STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. BUILDING _____ B. WING _____	05/22/2025

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COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Re-certification Survey with one (1) Complaint Investigation (CI MS # 29016) at the facility from 5/19/25-5/22/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F565, F578, F582, F656, F677, F725, F761, and F880. There were no deficiencies cited for CI MS#29016 related to the environment, rodents, Quality of Care and treatment. The census at the time of the survey was 61 and the facility is licensed for 66 beds.	F 000		
F 565 SS=D	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.	F 565		6/20/25

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

Electronically Signed | 06/04/2025

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F 565	Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (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 staff and resident interviews, record review, and facility policy review, the facility failed to make prompt efforts to resolve a grievance from resident Council meetings and communicate steps towards a resolution of a grievance concerning sheets not being changed on shower days for three (3) of six (6) meeting minutes reviewed. Meeting dates of 3/11/25, 4/7/25, and 5/6/25 Findings include: Record review of facility's policy titled, "Grievances and Complaints", dated 2/14/23, revealed, "Process - Social Services will act as the grievance officer for the facility and oversee the grievance process. ... Upon receipt of a grievance, Social Services will complete a written report within 5 (five) working days of the filed grievance and determine what corrective actions, if any, should be taken... Social Services must notify the person who filed the grievance, within 10 working days of the filed grievance, in the form	F 565	Plan of Correction F565 All residents were observed by Director of Nursing on May 27, 2025, to assess the need for sheet changes. No residents were identified as needing immediate linen changes. All residents have the potential to be affected. A one hundred percent audit of all resident bed linens was completed on May 27, 2025, by the Director of Nursing. There were no additional negative findings identified during this review. An in-service training began on May 27, 2025, and will be completed by June 15, 2025. This training provided by the Director of Nursing and includes the expectation that certified nursing assistants assigned to showers are	

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F 565	Continued From page 2 of a report. Copies of this report will be available to the person filing the grievance at any time. If filer is not satisfied with the results of the investigation, the filer may file a report with the local ombudsman. Contact information for the local ombudsman should be easily accessible and visible in the facility..." During the Resident Council meeting held on 5/20/25 at 3:00 PM, the Resident Council President stated there was a concern for several months regarding the bed sheets not being changed on the residents' shower days. Other members present as well as the president stated this had been a concern, but felt the situation had recently improved. They all agreed that other concerns expressed by the council members were addressed and corrected timely, but the concern with sheets not being changed took longer than it should have to resolve. During an interview on 5/21/25 at 10:20 AM, the Director of Nursing (DON) revealed the residents expressed a grievance of the sheets not getting changed on shower days during the last three Resident Council meetings and the facility failed to timely resolve this concern. She acknowledged the residents had the right to voice a grievance in resident council and the staff had the responsibility to address the concern and follow up with the resolution reported back to the council members. She acknowledged there had been changes in staff roles and positions, and following the grievance process to ensure the concern was resolved timely was overlooked. She confirmed the facility failed to follow the grievance process for a concern voiced in Resident Council in a timely manner.	F 565	responsible for stripping and changing the bed linens on the scheduled shower day. If the certified nursing assistant responsible for showers is not available, certified nursing assistants working on the floor will ensure that bed linens are changed according to protocol. The shower/bath exception report will be reviewed in daily in clinical meetings by the Director of Nursing. Social Service Director informed resident council on 06/02/25 of the plan of correction. Beginning May 27, 2025, the Director of Nursing will observe the bed linens of four residents per day, five days a week for two weeks. Following this, observations will occur three days a week for four weeks, then two days a week for an additional two weeks, and one day a week for 4 weeks. Any negative findings will be brought to the Quality Assurance and Performance Improvement committee meetings for review beginning 06/19/25, for revision, and resolution for a minimum of three months to ensure continued compliance. Resolution of greivences will be discussed for 3 months in resident council with the first meeting beginning 06/17/25.	

