| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255097 | A. BUILDING _____ B. WING _____ | 05/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARE CENTER OF ABERDEEN | 505 JACKSON ST ABERDEEN, MS 39730 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey and complaint investigation (CI MS# 28988) at the facility from 05/12/25 through 05/15/25. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F578, F585, F644, F656, F677, F689 and F812. The SA investigated complaint MS#28988 related to an allegation of verbal abuse with no deficiency cited.<br><br>The census at the time of the survey was 91 and the facility held a license for 105 beds. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the | F 578 | | 6/2/25 |

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

Electronically Signed | 05/28/2025

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| F 578 | Continued From page 1<br>facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews, record review, and facility policy review, the facility failed to ensure cognitive residents' right to determine their end-of-life care for three (3) of 24 residents reviewed. Resident #37, #73, and #75<br><br>Findings Include:<br><br>Review of the facility policy titled "Advance Directives" with a revision date of 6/15, revealed under, "Policy: The facility recognizes that all adults have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of the facility to encourage residents and their family/caregivers to participate in decisions regarding care and treatment..." | F 578 | On 05/14/2025, the Admission Coordinator (AC) reviewed Residents Rights and code status with Resident #37, Resident #73 and Resident #75. The residents were given the right to determine their end-of-life care, by indicating their wishes on the Advanced Directive consent form. Residents medical chart was updated to honor their wishes on 5/14/25 by AC.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Beginning 05/15/2025, an in-service was conducted for Admission Coordinator (AC), Licensed Social Worker (LSW) and Interdisciplinary team (IDT) on Advanced | |

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| F 578 | Continued From page 2<br>Resident #37<br><br>During an interview with Resident #37 on 5/13/25 at 3:26 PM, the resident stated she wanted to make her own healthcare decisions while she was able. She reported that no one from the facility had spoken to her about her end-of-life preferences. When asked whether she wanted the facility to do everything possible to resuscitate her if she stopped breathing or her heart stopped, she responded, "Yes, I want everything done."<br><br>A review of the "Resident/Family Consent for Cardiopulmonary Resuscitation (CPR)" form, dated 11/11/16, indicated that CPR should not be performed and was signed by a family member.<br><br>In an interview with Social Services (SS) #1 on 5/13/25 at 3:36 PM, she confirmed that Resident #37 was cognitively intact and capable of making her own healthcare decisions. She explained that she was unsure why the resident had not been allowed to sign her own code status form, explaining that she was not employed at the facility when the resident was admitted. She further stated it was the resident's right to make her own healthcare decisions, and the facility should have honored that.<br><br>During an interview with the Administrator on 5/14/25 at 8:50 AM, she confirmed that Resident #37 was cognitively intact and that advance directives should have been discussed with her. She stated the resident should have been given the opportunity to sign her own paperwork.<br><br>A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/02/25, revealed in Section C, a Brief Interview | F 578 | Directives policy by Director of Nursing (DON). On 05/21/2025, a one-hundred percent audit was initiated on all residents Advanced Directives to ensure that each resident has the right to make treatment decisions regarding their end-of -life care. The audit was completed on 05/23/2025. Starting on 05/19/2025 all new admissions will have advanced directives reviewed in our morning standup meeting (Monday Friday) to ensure that residents have the right to make decisions on their end-of-life care. On 05/26/25, the LSW will continue to review Residents Rights related to code status at the time of each residents Care Conference Review period and monthly at each Resident Council meeting.<br><br>Beginning 05/26/2025, the DON and/ or AC will monitor daily for four-weeks, weekly for four-weeks and then monthly for all new admits advanced directives to ensure all residents wishes are honored for end -of -life care. Beginning 05/26/2025 the Nursing Home Administrator (NHA) and/ or DON will review Care Plan Review Evaluations for five residents once weekly for four-weeks, once monthly for three-months and once quarterly thereafter until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial | |

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| F 578 | Continued From page 3<br>for Mental Status (BIMS) score of 14, indicating that Resident #37 was cognitively intact.<br><br>A record review of the "Admission Record" revealed that the facility admitted Resident #37 on 11/15/16 with a medical diagnosis that included End Stage Renal Disease.<br>Resident #73<br><br>During an interview on 5/13/25 at 2:25 PM, Resident #73 stated he had a family member that helped him with his financial information, but he would like to make his medical decisions. He revealed if he stopped breathing, he wanted to receive measures to be revived.<br><br>During an interview on 5/13/25 at 2:50 PM, the Director of Nursing (DON) revealed each cognitive resident had the right to determine their end-of-life care to be followed by the facility. She confirmed the facility failed to verify and document Resident #73's wishes and to ensure his preference for end-of-life care was honored.<br><br>During an interview on 5/13/25 at 2:55 PM, the Admission Coordinator revealed she was responsible for completing the Advance Directive forms on admission. She confirmed Resident #73 was cognitive, therefore, it was his right to determine his choice for end of life care.<br><br>Record review of Resident #73's "Order Summary Report" revealed an order dated 8/29/24 for "full code" status.<br><br>Record review of Resident #73's "Durable Power of Attorney", dated and signed by resident on 11/4/21, revealed, "If I become unconscious, incapacitated, or need for any reason to make a | F 578 | compliance is achieved with F-578.<br><br>Compliance date: 06/02/2025 | |

