One time a day to prevent declining contracture report to OT (Occupational Therapy) any complications."

An observation and interview with the Assistant Director of Nursing (ADON) on 3/12/25 at 9:45 AM confirmed Resident #12 was not wearing the ordered splint. She revealed the aides were responsible for applying the device and the nurses were to ensure it was applied. The ADON revealed failing to apply the splint could cause worsening contractures.

An interview with Licensed Practical Nurse (LPN) #3 on 3/12/25 at 9:51 AM confirmed she did not ensure Resident #12 had on his hand splint yesterday or today. She revealed she was unsure where the splint was but thought it could be in the laundry. She confirmed she signed off on the MAR as administered yesterday and admitted she did not go back to ensure it was applied.

An interview with Certified Nurse Aide (CNA) #1 on 3/12/25 at 10:15 AM revealed she worked last night, and Resident #12 did not have his splint in his room. She stated, "I guess someone took it to laundry because he didn't have it." She confirmed she did not look for it.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/24 revealed under section GG, Resident #12 had upper extremity (shoulder, elbow, wrist, hand) functional limitation in Range of Motion (ROM) on both sides.

Record review of the "Admission Record" revealed the facility admitted Resident #12 on

monthly for two(2) months, then quarterly on an ongoing basis.

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F 688	Continued From page 27 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on dialysis staff and facility staff interview, record review, and facility policy review, the facility failed to provide nutritional and hydration care and services to meet the needs of a resident receiving both enteral feedings and dialysis for one (1) of four (4) residents reviewed for nutrition. Resident #12	F 692	* On 3-13-25, the Director of Nursing (DON), contacted the dialysis clinic that Resident #12 receives services from to inquire about a faxed recommendation to decrease Resident #12 fluid intake. The recommendation was faxed to facility on 3-13-25 and the Assistant Director of Nursing (ADON) notified the primary	4/18/25

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F 692	Continued From page 28 Cross reference F580 Findings Include: Review of the facility policy titled "Enteral Nutrition" with a revision date of January 2014, revealed under, "Policy Statement: adequate nutritional support through enteral feeding will be provided to residents as ordered." Additionally revealed under, "8. The Dietician will monitor residents who are receiving enteral feedings and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings..." Record review of the "Registered Dietician Note" dated 2/18/25 for Resident #12 revealed, "RD (Registered Dietician) spoke with RD from dialysis regarding resident having issues with fluid overload. RD suggests changing TF (tube feeding) to Nutren 2.0 in order to meet needs for weight gain/wound healing without having excess fluids to prevent overload. Dialysis RD agrees and will monitor dialysis labs for elevated phosphorous. Dialysis RD states that fluid restriction for resident is 1000 ml (milliliters) H20 (water), however online orders (facility physician orders) show 1500 ml (milliliters) H20 (water)." Additionally revealed under, "Interventions: 1. Consult MD (physician) for fluid restriction clarification. 2. Change TF (tube feeding) to Nutren 2.0 (1) can 5 times per day. Flush with 50 ml (milliliters) H20 (water) after each feeding. TF (tube feeding) will provide 2500 calories, 100 grams protein, 1125 milliliters free H20 (water) 1500 milliliters total H20 (water). 3. Change med flushes to 15 ml (milliliters) H20 (water) before and after meds. Med flushes will provide 60-90 milliliters H20 (water). Goal: WG (weight gain) to	F 692	physician and the consultant dietician to report the omission of implementing the recommendation dated 2-18-25. An order was received to implement the recommendation on 3-13-25, which was completed by the ADON on 3-13-25. On 3-14-25, the DON did a 100% audit of all the dietary recommendations received for the month of February 2025 to determine any further non-compliance, with none being identified. * All residents of the facility are followed by the consultant dietician; therefore, all residents of the facility could have been affected by an omission of implementing a recommendation. * The policy titled "Enteral Nutrition" was reviewed by the QA Committee on 3-26-25 to determine if any revisions were needed to policy; with none being identified. The QA Committee determined that auditing of the recommendations should be an on going process. On 3-26-25, the Consultant Nurse in-serviced the DON, ADON, the Registered Nurse Supervisor and the Treatment Nurse on ensuring recommendations are implemented within the timeframe allowable per the policy. * Auditing of recommendations began on 3-14-25 by the DON. The DON will be responsible to audit 100% of dietary recommendations to ensure full compliance with implementing the recommendation per the facility policy on a monthly basis; as an on-going process.	