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F 565	Continued From page 3	F 565		

During an interview on 5/21/25 at 2:00 PM, the Activity Director stated she was new to the role of Activity Director, and she attended the Resident Council meeting in April and May and the bed sheets not being changed was mentioned during those meetings. She revealed that in the May meeting, the residents stated the concern with sheets not being changed had improved but still was an occasional concern. She stated the process she followed for a grievance during resident Council was to provide copies of the concerns to the Social Worker who was the grievance officer, and the Social Worker would give the information to the department heads of each area of concern. She stated that once the grievance process was discussed by other areas, she was informed of what resolution was found and she would discuss the grievance and resolution in the next meeting.

An interview on 5/22/25 at 9:40 AM with the Social Worker revealed she was the grievance officer in the facility, and she was notified of concerns from the Resident Council group. These concerns were given to the appropriate department head and the department heads would in-service and put a plan in place to resolve the grievance. She acknowledged the Director of Nursing and the Activity Director were new to these roles and she was also new to the social service role and these changes in staffing could have affected the communication of the grievance. She confirmed the facility failed to follow the grievance process timely to resolve the issue of the bed sheets not being changed.

Record review of "Resident Council Minutes" dated 3/11/25, revealed, "Sheets not changed on shower days". Record review of "Resident

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F 565	Continued From page 4 Council Minutes" dated 4/7/25, revealed, "Shower days - sheets still not being changed". Record review of "Resident Council Minutes" dated 5/6/25, revealed, "Still not changing sheets after showers". Record review of "Guidelines for Documentation of Resident Council Responses" dated April 7, 2025, revealed for nursing, "Day shift not changing sheets". Director of Nursing addressed and wrote comment, "Shower team will strip beds on shower days". Record review of "Guidelines for Documentation of Resident Council Responses" dated 5/6/25, revealed for nursing "Sheets not changed". This was noted and dated 5/12/25 by the DON. No comments were noted.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		6/20/25

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F 578	Continued From page 5 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to honor a resident's right to make healthcare decisions for one (1) of twenty-four residents reviewed for Advance Directives (Resident #53). Findings include: A review of the facility policy titled "Advance Directives," with a revision date of 11/2022, revealed: "Decision-Making Capacity upon admission, the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity ..."	F 578	Plan of Correction F578 The Social Worker met with Resident #53 on 05/21/25 to discuss and document his preferences regarding code status. The care plan and advanced directive form was updated on 05/21/25 to align with resident's code status wish. The Code Status form was updated by Social Service Director on 05/21/25. The Admission Coordinator and RN Supervisor reviewed Resident #53 chart on 05/21/25 to confirm that the updated code status is clearly documented and communicated to the interdisciplinary team.	

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F 578	Continued From page 6 A review of the facility policy titled "Resident Rights," with a revision date of 11/28/2016, revealed, "(a) Residents' Rights. The resident has a right to... self-determination ..." During an interview with Resident #53 on 05/21/25, at 8:05 AM, he was asked about his code status, and resident stated that he would like staff to "do everything possible to save his life." He confirmed that no one in the facility had ever asked him about his wishes related to code status. Record review of the Code Status form for Resident #53 revealed "Do Not Attempt Resuscitation" signed by the resident representative on 04/10/24. During an interview with the Admission Coordinator at 10:05 AM on 05/21/25, she confirmed that Resident #53 had a high Brief Interview for Mental Status (BIMS), and that staff should have asked him about his choice related to Cardiopulmonary Resuscitation (CPR) status and should have updated his record accordingly and stated, "At the end of the day, it should be the resident's choice." During an interview with Registered Nurse (RN) #1 on 05/21/25, at 4:14 PM, she confirmed that Resident #53 had a high BIMS score and should have been asked what he preferred his code status to be. She acknowledged that by failing to ask the resident about his wishes, staff did not allow him to exercise autonomy and self-determination. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of	F 578	All residents have the potential to be affected. A one hundred percent audit for residents of a Brief Interview for Mental Status greater than or equal to a 10 began on 05/21/25 and was completed 05/30/25 by the Social Service Director with one resident requesting a code status change. Education was provided to the social services director by the Administrator on 05/21/25, regarding code status and advance directives documentation. Education was provided by the Administrator to the interdiscplinary team on 06/04/25 regarding code status and advance directive documentation. Education to medical records will be provided by the Administrator regarding code status and advance directives documentation on 06/04/25. Social Services Director upon admission will ensure code status of resident is documented and medical records will audit all new admissions, significant changes, and quarterly along with the Minimum Data Set schedule. On 06/03/25, Social Services Director began reviewing of five charts a week for four weeks, then two charts for eight weeks. The audit results will be reported to the Quality Assurance and Performance Improvement Committee for review for three months, with the first Quality Assurance and Performance Improvement Committee meeting being held on 06/19/2025, for review or	

