STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255185	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANOLA REHABILITATION AND HEALTHCARE CENTER	401 HIGHWAY 82 WEST INDIANOLA, MS 38751

(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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 4/22/25 through 4/24/25. 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 F558, F565, F584, F656, F677, and F761. The census at the time of the survey was 68 and the facility is licensed for 75 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure that a resident's call light was within reach, which limited the ability to request assistance as needed for two (2) of three (3) survey days. Resident #14 Findings include: Review of the facility policy titled "Answering the Call Light" with a revision date of September 2022 revealed "5. Ensure that the call light is accessible to the residents ..." An observation and interview with Resident #14	F 558	Preparation and submission of this plan of correction by Indianola Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. Tag F558 Reasonable Accommodations Needs/Preferences " On 4/24/2025, Resident #14□s call	5/20/25

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

Electronically Signed | 05/08/2025

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F 558	Continued From page 1 on 4/22/25 at 11:00 AM, revealed the resident sitting on the side of her bed. Her call light cord was hanging from the wall by the foot of her bed and laying on the floor. The call light was not in reach. Resident #14 revealed, "I can't reach it, they don't put it up here where I can. It's always hanging down there." An observation on 4/22/25 at 12:05 PM, and again at 3:09 PM, revealed the call light remains hanging from the wall, inaccessible to the resident An observation and interview on 4/23/25 at 8:25 AM, revealed the call light hanging from the wall, inaccessible to the resident. Resident #14 revealed the call light has been there all night, stating "I guess they think I don't need my call button where I can reach it." During an interview and observation on 4/23/25 at 10:25 AM, Certified Nurse Aide (CNA) #2 confirmed Resident #14's call light was on the floor and inaccessible. She revealed the call light should have been placed on her bed where she could reach it. She stated, "we are always supposed to make sure each resident's call light is where they can reach it." In an interview on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) confirmed that staff are expected to ensure call lights are always within residents' reach so they can request assistance. This is important for residents' safety and care. During an interview on 4/24/25 at 8:40 AM, the Administrator confirmed that all residents are supposed to always have a call light accessible to	F 558	light was placed within reach by Assistant Director of Nursing (ADON). " 68 residents have the potential to be affected. " Beginning 4/24/2025, in-service was initiated by Staff Development Coordinator with all staff on the call light policy with emphasis on ensuring call light is accessible to the residents. On 4/24/2025, an audit of all rooms was performed to ensure call lights were within reach of each resident. " Beginning 4/24/2025 ADON (B Wing) and RN Supervisor (A Wing) will conduct observations rounds for call lights being accessible for fifteen (15) residents two (2) times a week for four (4) weeks, and then monthly for three (3) months and quarterly thereafter to ensure the call light policy and procedures are being followed and call lights remain within reach. A report will be submitted by the Director of Nursing to the Quality Assurance Performance Improvement meeting beginning on 5/6/2025 for review and recommendations and monthly for three (3) months. Director of Nursing is responsible for monitoring and compliance. The completion date for compliance will be 5/20/2025.	

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F 558	Continued From page 2 them. A review of Resident #14's Admission Record revealed she was admitted to the facility on 07/03/2020 with diagnoses that include Osteoarthritis, Anxiety Disorder, and Convulsions. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1-21-2025 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		5/20/25

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F 565	Continued From page 3 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to promptly resolve resident grievances related to food quality and temperature for five (5) of nine (9) residents attending the Resident Council meeting. Residents #11, #14, #21, #25, and #46 Findings Include: Review of the facility policy titled "Filing Grievances/Complaints," revised 6/2024 revealed under, "Policy Statement: Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such request are made..." An interview with Resident #21 (Resident Council president) on 4/22/25 at 10:55 AM revealed they (the residents) have been discussing concerns with the food quality and temperature (cold food) in the previous monthly meetings. During a Resident Council meeting held on 4/22/25 at 2:45 PM, Resident #11, #14, #21, #25,	F 565	Tag F565 Resident/Family Group and Response * On 4/28/2025, a Food Committee Meeting was held with residents to review the new menus that would be implemented and served beginning 5/5/20225. Residents #14, #21, and #25 attended the meeting along with eighteen (18) other residents. New Menus were discussed, and options and substitutions were put in place for items that they did not want to eat. Residents were educated on other options available if the menu is not satisfactory to their liking, such as Alternate Menu and Bistro Menu. During the Food Committee Meeting on 4/28/2025, Tilapia was changed to Catfish, and Zucchini was changed to Lima Beans on the menus; Residents approved of these two changes. Resident #51 requested no broccoli to be served with her meals. Resident #21 requested that he did not want Roasted Potatoes of any kind. Resident #25 requested that she wanted dry cereal for breakfast and a cup	