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| F 578 | Continued From page 4 | F 578 | | |

decision regarding termination of life support, when in the opinion of medical experts or opinions, and there is not reasonable expectation of my recovery, they I specifically authorize my attorney-in-fact to determine when to terminate life support".

Record review of Resident #73's "Resident/Family Consent for Cardiopulmonary Resuscitation", dated and signed by resident's representative on 10/29/21. The form indicated, "I understand that CPR constitutes an extraordinary measure and should be done on this resident in the case of extreme emergency".

Record review of Resident #73's "Admission Record" revealed the facility admitted the resident on 10/29/21 with diagnoses that included Schizophrenia, Epilepsy, and Major Depressive Disorder.

Record review of Resident #73's MDS Section C dated 3/10/25, revealed a BIMS score of 14 which indicated the resident was cognitively intact.

Resident #75

During an interview on 5/13/25 at 11:00 AM, Resident #75 revealed he was able to make decisions about his health care and when something happened to him, he did not want to be resuscitated.

During an interview on 5/13/25 at 2:50 PM, the DON confirmed the facility failed to verify and document Resident #75's wishes for end-of-life care to ensure his preference was honored.

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| F 578 | Continued From page 5<br>During an interview on 5/13/25 at 2:55 PM, the Admission Coordinator confirmed Resident #75 was cognitive, therefore, it was his right to determine his choice for end-of-life care.<br><br>A record review of the electronic "Order Summary Report" revealed a Do Not Resuscitate "DNR" order dated 9/1/24.<br><br>Record review of "Resident/Family Consent for Cardiopulmonary Resuscitation" dated 8/30/23, revealed Resident #75's representative signed this form as "the representative that has legal authority to act on behalf of the resident" and chose "I understand that CPR constitutes an extraordinary measure and should not be done on this resident..."<br><br>Record review of Resident #75's "General Durable Power of Attorney" revealed the person listed was authorized "...to make any and all health care decisions for me if I be unable to give informed consent with respect to any given health care decision..."<br><br>Record review of Resident #75's "Admission Record" revealed the facility admitted the resident on 8/30/23 with diagnoses that included Type 1 Diabetes Mellitus, Depression, and Hypertension.<br><br>Record review of Resident #75's MDS Section C dated 4/29/25, revealed a BIMS score of 13 which indicated the resident was intact cognitively. | F 578 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances. | F 585 | | 6/2/25 |

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| F 585 | Continued From page 6<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her | F 585 | | |

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grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

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| F 585 | Continued From page 8<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to address and resolve a resident grievance related to timely Activities of Daily Living (ADL) care for one (1) of 20 sampled residents. Resident #247<br><br>Findings include:<br><br>Review of the facility policy titled "Grievances-Resident" with a revision date of 05/24 revealed, "All residents are to be encouraged and assisted (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff ... The Administrator or Designee has been appointed as the Grievance official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigation by the facility ...Upon receipt of a grievance/complaint the staff receiving the complaint will report to their supervisor, grievance official, or will initiate the Grievance/Complaint Form NS-795." | F 585 | On 05/15/2025 Licensed Social Worker (LSW) opened a grievance for Resident #247 and an investigation was initiated per facility Grievance Policy. Grievance was resolved on 05/15/2025.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>On 05/15/2025 an in-service was initiated for all staff by the Director of Nursing (DON) and/ or Staff Development Registered Nurse on facility Grievance Policy. All education will be completed by 05/26/2025. Resident Council was held on 05/22/2025 to ensure all grievances were resolved. Beginning on 05/19/2025, all grievances will be discussed in our Morning standup meeting (Monday-Friday) to ensure the facility addresses and resolves all grievances in a timely manner.<br><br>On 05/26/2025 the Nursing Home Administrator (NHA) and/ or LSW will | |