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F 578	Continued From page 7 04/17/25, revealed his BIMS score was a 14, indicating that the resident was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #53 on 04/17/24, with a medical diagnosis including Essential (Primary) Hypertension.	F 578	resolution of the plan.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582		6/20/25

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F 582	Continued From page 8	F 582		

reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, record review, and facility policy review, the facility failed to provide the required Advanced Beneficiary Notice to residents discharged from Part A and continued to live in the facility and had skilled benefit days remaining for two (2) of three (3) residents reviewed for Advanced Beneficiary Notice. Residents #26 and Resident #58

Findings include:

Record review of facility's policy, "Medicare Advanced Beneficiary Notice", dated 7/24/23, revealed, "Residents are informed in advance when changes will occur to their bills. ... The

Plan of Correction F582

Resident number twenty-six's representative and resident fifty-eight were educated regarding changes in payment services by the Business Office Manager on 05/30/25. The Director of Social Services also interviewed resident fifty-eight and resident twenty-six representative to assess any psychosocial concerns related to the missed issuance of the Advance Beneficiary Notice on 05/30/25. No distress or unresolved concerns were identified during the interviews.

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F 582	Continued From page 9 facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered 'not medically reasonable and necessary' or 'custodial'..." During an interview on 5/21/25 at 10:00 AM, the Business Office Manager revealed she failed to provide the "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage" CMS Form #10055 to Resident #26 and Resident #58. She revealed both residents remained in the facility after being discharged from Part A with time remaining and she mistakenly omitted these residents from receiving the required notification. During an interview on 5/21/25 at 10:10 AM, the Director of Nursing revealed Resident #26 and Resident #58 remained in the facility after being discharged from Part A with time remaining. She confirmed that it was required to provide the resident or resident's representative information of non-coverage for skilled nursing service and the facility failed to provide written notifications to these two residents/representatives. Record review of "Beneficiary Notice - Residents Discharged Within the Last Six Months" revealed Resident #26 was discharged from Part A on 3/7/25 and remained in the facility. Review revealed Resident #58 was discharged from Part A on 1/30/25 and remained in the facility. Record review of Resident #26's "SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review" revealed Medicare Part A Skilled Services start date was 2/12/25 and the last covered day of Part A service was 3/6/25.	F 582	All residents receiving Medicare benefits have the potential to be affected. A complete audit of all current residents receiving Medicare services was conducted by the Business Office Manager on 05/22/25. The audit revealed no additional residents missing required notices, and no negative findings were identified. The Business Office Manager received formal education on proper issuance and documentation of Advance Beneficiary Notices on 05/22/25, from the Administrator. Additionally, the full interdisciplinary team was educated on the importance of timely delivery of these notices, including when and how to provide them, on 05/27/25 by the Administrator. All changes in payer source, including planned changes in Medicare coverage, will now be reviewed daily during stand-up meetings and discussed by the interdisciplinary team. The Business Office Manager will conduct weekly reviews, beginning 06/02/25, for 12 weeks of all residents receiving skilled services for potential need of an Advance Beneficiary Notice. All findings will be reported to the Quality Assurance and Performance Improvement committee,with first Quality Assurance and Performance Improvement committee meeting being held 06/19/2025, monthly for a minimum of three months to ensure ongoing compliance, identify patterns, and revise	