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F 692	Continued From page 29 IBW (ideal body weight), TF (tube feeding) to meet needs for dialysis and desired WG (weight gain)." Record review of Resident #12's Medication Administration Record (MAR) revealed the RD recommendations dated 2/18/25 were not put in place. Record review of Resident #12's MAR revealed an order dated 2/12/25, "Enteral Feed Order ... Nepro 1 can 6 times per day via bolus. Flush with 30 ml (milliliters) H20 (water) after each feeding. Tube feeding will provide: 2560 calories, 115 grams protein, 1394 cc (cubic centimeter) free H20 (water), 1782 cc (cubic centimeter) total H20 (water)." Also revealed an order dated 3/7/25, "Enteral Feed Order every shift: Flush peg tube (Percutaneous Endoscopic Gastrostomy) with 15cc (cubic centimeters) of water before and after administration of medication and 5cc (cubic centimeters) in between each medication. Record review of Resident #12's MAR revealed an order dated 1/09/25, "Dialysis Fluid Restriction 1,500cc (cubic centimeters). " On 3/12/25 at 10:40 AM, a telephone interview with the facility RD revealed the last time she saw Resident #12 was on 2/18/25. She stated that she talked with the dialysis RD because the resident was having fluid overload during his dialysis treatments. She admitted they also discussed concerns about the resident's enteral feedings and not gaining weight. The RD revealed that after speaking with the dialysis RD, she was made aware that the resident should be on a 1200 ml fluid restriction. The RD explained that she made recommendations to the Director	F 692	On 3-26-25, the QA committee met and reviewed plan of correction; with approval being agreed upon. The QA committee will be updated on a weekly basis for six(6) weeks; then monthly for two (2) months for any recommendations or changes to plan of correction. The QA committee has scheduled meetings for Wednesday of each week for review.	

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of Nurses (DON) or the Assistant Director of Nurses (ADON) that day to change the enteral feedings to Nutren 1 can bolus 5 times daily and to change up the flushes. She revealed she also recommended contacting the MD for a clarification on the fluid restriction. Furthermore, she confirmed failure to act promptly on these recommendations could place the resident at risk for continued fluid overload.

On 3/12/25 at 10:53 AM, an interview with the DON confirmed that she remembered talking to the RD and then going back and forth about Resident #12's changes. She revealed that once the RD makes a recommendation, she usually places it in the physician's folder for him or the nurse practitioner to review. She admitted that those recommendations must have been misplaced because she was unable to locate it and confirmed that they should have been put into place.

On 3/12/25 at 1:18 PM, a telephone interview with "Proper Name of Dialysis Company" RD confirmed she spoke with the Facility RD related to Resident #12 being NPO (nothing by mouth) and receiving Nepro enteral feedings and losing weight, plus concerns related to the resident's interdialytic (between dialysis sessions) weight gain. She stated that she had faxed a 1200 ml (milliliter) fluid restriction physician order to the facility on 2/20/25, but the facility continued to have the resident on a 1500 ml (milliliter) fluid restriction. She expressed that the resident was normally over his pre-dialysis target weight with excessive fluid. She confirmed that if the resident did not follow the recommended fluid restriction, and the RD recommended enteral feedings/flushes then that could result in elevated

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blood pressure.

Record review of the "(Proper Name Dialysis) Orders Log" for Resident #12 confirmed an order dated 2/20/25, "Patient to follow a fluid restricted diet, limiting fluid intake to 1200 ml (milliliters) per day. Monitor fluid closely and report any concerns to dialysis unit."

On 3/12/25 at 1:26 PM, a telephone interview with "Proper Name of Dialysis Company" Registered Nurse (RN) Clinical Director revealed that Resident #12 was normally 3-4 kilo's (kilograms) (6.6 to 8.8 pounds) over on his pre-dialysis weight and the goal was not to be above 1 kilo (2.2) pounds or to exceed 2 kilos (4.4) pounds. She stated that the residents' last visit was on Monday 3/10/25, and he was 4 kilos (8.8) pounds over.

An interview with the DON on 3/12/25 at 2:48 PM revealed the physician was not made aware of Resident #12's new Registered Dietician (RD) recommendations via telephone because the nurse practitioner intended to come to the facility a couple of days later and could review it then. She confirmed the resident's fluid volume status was of high importance and acknowledged the physician should have been made aware as the resident had had a delay getting the care. She revealed they (the facility) did not receive the faxed physician order from dialysis to reduce Resident #12's fluid restriction to 1200 milliliters.