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| F 585 | Continued From page 9<br>Resident #247<br><br>Record review of "Grievance/Complaint" with an effective date of 03/24/2025, 3. Name of Staff who received this Complaint. (Name of Social Worker/Internet Review left by family member) revealed under Explanation/Nature of Complaint, "...Well my sister (Resident 247) had an issue a little while back when she came to visit. I cut my call light on and asked to be changed when she (Name of CNA)(Certified Nursing Assistant) came in. CNA responded, "You'll have to wait til I get back from my lunch." Her sister responded, "So she's just supposed to sit in this while you go to lunch and then she got changed."<br><br>On 5/12/25 at 11:00 AM, an interview with Resident #247 revealed she feels like it takes too long to be changed when she has had a bowel movement, and she has reported it at least three times and it is still not resolved.<br><br>During an interview on 5/15/25 at 8:20 AM, the Licensed Social Worker (LSW) revealed the resident has complained before about CNAs not answering the call light promptly and leaving her soiled for a long period. She revealed the resident has complained to me at least 3 times about this issue, and it could be more, and the Director of Nursing (DON) is aware of it as well. She confirmed she had not opened additional grievances each time the resident complained, but would report it to the DON, and if she were instructed to open a grievance, she would have done it.<br><br>An interview on 5/15/25 at 10:12 AM, Resident #247 revealed she had a good day yesterday until her sister brought her in from the outside | F 585 | interview five residents per week to ensure there are no grievances unresolved for four-weeks and then monthly for three-months per facility Grievance Policy. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-585.<br><br>Compliance date: 06/02/2025 | |

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activities. She revealed, "I saw my aide in the hallway, and I told him that I had a bowel movement and needed to be changed. He said ok, let me finish passing this ice and get my vital signs, and then I'll be right in there. My sister pushed me into my room, and I waited about an hour and a half. I have always reported it to the social worker (SW), and I called her yesterday and reported it to her again."

An interview on 5/15/25 at 10:30 AM, the DON revealed that she was aware of a grievance that the resident had on 3/24/25 that an aide had told her she was going to lunch and couldn't change her brief. She revealed we did address that grievance and thought we had a resolution and confirmed that she was unaware that it was still an ongoing concern and grievance for the resident.

During an interview on 5/15/25 at 10:45 AM, the Administrator (ADM) revealed she is the grievance officer, and she or the social worker usually opens a grievance form for any issue to be investigated. She confirmed that she was unaware of any other grievances voiced regarding Resident #247 not getting her care in a timely manner until yesterday. She revealed that a grievance form should have been opened if additional complaints were voiced to the social worker or any staff member. Then it would have been investigated correctly and followed through with a resolution and a follow-up.

A review of the "Admission Record" revealed the facility admitted Resident #247 on 2/3/25 with medical diagnoses that included Paranoid schizophrenia and Encephalopathy.

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| F 585 | Continued From page 11<br>A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #247 was cognitively intact. | F 585 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, record review and facility policy review, the facility failed to submit a change in status referral for a Level II PASRR (Pre-admission Screening and Resident Review) for a resident with a new mental diagnosis for one (1) of four (4) PASRR's reviewed. Resident #5.<br><br>Findings Include: | F 644 | The Licensed Social Worker (LSW) submitted a significant change in status form for Resident # 5 on 05/14/2025.<br><br>All residents with new mental health diagnosis have a potential to be affected by this deficient practice. | 6/2/25 |

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| F 644 | Continued From page 12<br><br>Review of the Facility Policy "Pre-Admission Screening (PAS)/PASRR" with latest revision date of 08/24 documented "A change in status referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances: *A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42CFR (Code of Federal Regulations) 483.100 (where dementia is not the primary diagnosis)..."<br><br>Record review of Resident 5's "Admission Record" revealed an admission date of 03/03/25 and that he had diagnoses that included Depression and Unspecified Psychosis.<br><br>Record review of Resident #5's "Initial Behavioral Medicine/Psychiatric Assessment" dated 03/11/25 revealed that he had a new diagnosis of Mood d/o (disorder) with Psychosis and the assessment was signed by Mental Health Nurse Practitioner.<br><br>Record review of Resident #5's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/10/25 under Section I - Active Diagnoses revealed that he had a Psychotic Disorder. Section N revealed that he was taking antipsychotic medication.<br><br>An interview on 05/13/25 at 9:00 AM with Admissions Coordinator revealed that she completed a Level I PAS on Resident #5 prior to his admission and he did not trigger for a Level II. She revealed that they went by the hospital | F 644 | On 05/13/2025, the Nursing Home Administrator (NHA) in-serviced LSW on submitting a change of status form pre-admission screening and resident review (PASARR) for all residents with a new mental health diagnosis. The Director of Nursing (DON) started a one-hundred percent audit on 05/21/2025 and completed by 05/22/2025 to identify any new mental illness diagnosis that would indicate a PASARR change of status. Beginning on 5/15/2025, the Admissions Coordinator, LSW, Nurse Case Manager and Registered Nurse Supervisors were in-serviced on the PASARR policy by the NHA and or DON. Beginning on 05/19/2025, DON and/ or Medical Record Nurses will review all provider progress notes daily in our morning standup meeting (Monday-Friday) with Interdisciplinary Team (IDT) to determine if a PASARR change of status form is needed.<br><br>Beginning on 5/21/2025, the DON and/or LSW will perform weekly audits for four-weeks and monthly for three- months on provider progress notes to identify any change of status forms needed. Any concerns will be reported to the NHA immediately to be taken before the QAPI committee. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial | |