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F 565	Continued From page 4 and #46 all agreed the main concern from the previous council meetings was the food and continued to be an ongoing problem. The residents verbalized the food was not good, and Resident #14 stated, "It's garbage." Resident #11 stated, "We may have one good meal once or twice a week." She explained that the vegetables were always mushy and overcooked. All the residents said they had discussed the food concerns in the Resident Council and also in the monthly food committee meeting. They verbalized that nothing gets done about it. Resident #14 revealed the dietary manager asked her about the food, and she told her, "It's terrible." Residents #11 and #25 revealed they would like more variety of foods and explained the facility serves the same thing over and over. Resident #11 explained that they get too many carbohydrates in a day and sometimes get mashed potatoes and french fries at the same meal. She revealed the french fries were always served cold. She stated, "The cold foods are not cold, and the hot foods are not hot." Furthermore, she revealed they were served tea with no ice and stated, "I just try to eat enough to live." The residents verbalized they would like more tacos and stated they had discussed this with dietary, but this had not been implemented. Resident #46 revealed he used to get a sandwich for supper, and he liked that, but the facility cut that out. Resident #21 (Resident Council president) stated, "The Easter Sunday meal was good, but we only have one Easter a year." He explained that all the other meals were poured out of a can. He stated, "These people can't cook." They all agreed they would like to have more fresh fruit and vegetables. Resident #21 revealed that he had suggested having a CNA (certified nurse aide) that floated on the hall to help deliver trays faster.	F 565	of ice cream and a dessert with lunch and dinner. Resident #14 requested she would like a small side salad with no cucumbers every day for lunch and dinner. Resident #14 also would like more Tacos. All these requests were added to their Food Preference Cards and implemented in the next meals. Resident #46 and Resident #11 chose not to attend the Food Committee Meeting and menus were reviewed privately in their rooms by the Dietary Manager. Resident #11 requested a chef salad to be served every other night and substitute sandwiches for salad or alternative menu item. Resident #46 did not have any menu changes and stated that he preferred to order from Bistro Menu on days he did not like the selection from main menu. * 68 residents residing in the facility have the potential to be affected. * On 4/24/2025, in-services began with all staff members of the policy titled “Filing Grievances/Complaints” and “Resident Rights”. On 4/25/2025, grievance forms began on food complaints for Resident #14, 21, 25, 46, and 11. On 4/25/2025, the Administrator met with the Activities Director to discuss that all verbal discussions, whether positive or negative, during Resident Council Meetings should be documented and included in the Resident Council Minutes. All minutes should be reviewed and signed by the Administrator and any complaints should be made to the Facility Grievance Officer. The Activities Director understood the	