Record review of the "Weights and Vitals Summary" for Resident #12 revealed the following weights:

12/03/24 115.3 pounds

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F 692	Continued From page 32 12/26/24 110.4 pounds 1/03/25 - 106.9 pounds 1/17/25 - 109.1 pounds 2/03/25 - 117.7 pounds 2/17/25 - 116.6 pounds 3/07/25 - 112.6 pounds Record review of the "Admission Record" revealed the facility admitted Resident #12 on 12/19/24 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease and End Stage Renal Disease.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review, the facility failed to ensure care was delivered to a resident with Post Traumatic Stress Disorder (PTSD) in a manner that would minimize triggers and the possibility of re-traumatization for one (1) of two (2) residents reviewed with PTSD. Resident # 41	F 699	* On 3-14-25, the Director of Nursing (DON) in-serviced the Social Worker (SW) on the policy titled "Trauma Informed Care Proc". A copy of the said policy was provided to the SW by the DON on 3-14-25. On 3-13-25, the SW revised Resident #41 care plan to include	4/18/25

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F 699	Continued From page 33 Findings Include Review of the facility policy titled, "Trauma Informed Care" with no revision date revealed under, "Purpose...To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma". Record review of Resident #41's Admission Record" revealed the resident was re-admitted to the facility on 12/02/2024 with medical diagnoses that included Post Traumatic Stress Disorder (PTSD) and Bipolar Disorder. Record review of Resident #41's "Care Plan Detail" revealed under, "Focus: Resident has a dx (diagnosis) of PTSD related to killing other humans with a machine gun in combat. Resident has experienced other trauma such as death of close family, being assaulted in lifetime..." Under Interventions/Tasks, the care plan was not developed for triggers or trigger-specific interventions. During an interview on 3/12/25 at 8:35 AM, Resident #41 confirmed that he does have PTSD that stems from when he came home from Vietnam and the treatment that he received during the war. In an interview on 3/12/25 at 8:50 AM, Certified Nurse Assistant (CNA) #5 revealed she had no idea if Resident #41 had PTSD. In an interview on 3/12/25 at 9:40 AM, the Social Worker (SW) confirmed that Resident #41 did have PTSD, but that she didn't know what his triggers were and had never discussed his PTSD	F 699	triggers Resident #41 had told her about. On 3-13-25, the SW implemented interventions to ensure staff are aware of what triggers to avoid to minimize the potential of the resident being re-traumatized. * On 3-25-25, the social worker completed a 100% audit on all residents to determine if any other resident had the potential to be affected. During this audit, it was determined that five (5) other residents had the potential of being affected by the deficient practice. * On 3-17-25, the SW began a 100% audit on all residents to determine any others that may have past trauma without triggers being identified. On 3-19-25, SW was able to update care plan that required triggers to be listed. On 3-13-25, the Assistant Director of Nursing (ADON) began in-servicing all staff on trauma informed care to include where to find the listed triggers, what to do if a trigger occurs and how to report any identified but not listed triggers. * The SW began auditing the Trauma Informed Assessments on 3-14-25, to complete a Trauma Informed Assessment with each new resident and to update the Trauma Informed Assessment when any trauma based issues arise, per the policy titled, "Trauma Informed Care Proc". Per the policy titled, "Trauma Informed Care Proc", the Quality Assurance Committee will oversee trauma informed care in the Quality Assessment Performance	

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F 699	Continued From page 34 or triggers with him. During an interview on 3/12/25 at 10:00 AM, the Director of Nurses (DON) confirmed that Resident #41's plan of care did not address any triggers. She stated that she knew what his triggers were, and they included being awakened in the middle of the night by staff knocking on the door and entering the room. She confirmed that since the staff were not made aware of the resident's triggers and interventions to prevent them it could lead to re-traumatization. Record review of Resident #41's MDS revealed an ARD of 1/15/2025 and, in Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 699	Improvement Plan (QAPI), so that needs and problem areas are identified and addressed. Each new resident will be audited by the Interdisciplinary Team (IDT), beginning on 3-26-25, during the first care plan meeting to ensure the Trauma Informed Care Assessment has been completed and care plan addresses any past trauma and triggers are identified and listed on the care plan. The QA committee will receive a report on any non-compliance weekly for 6 weeks during the already scheduled QA meetings each Wednesday; then monthly for two(2) months. This was approved by QA Committee on 3-26-25.	
F 761 SS=D	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	F 761		4/18/25