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| F 644 | Continued From page 13<br>history and physical and this documentation did not indicate a diagnosis that would trigger a Level II. Admissions Coordinator revealed that anytime a resident received a new mental health diagnosis or had a new or discontinued antipsychotic medication, they were supposed to submit a status change.<br><br>On 05/13/25 at 1:35 PM an interview with Licensed Social Worker (LSW), revealed that a change in status was required to be submitted with any new diagnosis and with any new antipsychotic medication addition or discontinuation. LSW revealed that she reviewed Resident #5's records and could not find in the hospital transfer where he had the Psychosis diagnosis when he admitted to the facility. She revealed that Resident #5 was admitted to the facility on 03/03/25 and she confirmed that he did not have the Psychosis diagnosis at that time.<br><br>A phone interview on 05/15/25 at 8:50 AM with Mental Health Nurse Practitioner (MHNP), revealed that she assessed Resident #5 on 03/11/25 due to paranoid behaviors and because he was feeling like all the staff were against him. MHNP revealed that Resident #5 was admitted to the facility on antipsychotic medications and on 03/11/25, she diagnosed him with Mood Disorder with Psychosis.<br><br>An interview on 05/15/25 at 9:28 AM, the LSW revealed she was responsible for submitting the change of status forms for a Level II PASRR. She revealed that she was aware that with any new mental illness diagnosis, she was required to submit a new change of status form for a Level II PASRR. She revealed that she did not submit the change of status form on Resident #5 because | F 644 | compliance is achieved with F-644.<br><br>Compliance date: 06/02/2025 | |

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| F 644 | Continued From page 14<br>she wasn't aware of the new diagnosis. LSW revealed that the purpose of the Level II evaluation was to make sure the resident received the proper psychiatric care that they may need. She revealed that while searching through Resident #5's medical records they found that the Mental Health Nurse Practitioner had diagnosed him with Psychosis on 03/11/25. LSW confirmed that the new diagnosis was missed and that a Level II change in status had not been completed and should have been.<br><br>An interview on 05/15/25 at 11:15 AM with the Director of Nursing (DON), revealed that she received and reviewed the Physician and Nurse Practitioner Progress Notes when completed and that she just missed the new diagnosis for Resident #5. DON revealed that she received Resident #5's assessment dated 03/11/25 that was completed by the Mental Health Nurse Practitioner and confirmed that she did not realize that the Psychosis diagnosis was new for him. | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable | F 656 | | 6/2/25 |

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| F 656 | Continued From page 15<br>physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for Activity of Daily Living (ADL) related to nail care for two (2) of 20 sampled residents. Resident #63 and #75 | F 656 | Resident #63 and resident #75 were assessed by the Director of Nursing (DON) on 05/13/2025. The comprehensive care plan for nail care was updated for resident #63 and resident #75 on 05/13/2025 by the DON. | |

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| F 656 | Continued From page 16<br><br>Findings include:<br><br>Record review of facility policy titled "Care Plan Process" dated 12/24, revealed, "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs in relation to a number of specified areas. ... The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care. ... The facility staff shall follow the care plan".<br><br>Resident #63<br><br>A review of Resident #63's ADL care plan revised 4/3/25 indicated: "Resident needs assist with ADLs ...Interventions: ...Nail care - cut and file weekly and as needed..."<br><br>Observations and an interview with Resident #63, on 5/12/25 at 11:49 AM and again on 5/13/25 at 10:45 AM, revealed that his fingernails were one (1) inch in length, jagged and had a brown substance underneath and Resident #63 expressed a desire to have his nails trimmed.<br><br>On 5/13/25 at 10:50 AM, during an interview and observation Registered Nurse (RN) #1 confirmed Resident #63's fingernails were very long and needed trimming. She noted that the resident could "scratch and make wounds" due to the length and condition of the nails.<br><br>An interview on 5/15/25 at 11:16 AM with the | F 656 | All residents have the potential to be affected by the deficient practice.<br><br>Beginning on 05/13/2025, Licensed Nurses and Certified Nursing Assistants (CNAs) were educated by the DON and/or Staff Development RN on facility policy for Care Plan Process and Nail Care. Education will be completed by 05/26/2025. On 5/21/25 an audit was conducted by the DON to ensure the implementation of a comprehensive care plan related to nail care was in place for all residents with a completion date of 5/26/25. New hires will be educated by DON and/ or Staff Development RN upon hire on ensuring the implementation of a comprehensive care plan related to nail care.<br><br>Beginning on 05/27/2025, the DON and/or Nurse Case Manager RN will review care plans for five residents five times a week for four-weeks and five residents monthly for three-months to ensure the implementation of a comprehensive care plan that has an intervention related to nail care for all residents. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-656.<br><br>Compliance date: 06/02/2025 | |

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| F 656 | Continued From page 17 | F 656 | | |

Minimum Data Set (MDS) Coordinator revealed staff were not following the established plan of care for Resident #63. She further confirmed there was no documentation indicating a refusal of nail care by the resident.