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F 565	Continued From page 5 He explained that he believed the food was getting cold because staff got delayed in the rooms. Record review of the "Resident Council Minutes" dated 1/07/25, 2/03/25, 3/03/25, and 4/07/25 revealed there was no documentation regarding resident food complaints. An interview with the Activities Director (AD) on 4/23/25 at 8:10 AM revealed the residents had told her in previous Resident Council meetings the food was not good, and they were not satisfied. She revealed that she went and got the dietary manager to come and talk to the residents. She explained that she did not write anything up on the food complaints and allowed the dietary manager to write up the residents' concerns in her notebook. The AD revealed she was not aware of what the dietary department had done about the complaints. Record review of the "Food Committee Meeting Minutes" dated 12/27/24 revealed under, "How can we improve your dining experience?" Change the menus to something interesting was indicated. Documentation lacked details identifying which residents made complaints or what actions were taken to address the concern. Record review of the "Food Committee Meeting Minutes" dated 2/28/25 revealed under, "What would you like to see instead?" Less mashed potatoes, more diced potatoes were indicated. Documentation lacked details identifying which residents made complaints or what actions were taken to address the concern. Record review of the "Food Committee Meeting	F 565	process and agreed to follow the protocol going forward. On 4/25/2025, the Administrator met with the Dietary Manager that all verbal discussions, whether positive or negative, during Food Committee Meetings should be documented and included in the Food Committee Minutes. All minutes should be reviewed and signed by the Administrator and any complaints should be made to the Facility Grievance Officer. The Dietary Manager understood the process and agreed to follow the protocol going forward. On 5/6/2025, new insulated dome covers, and insulated bases were ordered for each resident to assist in temperature control of meals. On 5/6/2025, new carafe lids were ordered to replace carafe lids to assist in temperature control of coffee. * Beginning the week of 5/5/2025, weekly Resident Council meetings will meet weekly for 4 weeks. Issues from the previous week's meeting will be presented by the Administrator with solutions to these issues and the issues will be agreed upon by the Residents and Administrator. The Administrator will conduct private interviews with a random selection of five (5) residents and include an interview with Resident #11, # 14, 21, 25, and #46 which will total interviews of ten (10) Residents two (2) times a week for four (4) weeks and then one (1) time a week for four (4) weeks. The Activities Director and Dietary Director will report all negative responses to the Grievance Officer for follow-up and solution to issues. These interviews will be	

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F 565	Continued From page 6 Minutes" dated 3/28/25 revealed under, "What would you like to see instead?" Fresh fruits and vegetables were documented. Also revealed under, "Are foods served at the proper temperature?" No was indicated with additional comments, "Resident asked could the facility purchase a heating cart." There was a lack of documentation to identify the residents that made complaints or what actions were taken to resolve the issues that were discussed. An interview with the Administrator (ADM) on 4/23/25 at 12:15 PM revealed she was aware of some food concerns. She explained the residents wanted more of a variety of potatoes, so the kitchen has been changing up and doing roasted potatoes, au gratin potatoes, and others. She revealed that at one time the residents were complaining about the vegetables being too soft. The ADM explained that she went to the kitchen and found that staff were cooking the vegetables around 9 to 10 in the morning and then placed them on the steam table until they were served. She revealed they had tried multiple things to fix Resident #21's food concerns and tried to focus on what he liked. The ADM stated, "I understand they all like different things." She confirmed she was aware of the complaints regarding cold food from time to time. An interview with the Dietary Manager (DM) on 4/23/25 at 1:10 PM, revealed she goes to the monthly Resident Council meetings, and she has been writing down the resident food concerns. She explained that she documented the residents' concerns in a notebook and confirmed a grievance was not completed. She revealed they (the staff) did not have any documentation to prove the residents' food concerns were	F 565	reviewed and reported by the Administrator monthly in QAPI meetings beginning 5/6/2025 and monthly thereafter as needed. The completion date for compliance will be 5/20/2025.	

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F 565	Continued From page 7	F 565		

addressed or what action they took to correct and resolve their issues.

An interview with the Regional Dietary Manager (RDM) on 4/23/25 at 2:30 PM revealed she knew the residents had complained about cold food in a previous Resident Council meeting. She revealed she was unsure why the food complaints were not written up as a grievance. She acknowledged they (staff) did not have a paper trail to track what was done to resolve the residents' complaints regarding food.

An interview with the Administrator (ADM) on 4/24/25 at 8:44 AM confirmed that grievances should have been completed on the residents' food concerns so that all the staff were aware of the concerns and could work toward getting the concerns resolved.

Record review of the "Admission Record" revealed the facility admitted Resident #11 on 10/03/24.

Record review of the "Brief Interview for Mental Status (BIMS)" dated 4/17/25 revealed a summary score of 15, which indicated Resident #11 was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #14 on 7/03/20.