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F 761	Continued From page 35 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 23 sampled residents. Resident #10 Findings include: A review of the facility policy titled, "Storage of Medications" revised April 2007 revealed, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner." An observation on 3/11/25 at 10:15 AM revealed Resident #10 had a bottle of Tums Ultra Strength 1000 mg (milligrams)and Equate Nasal Spray 3 fluid (fl) ounces (oz) sitting on his overbed table. An observation and interview on 3/12/25 at 11:10 AM revealed Resident #10's medication of a bottle of Tums Ultra Strength 1000 mg and Equate Nasal Spray 3 fl. oz remained sitting on his overbed table. Resident #10 revealed that he has bad indigestion and needs his medicine and stated, "If they come in here and try to take them, I'll walk out right now." A record review for Resident #10 revealed there was no self-administration of medication	F 761	* On 3-12-25, the Assistant Director of Nursing (ADON) removed over the counter (OTC) medications from Resident #10 room. On 3-12-25, the Director of Nursing (DON) called resident #10 responsible party and informed her that OTC medications were found in Resident #10 room and it has been removed. She was informed during that telephone call of the violations of having OTC medications in the room. Resident #10 was notified that he must meet a certain criteria on an assessment and have a lock box to keep medications in, if he was able to meet criteria. * The QA Committee determined, through discussion in scheduled QA meeting on 3-26-25, that all residents have the potential to be affected by this deficient practice. * On 3-25-25, specific key staff were in serviced, by the DON, to include observing for and removing OTC medications in resident rooms during daily room rounds. * Beginning 3-26-25, the key personnel, that has been assigned rooms to audit on	

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F 761	Continued From page 36 assessment. During an interview on 3/12/25 at 11:15 AM Licensed Practical Nurse (LPN) #4 revealed she is assigned to Resident #10 and gives him his medicines; she revealed she was not aware that the resident had medicine sitting on the overbed table because she gives him all of his medications and stands there while he takes them. During an observation and interview on 3/12/25 at 11:25 AM LPN #4 confirmed that the resident had medications sitting on his overbed table and revealed he was not supposed to have them. She revealed his family brought these medicines in for him, and she had overlooked them sitting there. In an interview on 3/12/25 at 11:35 AM, the Assistant Director of Nurses (ADON) confirmed that Resident #10 did not have a medication self-administration form filled out and had not been evaluated to self-administer medications. She confirmed the medications were not supposed to be left at the bedside, but all medications were to be kept locked in the medication cart. She revealed with the resident having access to these medications, he could take too much, or someone could wander into his room and take them. A record review of Resident #10's "Admission Record" revealed the resident was admitted to the facility on 11/10/2024 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1 through Stage 4 Chronic Kidney Disease, and Gastro-Esophageal Reflux Disease.	F 761	a daily basis will ensure they are reporting on a daily basis any concerns related to medications found in any rooms. This audit is added to the morning meeting report; as a daily item discussed. Upon admission or if resident requests to administer medications after admission, the RN Supervisor will be responsible to assess whether the resident is able to perform self administration of medications and the ability to keep at bedside via the Self Administration Assessment and a physician order. The Quality Assurance Committee will review each self administration assessment as they occur; with a special called QA meeting or the upcoming one; whichever is the earliest for six (6) weeks then monthly for two (2) months, to ensure compliance. A QA meeting has been scheduled for 3-26-25.	

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F 761	Continued From page 37 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/2024 revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #10 has moderate cognitive impairment.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure dietary staff followed proper hand hygiene practices and monitor food temperatures in a manner that prevented cross-contamination for one (1) of two (2) kitchen tours. Findings Include:	F 812	* On 3-12-25, the Dietary Manager (DM), in-serviced Dietary Staff #2 in regards to the proper hand hygiene using the Nutrition Systems guidance titled, "Hand Washing Importance and Technique". On 3-12-25, the DM also in-serviced Dietary Staff #2 on proper procedures of using thermometers with the Nutrition Systems guidance titled, "Guidelines for Using	4/18/25