Review of the "Admission Record" indicated that the facility admitted Resident #63 on 2/10/2020 with a medical diagnosis that included Hemiplegia, Unspecified Affecting Right Dominant Side.

A review of the MDS with an Assessment Reference Date (ARD) of 4/4/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14 which indicated Resident #63 was cognitively intact.

Resident #75

Record review of Resident #75's care plan revised 2/5/25 revealed "Resident needs assist with ADLs". Interventions included to "Assist ADLs as needed. Bathing: observe nail length, clean on bath day and as needed ..."

During an interview and observation on 5/12/25 at 10:55 AM, Resident #75's fingernails were long and overgrown with a brown substance noted underneath his nails. He confirmed he wanted his fingernails trimmed.

During an interview and observation of Resident #75's nails on 5/13/25 at 11:10 AM, the Director of Nursing (DON) acknowledged the resident's nails were long with a brown substance under the nails. She acknowledged that the care plan was a guide for each resident's care, and she

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| F 656 | Continued From page 18<br>confirmed the facility failed to implement the care plan related to nail care.<br><br>An interview with the MDS Coordinator on 5/13/25 at 2:20 PM, revealed she was responsible for developing and updating the care plans. She revealed the care plan was an individualized guide for each resident's care and preferences and confirmed the facility failed to follow Resident #75's developed care plan for ADLs related to nail care.<br><br>Record review of Resident #75's "Admission Record" revealed the facility admitted the resident on 8/30/23 with diagnoses that included Type 1 Diabetes Mellitus, Depression, and Hypertension.<br><br>Record review of Resident #75's MDS Section C dated 4/29/25, revealed a BIMS score of 13 which indicated the resident was intact cognitively. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for two (2) of 20 sampled residents. Resident #63 and #75.<br><br>Findings include: | F 677 | Resident #63s and resident #75s fingernails were cut, trimmed, and filed on 05/13/2025 by the Registered Nurse Supervisor (RN SPV).<br><br>Residents who require assistance with ADL for nail care have the potential to be affected by this deficient practice. | 6/2/25 |

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| F 677 | Continued From page 19<br><br>Record review of facility policy titled, "Resident Quality of Care", dated 8/24, revealed, "Each resident shall receive optimal care to attain and/or maintain the highest possible mental and physical functional status as determined by the comprehensive assessment and person-centered plan of care. Each resident's care is tailored to the functional status and needs they may have. ... At the time of the bath, all residents shall also receive, if applicable, nail care".<br><br>Record review of facility policy titled, "Nail Care", dated 1/24, revealed, "Purpose - to promote cleanliness, safety, and a neat appearance".<br><br>Resident #63<br><br>On 5/12/25 at 11:49 AM and again on 5/13/25 at 10:45 AM, an observation and interview of Resident #63 revealed that his fingernails were one (1) inch in length, jagged and had a brown substance underneath and the resident expressed a desire to have his nails trimmed.<br><br>During an interview of the observations on 5/13/25 at 10:50 AM, Registered Nurse (RN) #1 confirmed Resident # 63's fingernails were very long and needed trimming. She noted that the resident could "scratch and make wounds" due to the length and condition of the nails.<br><br>During an interview on 5/14/25 at 1:46 PM with the Administrator, it was confirmed that a resident with long, jagged fingernails could potentially cause a skin tear.<br><br>Record review of the "Admission Record" indicated that the facility admitted Resident #63 | F 677 | On 05/13/2025, a one-hundred precent audit was conducted by the Director of Nurses (DON) to ensure ADL nail care was provided to residents and nail care performed if needed. Beginning on 05/13/2025, the Licensed Nurses and Certified Nursing Assistants (CNAs) were educated by the Director of Nursing (DON) and/or Staff Development RN on ensuring ADL nail care is provided to residents and nail care performed if needed. Education will be completed by 05/26/2025. New hires will be educated upon hire on ensuring ADL nail care is provided to residents and nail care performed if needed by completing CNA Performance Evaluation Checklist.<br><br>Beginning on 05/19/2025, the DON and/or Nurse Supervisor will audit to ensure ADL nail care has been provided on five residents once a week for four-weeks, then five residents monthly for three-months and quarterly until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-677.<br><br>Compliance date: 06/02/2025 | |

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| F 677 | Continued From page 20 | F 677 | | |

on 2/10/2020 with a medical diagnosis that included Hemiplegia, Unspecified Affecting Right Dominant Side.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/25 revealed under section C, a Brief Interview for Mental Status "BIMS" summary score of 14 which indicated Resident #63 was cognitively intact.