Record review of the BIMS dated 4/23/25 revealed a summary score of 15, which indicated Resident #14 was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #21 on

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F 565	Continued From page 8 6/08/15. Record review of the BIMS dated 2/27/25 revealed a summary score of 15, which indicated Resident #21 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #25 on 7/14/24. Record review of the BIMS dated 1/31/25 revealed a summary score of 15, which indicated Resident #25 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #46 on 5/03/21. Record review of the BIMS dated 1/06/25 revealed a summary score of 15, which indicated Resident #46 was cognitively intact.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		5/20/25

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F 584	Continued From page 9 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide a clean, home-like environment for one (1) of 68 resident rooms observed. Room A-21-W. Findings included: Record review of the facility policy, titled "Cleaning and Disinfection of Resident-Care Items and Equipment" reviewed 3/19/25 revealed "Policy Statement, Resident-care equipment, including reusable items and durable medical	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment " On 4/24/2025, the RN Supervisor cleaned and disinfected Room A 21W oxygen concentrator. " 68 residents residing in the facility have the potential to be affected. " Beginning 4/24/2025, Staff Development Coordinator initiated a Licensed Nursing in-service on Cleaning and Disinfection of Resident-Care Items	

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F 584	Continued From page 10 equipment will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations..." An observation on 4/22/25 at 10:50 AM, revealed that an oxygen concentrator was in use by the resident in room A-21-W. Three (3) dime-sized, light brown dried substances were visible on top of the concentrator, along with a two(2)-inch streak of a similar light brown substance down the front. During an interview with Housekeeper #1 on 4/22/25 at 1:01 PM, she stated that housekeepers do not clean any medical equipment currently in use by residents, as they are concerned about interfering with the device's settings. She further explained that the Nursing Department is responsible for cleaning the oxygen concentrator. In an observation of the oxygen concentrator in Room A-21-W and an interview with Registered Nurse (RN) #1 on 4/22/25 at 1:10 PM, she verified that the concentrator was soiled with formula from the resident's tube feeding. She stated that the concentrator should have been cleaned by nursing staff to prevent attracting pests, such as ants. In an interview with the Director of Nursing on 4/23/25 at 11:15 AM, she stated that it was her expectation that nursing staff would clean the oxygen concentrator if it became soiled.	F 584	and Equipment. On 4/24/2025, an audit of all rooms was completed by ADON to ensure all Resident-Care Items and Equipment were clean. " Beginning 4/24/2025, RN Supervisor and ADON will audit ten (10) resident rooms three (3) times a week for four (4) weeks then two (2) times a week for four (4) weeks and weekly thereafter. The Director of Nursing (DON) will submit a report of the audit findings to the Quality Assurance Performance Improvement committee monthly for review and recommendations. All findings and audits will be discussed and reviewed monthly at Quality Assessment and Performance Improvement (QAPI) meetings beginning on 5/6/2025 and monthly thereafter. DON is responsible for monitoring and compliance. The completion date for compliance will be 5/20/2025.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		5/20/25

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F 656	Continued From page 11 §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	F 656		

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F 656	Continued From page 12 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, staff interview, record review, and facility policy review, the facility failed to implement a person-centered care plan for providing personal hygiene for two (2) of 30 sampled residents care plans reviewed. Resident #23 and Resident #62. Findings Include: Review of the facility policy titled "Care Plans, Comprehensive Person-Centered," with a review date January 2023, revealed: "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 #23 Record review of the "Care Plan Report" for Resident #23 revealed: "I require staff assist with Activities of Daily Living (ADL) self-care performance deficit r/t (related/to) Dementia with confusion/impaired mobility and cognition, contractures to extremities," last revised 3/14/25. Interventions listed included: "Personal Hygiene...Nail care as needed. ..." An observation on 4/22/25 at 10:45 AM, revealed Resident #23's fingernails were long, approximately one-half (1/2) inch in length, with a	F 656	F656 Develop/Implement Comprehensive Care Plan * On 4/24/2024, ADON provided Resident #23 nail care which entailed fingernails cleaned, trimmed, and filed. CNA #1 provided Resident #23 with a bath and shampooed and styled hair. On 4/24/2025, ADON provided Resident #62 with nail care which entailed fingernails cleaned, trimmed, and filed. CNA #2 provided Resident #62 with a bath and hair was shampooed and styled. One on One/Counseling Record was performed by DON with CNA #1 and CNA #2 on 4/24/2025 on how to find the Kardex in PCC to identify resident's preference and assistance needed for ADL care. The care plan for Resident #23 was revised on 4/25/2025 to include fingernail care for non-diabetic residents consisting of cleaning of nails, trimming of nails and filing of nails for Resident #23 when needed by CNA. The care plan for Resident #62 was revised on 4/25/2025 to include fingernail care for non-diabetic residents consisting of cleaning of nails, trimming of nails and filing of nails for Resident when needed by CNA. * 68 Residents in the facility are at risk of being affected by deficient practice.	