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F 582	Continued From page 10 The review revealed, "The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted". Record review of Resident #58's "SNF Beneficiary Protection Notification Review" revealed Medicare Part A Skilled Services start date was 12/4/24 and the last covered day of Part A service was 1/29/25. The review revealed, "The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted".	F 582	the process as needed.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable 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	F 656		6/20/25

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F 656	Continued From page 11 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to implement comprehensive care plans for two (2) of the twenty-four resident care plans reviewed. (Resident #8 and Resident #53). The scope for F 656 was increased to "E" due to a prior citation on the last annual recertification survey on 2/20/24, which represents a pattern of deficiency. Findings include: Review of facility policy titled "Care Plans, Comprehensive Person-Centered," reviewed on 10/22, revealed: "Policy Statement: A	F 656	Plan of Correction F656 Nail care for Resident number eight was performed on May 21, 2025 by Medical Records RN, and nail care for Resident number fifty-three was completed on May 21, 2025 by Medical Records RN. Both residents were interviewed on May 21, 2025 by the Director of Social Services to assess any psychosocial concerns related to nail care. No negative findings or distress were reported during the interviews. Resident number 53 received a shower and was shaved on 05/22/25 by	

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F 656	Continued From page 12 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... 7. Policy Interpretation and Implementation...The comprehensive, person-centered care plan:.. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Resident #8 Record review of the care plan date initiated 10/7/24 revealed, "The resident has an Activities of Daily Living (ADL) self-care performance deficit related to sequela of Cerebrovascular Accident (CVA), dementia, muscle weakness, difficulty walking and unsteadiness. Intervention: Check nail length and trim and clean on bath day and as necessary ..." During an observation and interview on 5/19/25 at 6:43 PM with Resident #8, it was revealed that the resident was lying in bed wearing a white t-shirt, and his fingernails were one-half inch (1/2") long with a brown substance underneath and jagged edges. The resident confirmed that he preferred his nails to be trimmed short and kept clean. An observation and interview on 5/20/25 at 3:20 PM with Certified Nursing Assistant (CNA) #1 confirmed that Resident #8 did indeed have long, dirty fingernails with a brown substance underneath. She revealed that nails were supposed to be cleaned and trimmed on shower days, and that Resident #8's shower days were Monday, Wednesday, and Friday (M/W/F) but that the resident did not receive his shower	F 656	the certified nursing assistant assign to resident's care. All residents with natural fingernails or toenails, and residents that rrequire assistance with bathing or shaving have the potential to be affected. A one hundred percent audit of resident nail care was completed on May 30, 2025 by the Medical Records Nurse. The audit revealed eleven residents requiring immediate nail care, which was completed at the time of the audit. In-service education on nail care, including cleanliness and trimming during shower days, was provided to all nursing staff beginning on May 27, 2025, and will be completed by June 15, 2025. The training was conducted by the Director of Nursing and included proper technique, safety, and monitoring for residents who require assistance with personal grooming as part of their care plan. Nail care added to the tasks in the EHR to be completed on shower days and shower/bath exception report will be reviewed five times a week in daily stand up meeting by Director of Nurses. Registered Nurse Supervisor and certified nursing assistants were educated on June 3rd, 2025 by the Director of Nursing regarding adherence to the shower schedule and personal hygiene expectations and will be completed by June 15th. Education will include that any changes to the scheduled showers must be documented. Shower-assigned certified nursing assistants will perform bathing and	