Resident #75

During an interview and observation on 5/12/25 at 10:55 AM, Resident #75 revealed he wanted his fingernails trimmed. His fingernails were observed to be slightly long with a brown substance noted under nails.

During an interview and observation of Resident #75's nails on 5/13/25 at 11:10 AM, the Director of Nursing (DON) observed the long nails with the brown substance under the nails. The resident informed the DON that he preferred his nails to be shorter than they were. She acknowledged it was important to keep the nails clean and trimmed to protect the resident from skin concerns and infections. She confirmed the facility failed to maintain the resident's nails at a length he preferred and failed to keep the nails clean.

Record review of Resident #75's "Admission Record" revealed the facility admitted the resident on 8/30/23 with diagnoses that included Type 1 Diabetes Mellitus, Depression, and Hypertension.

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| F 677 | Continued From page 21<br><br>Record review of Resident #75's MDS Section C dated 4/29/25, revealed a BIMS score of 13 which indicated the resident was intact cognitively. | F 677 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to protect a resident's safety and prevent an accident when staff failed to use a wheelchair lift safety belt to secure a resident's wheelchair on the lift gate during the lift procedure to place the resident into the back of the van. This resulted in the resident rolling backwards in the wheelchair and flipping off the lift gate when it was lifted around four (4) feet high in the air and the resident hit backwards onto the concrete injuring her head and received a three (3) centimeter (cm) laceration to the back of her head. This was for one (1) of two (2) residents incidents reviewed. Resident #37<br><br>Findings Include:<br><br>Review of the facility policy titled "Policies for Company Owned Vehicle" with a revision date of | F 689 | On 3/14/2025, resident # 37 was assessed upon return by Director of Nursing (DON). Treatment initiated and care plan updated on 03/14/25. Certified Nurse Aide (C.N.A) #1 was suspended on 03/14/2025 and did not work past this date.<br><br>All residents who are transported in facility vehicle are at risk for this deficient practice.<br><br>All Licensed Class D facility drivers were in-serviced on facility policy Company Owned Vehicle Checklist and the Vehicle Lift Operations Proficiency Checklist which was completed on 03/14/2025 by DON. Beginning on 03/15/2025 DON conducted safety checks on facility van daily Monday-Friday for one-month to | 6/2/25 |

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| F 689 | Continued From page 22<br>5/18 revealed under, "3. Seatbelts: The driver and all passengers in the company/facility owned vehicle must be safely restrained by buckled seat belts, wheelchair floor tie downs and wheelchair harness type seatbelts at all times the vehicle is in use. A qualified individual shall assist patients/residents/clients with seatbelts and wheelchair tie downs and belts, and is responsible for ensuring that all person(s) in the vehicle are safely seat belted ..."<br><br>An interview with Resident #37 on 5/12/25 at 2:15 PM revealed she goes to dialysis three times a week and requires the use of the facility transport van. She revealed that she had a recent fall from the van and indicated her wheelchair rolled off the wheelchair lift while loading onto the van.<br><br>Record review of Resident #37's "Witnessed Fall" dated 3/14/25 revealed, "This nurse was notified that resident rolled off lift and fell backwards while being loaded to be transported to dialysis. Resident lying on flat concrete. Resident able to sit up. Resident has laceration to back of head and complained of right side pain." Resident stated, "I fell backwards out of my chair and hit my head." Additionally, the facility started neurological checks, physician was contacted, and the resident was transported to the hospital via ambulance.<br><br>Record review of Resident #37's "Progress Notes' dated 3/14/25 revealed, "Abrasion to the back of head is 3 cm by 3 cm - dry with no active bleeding."<br><br>Record review of the Emergency Department Records dated 3/14/25 revealed, Resident #37 had a computed Tomography scan (CT) of head | F 689 | ensure safety belt was in use while operating the lift gate.<br><br>Beginning 05/22/2025, the DON and /or Charge Nurse will observe the loading of residents onto the van with the safety belt in use for residents who require the lift gate. Observations will be done Monday-Friday for four-weeks, once weekly for three-weeks and then once monthly until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-689.<br><br>Compliance date: 06/02/2025 | |

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| F 689 | Continued From page 23 | F 689 | | |

and cervical spine and an X-ray of the right shoulder with no acute findings.