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F 812	Continued From page 38 Review of the facility policy titled "Hand and Single Use Glove Sanitation Practices" with a revision date of October 2017, revealed "Policy: Facility employees shall follow sanitary practices when handling food to prevent the spread of foodborne illness..." Review of the facility policy titled "Guidelines for Using Thermometers" with a revision date of October 2017, revealed "Policy: the facility shall monitor temperatures of hazardous foods to maintain quality and safety of food served using an appropriate thermometer..." An observation of the kitchen on 3/12/25 at 11:00 AM revealed Dietary Staff #2, located near the 3-compartment sink, gathering kitchen utensils. He walked over to the steam table with a white dish cloth in his hands and began setting up to check food temperatures. Dietary Staff #2 did not wash his hands before proceeding. After measuring the temperature of the hamburger patties, he picked up the dish cloth from the plate rest and wiped the end of the thermometer probe. He then inserted the thermometer into a pan containing lettuce and tomatoes. After removing the thermometer, he again wiped the probe with the dish cloth, continuing this same process - checking temperatures and wiping the probe with the dish cloth - until all food temperatures were measured. An interview with Dietary Staff #2 on 3/12/25 at 11:16 AM confirmed that he did not wash his hands before checking the food temperatures. He stated, "I just had my hands in Clorox water," and acknowledged that this practice could cause cross-contamination of the food. He further explained that it was common practice to use a	F 812	Thermometers". * All residents receive their meals through the dietary department; therefore, all residents had a potential to be affected by the deficient practice of improper hand hygiene and improper cleaning of the thermometers. * On 3-12-25, the DM began a 100% training in proper hand hygiene and the proper use of the thermometers for all dietary staff. The Quality Assurance Committee was updated on the trainings on 3-26-25 by the DM with no other recommendations being made. * The DM is responsible to in-service current and new dietary employees on the proper hand hygiene and proper usage of the thermometers. On 3-13-25, the DM began auditing dietary staff members regarding proper hand hygiene and proper usage of the thermometers on various shifts. The DM will continue audits, completing three (3) employees on various shifts per week, for six (6) weeks; then monthly as an on-going basis. The QA Committee met on 3-26-25 and approved the plan of correction and will receive a report on all non-compliance weekly at the scheduled QA meeting on Wednesdays for six (6) weeks then monthly for two (2) months; then quarterly for two (2) quarters.	

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F 812	Continued From page 39 dish cloth to wipe the thermometer probe between uses, and that this was how he had been trained to do it. Dietary Staff #2 admitted that this could potentially make a resident sick due to cross-contamination from the dish towel to the food. An interview with the Dietary Manager (DM) on 3/12/25 at 11:36 AM confirmed that dietary staff were required to perform hand hygiene before checking food temperatures and anytime they handle food. She explained that the kitchen had disposable wipes that should be used to clean the thermometer probe between uses. The DM acknowledged that improper hand hygiene and improper cleaning of the thermometer could result in cross-contamination and the spread of harmful bacteria to food.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and	F 851		4/18/25

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psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing

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F 851	Continued From page 41 information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Quarter 1 2025 Findings include Record review of facility policy titled, "Submission Timeliness and Accuracy" dated April 2016, revealed, "Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate." Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 1 2025 (October 1-December 31)", revealed the facility triggered on this report for excessively low weekend staffing. During an interview on 3/11/25 at 11:50 AM, the Administrator revealed I don't understand how we were running excessively low weekend staffing; we were adequately staffed during that time. He revealed we were transitioning between payroll systems then, and maybe it didn't transition accurately. Record review of the facility staffing grid for the weekends of quarter 1 revealed no issues with low weekend staffing. During an interview on 3/13/25 at 9:33 AM, the Human Resources Director revealed that after reviewing the discrepancy of low weekend	F 851	* On 3/18/25, the administrator reviewed the Payroll Based Journal submission of staffing data for quarter 1 2025 for the months of October-December 2024 revealing that data submission failed for a new contract staffing provider due to an incorrect facility ID code. The Payroll Based Journal System does not allow any corrections to be made after the submission deadline. The facility ID code has been corrected and submissions have been successful for quarter 2 2025 for the months of January and February. * The facility did not start using the new contract staffing provider until quarter 1 2025, therefore no other quarters would have been affected. * The administrator will be responsible for verifying the accuracy of data submission into the Payroll Based Journal system. After any file has been uploaded into the system, the administrator will review the My Submissions Page an verify that the file was uploaded successfully. * Prior to the submission deadline each quarter, the administrator will download the Payroll Based Journal 1702D report (detailed staffing report) and compare each weekend staffing count to the facility daily assignment sheets for the corresponding days to verify accurate	