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F 656	Continued From page 13 yesterday. An observation also revealed that Resident #8 was wearing the same clothing today as he did yesterday. During an interview on 5/22/25 at 9:05 AM with the Minimum Data Set (MDS) nurse, she revealed that comprehensive care plans were developed to help guide staff in providing resident-centered care. She confirmed that the care plan was not implemented for Resident #8 due to staff not providing him with a shower on his scheduled shower day or trimming and cleaning his nails as needed. MDS Nurse also verbalized that this could result in poor hygiene for the resident, skin tears due to the condition of his nails, which could lead to infection with potential for slow healing related to his Diabetes diagnosis. A record review of Resident #8's Admission Record revealed the resident was admitted to the facility on 10/6/24, with diagnoses that included Unspecified Sequelae of Cerebral Infarction, Type II Diabetes Mellitus with other Diabetic Kidney Complication, and Need for Assistance with Personal Care. A record review of Resident #8's MDS revealed an Assessment Reference Date (ARD) of 4/1/25 and, in Section C, a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. Resident #53 Record review of Resident #53's care plan date initiated 4/22/24 revealed, "I have an ADL self-care performance deficit related to dementia (progressive), aging and disease process ...Interventions ...Bathing/Showering: Check nail	F 656	hygiene duties when available; if not, floor staff will assume responsibility. The Medical Records Nurse will monitor the nail care and the need for showers and shaves of five residents beginning 06/03/2025 each week for four weeks, followed by biweekly monitoring for an additional two weeks and one resident to be monitored for six weeks. All findings will be reported to the Quality Assurance and Performance Improvement committee for review for three months with first Quality Assurance and Performance Improvement committee meeting held 06/19/2025, and appropriate actions will be taken to revise and strengthen the plan as needed to maintain ongoing compliance.	

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F 656	Continued From page 14	F 656		

length and trim and clean on bath day and as necessary ... Provide sponge bath when a full bath or shower cannot be tolerated ..."

During an observation and interview on 5/19/25 at 6:30 PM with Resident #53, it was revealed that he had one-fourth inch (1/4") facial hair and mild odor. The resident stated his shower days were Monday, Wednesday, and Friday (M/W/F), but he did not receive his shower today. He verbalized, "I guess they don't have enough girls working today." Resident #53 confirmed that they normally shave him while he's in the shower and that he preferred to be clean-shaven. He further stated, "I hope no one has to get close to me today because I haven't had a shower since Friday."

During an interview on 5/20/25 at 3:05 PM with CNA #1, it was revealed that Resident #53 did not receive his scheduled shower on Monday, 5/19/25 on the day shift or night shift. She also revealed that Resident #53 did not receive his shower yesterday or today, but she did shave him today.

During an interview on 5/22/25 at 9:00 AM with Minimum Data Set (MDS) nurse, she revealed comprehensive care plans were developed to help guide staff in providing resident-centered care. She confirmed that the care plan was not implemented on 5/19/25 for Resident #53 when he did not receive his scheduled shower. She also verbalized this could result in poor hygiene for the resident.

A record review of Resident #53's Admission Record revealed that the resident was admitted to the facility on 4/17/24, with diagnoses that included Unspecified Dementia, Unspecified Lack

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F 656	Continued From page 15 of Coordination, and Muscle Weakness. A record review of Resident #53's MDS revealed an ARD of 4/17/25 under Section C, a BIMS score of 14, which indicated that the resident was cognitively intact.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care for two (2) of 24 residents (Residents #8 and #53) observed during the initial tour. Specifically, the facility failed to ensure nail care was provided for Resident #8, failed to provide shaving for Resident #53, and failed to provide showers for both Residents #8 and #53 in accordance with their scheduled care routines and facility policy. The scope for F 677 was increased to "E" due to a prior citation on the last annual recertification survey on 2/20/24, which represents a pattern of deficiency. Cross reference F725 Findings include: Review of facility policy titled, "Bath, Shower/Tub" revised 8/25/14 revealed, "...Purpose: The	F 677	Plan of Correction 677 Resident number eight was offered and received a shower on May 22, 2025, by the certified nursing assistant assigned to showers. Resident number # 8 nail care performed by the medical records registered nurse on May 22, 2025. The resident was evaluated by the Director of Social Services to assess any psychosocial concerns related to missed bathing, with no negative findings noted. Resident number fifty-three was offered and received a shower on May 22, 2025 by the certified nursing assistant assigned to showers. The resident was also assessed by the Director of Social Services on May 22,2025 and no psychosocial concerns were identified. Resident # 53 received a shave on 05/22/25 by the certified nursing assistant assign to resident's care.	6/20/25