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F 656	Continued From page 13 brown substance under every nail bed. An interview with the Minimum Data Set (MDS) Nurse, on 4/23/25 at 10:45 AM, confirmed that Resident #23's ADL care plan had not been implemented in relation to personal hygiene. She stated the purpose of the comprehensive care plan is to direct staff on the resident-specific care needed. An interview with the Director of Nursing (DON) on 4/24/25 at 8:34 AM, confirmed that staff did not follow Resident #23's the ADL care plan. Record review of the "Admission Record" revealed the facility admitted Resident #23 on 2/09/22 with medical diagnoses that included Dementia and Contracture, unspecified joint. Record review of Resident #23's MDS with an Assessment Reference Date (ARD) of 3/06/25 revealed Section GG-Functional Abilities coded "Dependent" for Personal Hygiene. Record review of "Task: GG - Personal Hygiene" form for Resident #23 from 4/10/25 through 4/22/25 revealed no documentation of refusals. Resident #62 Record review of Resident #62's "Care Plan Report" revealed, "I require staff assist with ADL self-care performance deficit related to right side hemiparesis, with contracture to right arm, impaired mobility." Goal: "I will be neat, clean, and odor-free each shift." Under Interventions, "Bathing/Showering: Bath daily. Total dependent x (times)1 staff with bathing. "Personal Hygiene ... Total dependent x 1-2 staff with	F 656	* On 4/24/2025, the Staff Development Coordinator initiated in-services with nursing staff on policies for “Care Plans, Comprehensive Person-Centered”, “ADL-Care and Personal Hygiene”, and “Activities of Daily Living (ADL), Supporting”. On 4/24/2024, One on One/Counselling Record was performed with ADON by DON on resident nail care and following the plan of care and documenting refusals. On 4/24/2024, One on One/Counselling Record was performed with RN Supervisor by DON on resident nail care and following the plan of care and documenting refusals. Beginning 4/24/2025 an audit was conducted throughout the building to ensure all residents had proper nail care and hygiene. On 4/25/2025, fingernail care for non-diabetic Residents was added to the Plan of Care (POC) for Certified Nursing Assistant (CNA) to clean, trim, and file nails when needed. On 4/25/2025, diabetic nail care was added to the POC for CNA to clean and file as needed. On 4/25/2025, diabetic nail care was added to the Treatment Administration Record (TAR) for LPN/RN nursing staff to assess the need two (2) times a week for cleaning, trimming, and filing of nails. * On 4/24/2025, the ADON started an ADL Audit monitoring fifteen (15) residents three (3) times a week for eight (8) weeks and then two (2) times a week for four (4) weeks and then monthly thereafter, for length and cleanliness of fingernails, facial	

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F 656	Continued From page 14 hygiene/grooming." An observation on 4/22/25 at 11:04 AM, and again at 3:21 PM, revealed Resident #62 with unkempt, slick-appearing hair. Her fingernails were approximately one-half (1/2) inch long, jagged, and with a brown substance underneath them. An observation on 4/23/25 at 8:31 AM, revealed Resident #62 lying in bed, no change in her personal hygiene status. During an interview and observation on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) revealed that the nurses are responsible for trimming the residents' fingernails. She stated, "I would say they are done once a month and as needed, but nothing is set in stone as to when it is to be completed." The ADON confirmed Resident #62's fingernails were long, jagged, and had a brown substance underneath them, and needed to be cleaned and trimmed. She revealed that the resident's hair looked greasy and needed to be washed and revealed that we expect each resident to be kept clean and presentable. During an interview on 4/23/25 at 10:40 AM, the DON confirmed that while nurses are responsible for trimming fingernails, the Certified Nurse Aides (CNA's) are expected to clean under the fingernails and notify nursing staff when trimming is needed. She acknowledged that all aspects of personal hygiene for Resident #62 should have been done, and if it was not, then her care plan was not followed. During an interview on 4/23/25 at 2:30 PM, the MDS Coordinator revealed she is responsible for	F 656	hair, incontinence care, shower/bath and following plan of care. DON will submit a report of the findings to the Quality Assurance Performance Improvement (QAPI) committee beginning on 5/6/2025 for review and recommendations. DON is responsible for monitoring and compliance. The completion date for compliance will be 5/20/2025.	