Record review of the written witness statement dated 3/14/25 revealed, "I was loading Resident #37 on the bus when the lift remote stopped working. I locked her wheelchair and went on the inside of the bus to manually pump the lift. I instructed her to keep the chair locked. Once I got the lift up, I told Resident #37 to wait for me to unlock her chair. She proceeded to unlock it and before I could catch her chair, she rolled off the lift and fell backwards" and was signed by Certified Nurse Aide (CNA) #1.

A telephone interview with CNA #1 on 5/14/25 at 8:18 AM revealed she was transporting Resident #37 to dialysis on the day she fell from the van. She explained that she was loading the resident onto the van by herself using the wheelchair lift, and the lift remote control messed up and would not rise. She stated she told the resident not to unlock her wheelchair brakes, and she went inside the back of the van to manually work the van lift. CNA #1 revealed the resident rolled back off the van lift and fell backward onto the pavement. She stated, "I was later informed by the Director of Nursing that I should have been using a strap (safety belt) when lifting the resident on the lift gate. CNA #1 revealed that she had never been told to use the strap, and confirmed she did not apply it that day. She additionally added, "I was told that we had to have 2 people with van transfers, but nobody was out there with me." She explained that she had been trained on the old transport bus and had only ridden on the newer bus and did not get training.

An interview with the Director of Nursing (DON)

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| F 689 | Continued From page 24 | F 689 | | |

on 5/14/25 at 8:40 AM revealed staff called her to report Resident #37's fall from the van. She stated the resident was sent to the hospital, was evaluated, and had X-rays, which were all okay. She explained the fall was caused by the resident unlocking the wheelchair brakes, which caused her to roll back off the lift. The DON admitted that CNA #1 reported to her that she did not use the safety wheelchair strap during lift use and stated, "I believe she would have fallen off the lift regardless of using the strap, but I know the belt is there for a reason." She confirmed the belt should have been used. She stated, "After the fall, I started retraining and called corporate and suspended CNA #1." She explained that CNA #1 resigned after the incident and never returned to work. The DON revealed the aide was new to the transport position and had been working for less than 2 weeks when the event occurred. She revealed the aide had training and checkoffs before driving the van and knew the safety strap was required. She explained the facility only used one staff member for transport unless the resident had dementia (poor cognition) or was an amputee and stated, "Really, it's a case-by-case basis" on using one versus two staff members."

An interview with the Administrator (ADM) on 5/14/25 at 9:10 AM revealed CNA #1 hired in and worked for a while and then decided to become the backup van driver. She confirmed the aide trained for more than 2 weeks and had check offs prior to starting the position. She acknowledged she reviewed and signed off on the incident report for Resident #37's fall and explained that she was off during that time and the DON handled the investigation. The ADM revealed the aide had no prior write ups or concerns with the care she provided to the residents.

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| F 689 | Continued From page 25 | F 689 | | |

Record review of the "Employee Warning Report" dated 3/14/25 revealed, "Elder rolled off the back of the van lift- elder unlocked w/c (wheelchair). It rolled back off lift. Lift safety belt was not latched." Certified Nurse Aide #1 was suspended and signed acknowledgment of receipt.

Record review of the "Company Owned Vehicle Driver Inservice Checklist" dated 2/28/25 revealed under, "Patient/Passenger Safety & (and) Special Equipment: The proper and safe operation of the wheelchair lift" was initialed by Certified Nurse Aide #1 as completed. Further review revealed she signed the "Vehicle Lift Operations Proficiency Checklist" dated 2/28/25.

On 5/15/25 at 8:11 AM, during a follow up telephone interview with CNA #1, she revealed she did train with CNA #2 and CNA #3 and stated neither told her nor showed her to use the safety belt with the wheelchair lift. She confirmed she signed the training record and stated, "That's my fault; I should have paid more attention when I signed it." CNA #1 confirmed she knew the strap was there and it would make sense to use it for the residents' safety and acknowledge this would have prevented the fall.

An interview with CNA #2 on 5/15/25 at 8:24 AM revealed that she trained CNA #1 on the newer van for a total of five days. She stated, "I explained to her about the safety belt and how to use it."