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F 677	Continued From page 16 purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin..." Review of facility policy titled, "Fingernails/Toenails, Care of" revised date 2/18 revealed, "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections..." Resident #8 On 5/19/25 at 6:43 PM during an observation and interview with Resident #8, it was revealed that the resident was lying in bed wearing a white t-shirt, and his fingernails were one-half inch (1/2") long with a brown substance underneath and jagged edges. The resident confirmed that he preferred his nails to be trimmed short and kept clean. On 5/20/25 at 3:20 PM an observation and interview with Certified Nursing Assistant (CNA) #1 confirmed that Resident #8 had long, dirty fingernails with a brown substance underneath. She revealed that nails were supposed to be cleaned and trimmed on shower days, and that Resident #8's shower days were Monday, Wednesday, and Friday (M/W/F). She further mentioned that due to a staffing shortage yesterday (5/19/25), that Resident #8 did not receive his shower during the day shift. An observation revealed that Resident #8 was wearing the same clothing today as he did yesterday. CNA #1 confirmed that Resident #8 could develop an infection in his nails or could suffer a skin tear or even a staph infection due to the current condition of his nails.	F 677	All residents have the potential to be affected. A one hundred percent audit was conducted on June 2, 2025 by the RN Supervisor to review if any residents required assistance with personal hygiene, grooming, or bathing. The audit revealed no negative findings. Registered Nurse Supervisor and certified nursing assistants were educated on June 3rd, 2025 by the Director of Nursing regarding adherence to the shower schedule and personal hygiene expectations and will be completed by June 15th. Education will include that any changes to the scheduled showers must be documented. Shower-assigned certified nursing assistants will perform bathing and hygiene duties when available; if not, floor staff will assume responsibility. All refusals must be reported to the nurse during the same shift and documented accordingly. Nail care added to the tasks in the EHR to be completed on shower days and shower/bath exception report will be reviewed five times a week in daily stand up meeting by Director of Nurses. The Registered Nurse Supervisor will conduct weekly hygiene and cleanliness audits to begin 06/03/25, on five residents for four weeks, followed by three residents weekly for two weeks, and then one resident weekly for an additional six weeks. These findings will be reported to the Quality Assurance and Performance Improvement committee for review for three months beginning with first Quality	

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F 677	Continued From page 17 An observation and interview on 5/20/25 at 3:25 PM with Resident #8, it was revealed that the resident was lying in bed wearing the same white t-shirt, which was now covered with food stains and the resident confirmed he had not had a shower since Friday, 5/16/25. During an interview on 5/20/25 at 3:45 PM with the Director of Nursing (DON), she confirmed that nails should be cleaned and trimmed at least weekly and as needed (PRN). She further confirmed that long, dirty nails with jagged edges could cause a skin tear and could lead to infection. A record review of Resident #8's Admission Record revealed he was admitted to the facility on 10/6/24, with diagnoses that included Unspecified Sequelae of Cerebral Infarction, Type II Diabetes Mellitus with other Diabetic Kidney Complication, and Need for Assistance with Personal Care. A record review of Resident #8's Minimum Data Set (MDS) revealed an Assessment Reference Date (ARD) of 4/1/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated that he had moderate cognitive impairment. Resident #53 On 5/19/25 at 6:30 PM during an observation and interview with Resident #53, it was revealed that he had one-fourth inch (1/4") facial hair and a mild odor. The resident stated his shower days were M/W/F, but he did not receive his shower today. He verbalized, "I guess they don't have enough girls working today." Resident #53 confirmed that they normally shaved him while	F 677	Assurance and Performance Improvement committee meeting being 06/19/25, for resolution, and any necessary plan revisions to ensure ongoing compliance with hygiene.	

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F 677	Continued From page 18	F 677		

he's in the shower and that he preferred to be clean-shaven. He further stated, "I hope no one has to get close to me today because I haven't had a shower since Friday."