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F 656	Continued From page 15 developing the care plans for the residents, and they are individualized to address each resident's needs. She revealed Resident #62's ADL care plan addressed personal hygiene, which staff know includes her nail care and hair washing. She confirmed that if the resident was found to not be properly groomed and cared for, then her ADL care plan was not being followed, and it should have been. A record review of Resident #62's Admission Record revealed the resident was admitted to the facility on 4/30/24 with medical diagnoses that included Cerebral Infarction, Hemiplegia, Hemiparesis, and Dementia.	F 656		
F 677 SS=D	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, staff interview, record review, and facility policy review, the facility failed to provide personal hygiene for two (2) of 30 sampled residents. Resident #23 and Resident #62. Findings Include: Review of the facility policy titled "Activities of Daily Living (ADL), Supporting" with a revision date of March 2018, revealed: "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal	F 677	F677 ADL Care Provided for Dependent Residents " On 4/24/2024, ADON provided Resident #23 nail care which entailed fingernails cleaned, trimmed, and filed. CNA #1 provided Resident #23 with a bath and shampooed and styled hair. ADON provided Resident #62 with nail care which entailed fingernails cleaned, trimmed, and filed. CNA #2 provided Resident #62 with a bath and hair was shampooed and styled. One on One/Counseling Record was performed	5/20/25

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F 677	Continued From page 16 hygiene..." Resident #23 An observation on 4/22/25 at 10:45 AM revealed Resident #23's fingernails were approximately one-half (1/2) inch in length past the fingertip and each nail had a brown substance underneath. An observation on 4/23/25 at 10:37 AM revealed no change in Resident #23's fingernails. Record review of the Minimum Data Set (MDS) for Resident #23, with an Assessment Reference Date (ARD) of March 6, 2025, revealed Section GG-Functional Abilities coded "Dependent" for Personal Hygiene. An interview with Licensed Practical Nurse (LPN) #1, on 4/23/25 at 10:38 AM, confirmed that Resident #23's fingernails were too long and "nasty". She stated it appeared they had not been trimmed or cleaned in a while and confirmed they needed to be. She revealed that improper nail care could lead to a break in the skin that could increase the risk of infection. An interview with the MDS Nurse on 4/23/25 at 10:45 AM, revealed, after reviewing the last 30 days of the "Progress Notes" for Resident #23, no documentation was found regarding nail care or refusals. Record review of the "Progress Notes" for Resident #23 revealed no documentation of refusals for personal hygiene care or nail care from dates 3/22/25 through 4/22/25. An interview with Certified Nursing Assistant	F 677	by DON with CNA #1 and CNA #2 on 4/24/2025 on how to find the Kardex in PCC to identify resident□s preference and assistance needed for ADL care. " 68 residents that reside in the facility have the potential to be affected. " On 4/24/2025, the Staff Development Coordinator initiated in-services with all licensed nursing staff to include how to read and understand the Point Click Care Kardex which shows the electronic care plan chart and provides a plan of care. An audit by ADON was conducted throughout the entire building on 4/24/2025 to ensure all residents had proper nail care and hygiene. Any deficit practices were corrected immediately. " On 4/24/2025, ADON and RN Supervisor began ADL audit to monitor nails for length and cleanliness, facial hair, incontinence care, shower/bath schedules and following plan of care. This monitoring will be of fifteen (15) residents three (3) times a week for eight (8) weeks, two (2) times a week for four (4) weeks and monthly thereafter. All findings and audits will be discussed and reviewed monthly by DON at Quality Assessment and Performance Improvement (QAPI) meetings beginning on 5/6/2025. Corrective actions will be completed by 5/20/2025 and will be monitored and reported monthly to QAPI meetings by DON.	

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F 677	Continued From page 17	F 677		

(CNA) #1 on 4/24/25 at 8:30 AM, regarding Resident #23's fingernail care, revealed: "He does not refuse any type of ADL care."