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F 851	Continued From page 42 staffing for the first quarter of 2025, we have determined that all of the nursing hours did not show up accurately. She revealed we were transitioning to a different payroll system, and the hours did not transition over accurately. Therefore, the facility didn't report the required staffing information and ensure it's accuracy.	F 851	data submissions. The outcome of each review will be presented to the QA committee at the next scheduled meeting after the close of each quarter.	
F 880 SS=D	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	F 880		4/18/25

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infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident representative and staff interviews, record review, and facility

* On 3-13-25, the Assistant Director of Nursing (ADON)/Infection Control

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F 880	Continued From page 44 policy review, the facility failed to ensure proper catheter care and infection control practices were implemented for one (1) of four (4) residents direct care areas observed (Resident #37). Findings include: A review of the facility policy titled, "Catheter Care Urinary," revised September 2014, revealed under Infection Control: b.) Ensure the catheter tubing and drainage bag are kept off the floor. Further review of the policy under "Steps in the Procedure" revealed: 31.) Use a clean washcloth with warm water and soap or cleansing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward. An observation of Resident #37 and interview with the resident's representative on 3/11/25 at 2:23 PM revealed a catheter bag hanging on the left side of the resident's wheelchair, with the catheter bag and tubing observed resting on the floor. During an interview at that time with the resident's representative, she revealed the resident has a history of frequent urinary tract infections and has the catheter because her bladder does not empty. An observation of catheter care for Resident #37 on 3/12/25 at 10:20 AM revealed upon entrance to the room, the catheter bag and tubing were laying on the floor. Certified Nurse Assistant (CNA)# 6 was observed performing hand hygiene and cleansing the urinary meatus and catheter tubing with a wet washcloth. There was no observation of soap or cleansing products added to the water basin or washcloth. CNA #6 then dried the urinary meatus and catheter tubing with a dry cloth, completed the procedure, and	F 880	Preventionist (ICP), in-serviced CNA #6 on the proper technique for cleaning a foley catheter; and to reiterate the importance of ensuring the urinary bag and tubing does not touch the floor. On same date, the ADON/ICP in-serviced CNA #6 that if the bag or tubing falls to the floor, then she is to inform the assigned nurse or RN Supervisor allowing the tubing and the bag to be changed to decrease the risk of infection. On, 3-13-24, CNA #6 was in-serviced, by the ADON/ICP, on the proper cleaning agent for catheter care to include, soap and water or a disposable wipe. * The current census has six (6) residents that have orders for catheter care; therefore, six (6) residents had the potential to be affected by this deficient practice. * On 3-12-25, the policy titled, "Catheter Care Urinary" was reviewed and assigned per SNF Clinic Training, by the Director of Nursing (DON) to nursing staff for completion. Beginning on 3-17-25, the ADON/ICP began hands on, return demonstration on catheter care with each nursing employee. On 3-26-25, the DON, in-serviced each employee that is responsible for daily room rounds to observe proper placement of catheter bag and tubing. * On 3-17-25, the ADON/ICP began auditing proper catheter care on four (4) residents per week for six(6) weeks; then four (4) per month; this will be an on going	

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PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

(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
F 880	Continued From page 45 performed hand hygiene. In a concurrent interview, CNA #6 confirmed the catheter bag should not have been placed on the floor. She also acknowledged she cleaned the urinary meatus, perineal area, and catheter tubing using only water without soap or cleansing product. CNA #6 stated she avoided using soap because she did not want to irritate the resident's skin. Record review of the Order Summary Report for Resident #37 revealed an active order dated 1/29/25 to clean urinary catheter with soap and water every shift. During an interview with the Director of Nursing (DON) on 3/12/25 at 11:14 AM, she confirmed the catheter bag should not have been placed on the floor and that staff performing catheter care should have used soap and water to clean Resident #37 as ordered. She stated that placing the catheter bag on the floor and failing to cleanse with soap and water increases the risk of infection for the resident. Record review of Resident #37's "Admission Record" revealed the resident was admitted on 1/29/25 with diagnoses including Retention of Urine and Urinary Tract Infection. Record review of Resident #37's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 2/5/25, revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Section H-Bladder and Bowel was coded as having an indwelling catheter.	F 880	process. The Quality Assurance (QA) Committee will receive a report on any non-compliance weekly in the already scheduled QA meeting each Wednesday for six (6) weeks; then monthly for two (2) months; quarterly thereafter on an ongoing basis. This was implemented during the QA meeting that was held on 3-26-2025.	