An interview with CNA #3 on 5/15/25 at 9:05 AM revealed that she trained CNA #1 on the transport van and fully explained to her that she had to use the safety belt on the wheelchair lift. She revealed

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| F 689 | Continued From page 26<br>CNA #1 had more than 2 weeks of training on the safety of transportation and using seat belts and safety straps.<br><br>An interview with the Administrator with the DON in attendance on 5/15/25 at 9:21 AM confirmed the investigation into Resident #37's fall revealed CNA #1 did not use the safety belt during the van lift process, which resulted in the resident's fall backwards in her wheelchair from the lift gate which was lifted around four feet high, to the concrete below. The DON stated the aide admitted she did not use the strap and acknowledged she was trained to utilize the wheelchair strap when lifting residents on the lift gate.<br><br>A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/02/25, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 14, indicating that Resident #37 was cognitively intact.<br><br>A record review of the "Admission Record" revealed that the facility admitted Resident #37 on 11/15/16 with a medical diagnosis that included End Stage Renal Disease. | F 689 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | | 6/2/25 |

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| F 812 | Continued From page 27<br>and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, record reviews, and facility policy review, the facility failed to label and store food properly and maintain the kitchen and the equipment in a clean and sanitary condition for two (2) of three (3) kitchen tours.<br><br>Findings included:<br><br>Review of the facility's policy titled, "Food Storage Labeling," with revised date 5/18 revealed, "Policy: The facility will ensure the safety and quality of food by following good food storage labeling procedures ..."<br><br>Review of the facility's policy titled, "Cleaning Schedule," with revised date 5/18 revealed, " ...Procedure: ...All equipment and work areas are cleaned after each use, or, on a routine basis ...A cleaning schedule is established by the Director of Food and Nutrition Services ...The Director of Food and Nutrition Services checks routinely to see that the task is completed according to standards ..."<br><br>During the initial kitchen tour with the Dietary | F 812 | On 05/12/2025, the Dietary Manger (DM) discarded all items in all refrigerators and dry food storage that were not labeled per Centers for Medicare and Medicaid Services (CMS) guidelines. On 05/14/2025 the roll-up food service window and the steam table were cleaned by the DM to ensure sanitary conditions per CMS guidelines. Dietary staff responsible for the proper labeling/dating of food items were disciplined on 5/12/25 by the DM.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>On 05/12/2025 the DM in-serviced all kitchen staff on facility Labeling and Storage Policy. On 05/14/2025 the DM in-serviced all kitchen staff on the facility policy on Cleaning Schedule Procedure. On 05/14/2025 DM and/or Production Supervisor (PS) will inspect the rollup door weekly and steam table daily per cleaning schedules to ensure sanitary conditions per CMS guidelines. All | |

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| F 812 | Continued From page 28<br>Manager (DM) on 5/12/25 at 10:24 AM several observations were made regarding food storage practices. In produce refrigerator number one (1), several items, including mashed potatoes, spam, applesauce, orange juice, apple juice, cranberry juice, and a sliced onion were present without dates indicating when they were opened or when they expired. Similarly, in produce refrigerator number two (2), several items, such as pimento cheese, sweet and sour sauce, BBQ sauce, mayonnaise, and potato salad, were also opened and undated. The dry storage room revealed more of the same concerning practices, with items like creamy peanut butter, powdered sugar, brown sugar, key lime sauce, teriyaki sauce, Worcestershire sauce, and grits lacking appropriate dating with opened containers.<br><br>During an interview on 5/12/25 at 10:50 AM with the DM, he confirmed that no open food items should be stored without an open date. He further emphasized that this practice is unacceptable as it could lead to food-borne illnesses.<br><br>During an interview on 5/12/25 at 11:15 AM with the Administrator, she confirmed that the facility policy requires that open food items be labeled with an open date, underscoring the importance of adherence to safety protocols.<br><br>During an observation and interview on 5/14/25 at 11:05 AM with the Production Supervisor, she confirmed that the roll-up food service window located directly above the steam table was heavily covered across the top and down the sides with large accumulations of dust and grease. Additionally, other dirt and dust particles were in each individual slat. The steam tables also had old grease drippings on the bottom | F 812 | education will be completed by 05/26/2025.<br><br>On 05/26/2025 DM and/or PS will audit cleaning schedule checklist and labeling/dating checklist to ensure compliance per facility policy on Cleaning Schedule and Food Storage Labeling. The audit will be completed daily for four-weeks and monthly for three-months. The Nursing Home Administrator (NHA) will audit the cleaning schedule checklist and labeling/dating checklist weekly for four-weeks and monthly for three-months. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-812.<br><br>Compliance date: 06/02/2025 | |

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shelf. When questioned about the responsibility for cleaning the roll-up service window, she expressed uncertainty, stating, "I'm not sure who is responsible for cleaning the roll-up service window, whether it's dietary or maintenance."

During an interview on 5/14/25 at 11:08 AM with the DM, he revealed that both he and the Maintenance Supervisor were responsible for cleaning the roll-up service window. However, he acknowledged that it had not been cleaned in quite some time and was in a dirty state, indicating a need for immediate attention. He further expressed concern that the accumulation of dirt and dust could fall into the food as the roll-up window was opened for service. Additionally, he confirmed that this situation could cause the food to become contaminated and that proper cleaning protocols should be enforced to ensure the safety of the residents.