An interview with the Director of Nursing (DON) on 4/24/25 at 8:34 AM revealed that the facility's expectation is for nursing staff is to keep Resident #23's fingernails trimmed and cleaned.

Record review of the "Admission Record" revealed the facility admitted Resident #23 on 2/09/22 with medical diagnoses that included Dementia and Contracture, unspecified joint.

Resident #62

On 4/22/25 at 11:04 AM and again at 3:21 PM, observations revealed Resident #62 with unkempt hair that had a wet appearance. Her fingernails were long and jagged, reaching approximately one-half (1/2) inch past the fingertips with a brown substance underneath.

An observation on 4/23/25 at 8:31 AM revealed Resident #62 lying in bed with no change in appearance.

During an interview and observation on 4/23/25 at 10:15 AM, CNA #2 revealed that she was responsible for giving Resident #62 her bed bath, which was supposed to include washing her hair and cleaning underneath her fingernails. She stated, "I took a towel and went over the resident's hair this morning, but I did not wash her hair, and I tried to clean underneath her fingernails." She confirmed the resident had a

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F 677	Continued From page 18 brown substance under her fingernails and revealed that her hair was dirty, and she should have washed it. During an interview and observation on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) confirmed Resident #62's fingernails needed to be cleaned and trimmed and her hair looked greasy and needed washing. She stated that it was her expectation that each resident would be kept clean and presentable. During an interview on 4/23/25 at 10:40 AM, the DON confirmed that all aspects of personal hygiene for Resident #62 should have been done. She revealed it is both the nurses and the CNA's responsibility. A record review of Resident #62's Admission Record revealed the resident was admitted to the facility on 4/30/24 with medical diagnoses that included Cerebral Infarction, Hemiplegia, Hemiparesis, and Dementia. A record review of the MDS Section GG-Functional Abilities with an ARD of Feb 7, 2025, revealed the resident is Dependent for Personal Hygiene.	F 677		
F 761 SS=E	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.	F 761		5/20/25

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F 761	Continued From page 19 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure a medication cart was kept locked and attended for one (1) of three (3) survey days. Findings Include: Review of the facility policy titled "Storage of Medications" unrevised, revealed under, "Policy Statement: The facility stores all drugs and biologics in a safe, secure, and orderly manner." Additionally revealed, "9. Unlocked medications carts are not left unattended." On 4/22/25 at 10:11 AM and again at 1:20 PM, an unlocked medication cart was observed parked in front of the A Hall nurses' station with no staff nearby or in sight.	F 761	F761 Label/Storage Drugs and Biologicals " On 4/22/2025 RN#1 immediately locked the cart. On 4/22/2025 the DON conducted a one-on-one education with RN #1 on always securing the medication cart when the cart is unattended. " 68 residents residing in the facility have the potential to be affected. " An audit was initiated on 4/22/2025 by the DON and ADON of all medication carts and medication rooms was performed to ensure rooms and carts were locked securely. Two medication carts were observed locked, one treatment cart was locked, and medication rooms on A Hall and B Hall were locked securely. On 4/22/2025, the	

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F 761	Continued From page 20 An interview with Registered Nurse (RN) #1 on 4/22/25 at 1:28 PM, confirmed she left the medication cart unlocked and unattended. She revealed the cart should never be left unlocked and explained that a resident could get medication out and overdose. She acknowledged the facility had one wanderer on the hall that could get into the cart and take something. An interview with the Administrator (ADM) on 4/22/25 at 2:38 PM confirmed the medications carts must be locked anytime a nurse stepped away. She acknowledged the risk and revealed that anybody that wanted to take something from the cart could and stated, "There is a large potential there for an incident to occur."	F 761	Staff Development Coordinator initiated in-services for licensed nurses on Storage of Medications. " On 4/24/2025, ADON initiated Med Cart/Med Room Audits to monitor storage of medications for the facility. Audits will be done three (3) times a day for four (4) weeks, then two (2) times a day for four (4) weeks, and then daily thereafter. The DON will submit a report on 5/6/2025 and then monthly to the Quality Assurance Performance Improvement committee for review and recommendations. The completion date for compliance will be 5/20/2025.	