On 5/20/25 at 3:02 PM during an interview with CNA #3, it was revealed that on M/W/F, the odd-numbered rooms received showers and on Tuesday, Thursday, Saturday (T/Th/S), the even-numbered rooms received showers. She revealed that yesterday, 5/19/25, a CNA called in, and they pulled one of the CNAs from the shower team to cover the call-in, which left only one CNA to do showers. CNA #3 revealed that when that happens, the shower aide only gives showers to rooms one through ten during the day shift and rooms eleven through twenty-one were supposed to receive showers during the night shift. CNA #3 further confirmed that linens were normally changed on shower days and revealed that if the residents didn't receive showers on those scheduled days, their linens were not changed either.

During an interview on 5/20/25 at 3:05 PM with CNA #1, she confirmed that Resident #53 did not receive his scheduled shower yesterday.

During an interview on 5/20/25 at 3:46 PM with the DON, it was confirmed that staffing was a problem, especially over the last two weeks.

A record review of Resident #53's Admission Record revealed that the resident was admitted to the facility on 4/17/24, with diagnoses that included Unspecified Dementia, Unspecified Lack of Coordination, and Muscle Weakness.

A record review of Resident #53's MDS revealed

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F 677	Continued From page 19 an ARD of 4/17/25, and in Section C, a BIMS score of 14, which indicated that the resident was cognitively intact.	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 725	Plan of Correction F725	6/20/25

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F 725	Continued From page 20 and policy review, the facility failed to ensure sufficient nursing staff were available to meet the Activities of Daily Living (ADL) needs of dependent residents, as required by the residents' care plans and the facility's staffing policy. This failure resulted in two (2) of 61 sampled residents (Resident #8 and Resident #53) not receiving scheduled showers, hygiene care, and nail care. Findings include: Review of facility's policy titled, "Staffing" with review date 10/22 revealed, "Policy Statement Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment..." Record review of the Payroll Based Journal Staffing Data Report for Fiscal Year Quarter 1 2025 (October 1 - December 31)," revealed, "Excessively Low Weekend Staffing Triggered = Weekend Staffing data is excessively low." During an observation and interview on 5/19/25 at 6:30 PM with Resident #53 revealed one-fourth inch (1/4") facial hair and mild body odor. Resident #53 stated his shower days were Monday/Wednesday/Friday (M/W/F), but he did not receive his shower today. He verbalized, "I guess they don't have enough girls working today." Resident #53 confirmed they normally shaved him while he's in the shower and he preferred to be clean shaven. He also revealed that they normally changed his sheets too, but that had not been done either. Resident #53 further stated, "I hope no one has to get close to	F 725	A full staffing review was conducted on May 22, 2025 by the Director of Nursing to identify and address any staffing gaps. Adjustments to current staff schedules were made to ensure providing as closely adequate coverage as possible for all shifts. Additional support staff were pulled from the facilitys administrative pool to provide immediate assistance on uncovered shifts and to ensure resident care needs were met without interruption. All residents have the potential to be affected by staffing shortages. A comprehensive review of staffing patterns, call-ins, and shift coverage was completed on May 22, 2025 by the Director of Nursing and the Administrator. No unmet resident care needs were identified during this review. However, trends indicating staffing shortages on weekends and night shifts were identified. To address these trends, a job fair was held on May 22, 2025 by the Business office manager/Human Resources, and job postings were placed across multiple recruitment platforms, including Indeed, on May 22, 2025 by the business office manager/Human Resources. A wage and benefit analysis was also conducted on May 27, 2025 by Corporate Human Resources manager to ensure competitiveness in the current job market, with changes to certified nursing assistant, licensed practical nurses, and registered nurses receiving competitive wage adjustments.	

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F 725	Continued From page 21 me today because I haven't had a shower since Friday." A record review of Resident #53's Admission Record revealed that the resident was admitted to the facility on 4/17/24, with diagnoses that included Unspecified Dementia, Unspecified Lack of Coordination, and Muscle Weakness. A record review of Resident #53's MDS revealed an ARD of 4/17/25, and in Section C, a BIMS score of 14, which indicated that the resident was cognitively intact. An observation and interview on 5/20/25 at 3:20 PM with CNA #1 confirmed that Resident #8 had long, dirty fingernails with a brown substance underneath. She revealed that nails were supposed to be cleaned and trimmed on shower days, and that Resident #8's shower day was M/W/F. She further revealed that due to a staffing shortage yesterday (5/19/25) that Resident #8 did not receive his shower on day shift. Resident #8 stated he had not had a shower since 05/16/25. An observation revealed that Resident #8 had the same clothing on today as he did yesterday and now his shirt had food stains throughout the front of it. A record review of Resident #8's Admission Record revealed the resident was admitted to the facility on 10/6/24, with diagnoses that included Unspecified Sequelae of Cerebral Infarction, Type II Diabetes Mellitus with other Diabetic Kidney Complication, and Need for Assistance with Personal Care. A record review of Resident #8's MDS revealed an Assessment Reference Date (ARD) of 4/1/25	F 725	The Director of Nursing, in coordination with the Administrator, established an on-call staff list 06/03/2025 to improve shift coverage and reduce last-minute call-in impacts. Daily stand-up meetings beginning 06/03/2025 now include a dedicated staffing review segment to proactively identify upcoming shortages. Open shifts are addressed during these meetings and assigned in real time. The Business Office Manager will present all new applicants during stand-up meetings for immediate review and hiring decisions by the interdisciplinary team. Beginning 06/09/2025, the Administrator will conduct weekly staffing audits for four consecutive weeks, followed by biweekly audits for an additional two months. Staffing reports will be reviewed during the Quality Assurance and Performance Improvement committee meetings monthly, with the first meeting being held 06/19/2025, for a period of three months to monitor progress, identify patterns, and revise staffing strategies as needed to maintain compliance and ensure sufficient coverage for all resident care needs.	

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F 725	Continued From page 22	F 725		

and, in Section C, a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment.

During an interview with Certified Nursing Assistant (CNA) #3 on 5/20/25 at 3:02 PM, she stated there had been a call-in the previous day, which caused them to have to pull a shower aide to cover floor duties. She further verbalized that when such situations arise, the remaining shower aide was responsible for providing showers to residents in rooms 1 through 10, while the night shift staff was tasked with handling the remaining residents. CNA #3 confirmed that this staffing issue sometimes resulted in residents not receiving their showers on their scheduled shower days and not getting their bed linens changed. She confirmed that bed linens were supposed to be changed routinely on shower days.

During an interview on 5/20/25 at 3:46 PM, with the Director of Nursing (DON), revealed that the facility has been actively seeking to fill these open positions by utilizing platforms on social media, as well as hosting job fairs. Despite these efforts, she expressed difficulty in attracting and retaining qualified staff.

An interview on 5/21/25 at 9:08 AM with Registered Nurse (RN) #1, she revealed that she recently moved to the floor from Minimum Data Set (MDS) Nurse due to staffing problems. She confirmed that the facility had been struggling with staffing recently and stated, "We struggle a little bit, but we make do." RN #1 verbalized that the facility had participated in several job fairs, posted openings on social media, handed out flyers to local businesses and churches, etc. She

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F 725	Continued From page 23 further revealed that corporate held a job fair recently and had no nursing or CNA applicants/prospects to show up. RN #1 stated, "to say we are struggling is putting it mildly." She confirmed the pay scale for CNAs was low there and they were the backbone of the facility. An interview on 5/21/25 at 9:19 AM with CNA #4 (shower aide) she revealed that she was pulled from the shower team to work the floor often due to staff call ins, which meant residents would miss their shower days. She confirmed that this leaves only one (1) shower aide for the entire building which sometimes caused showers and other things to be missed.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		6/20/25

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F 761	Continued From page 24 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to safely store medications two (2) of (5) five residents medications observed. (Resident #5 and #56) Findings include: Record review of facility policy titled, "Medications, Individual Medication Storage Cabinets" dated 8/25/14, revealed, "Medication administration utilizing individual medication storage cabinets will meet the same criteria for timeliness, infection control, and medication safety as standard medication administration". Resident #5 On 5/20/25 at 8:42 AM, an observation and interview with Resident #5 revealed a Simethicone Capsule 125 milligram (MG) sitting in a medicine cup on her bedside table. Resident #5 confirmed that the capsule was her stomach medication, which the nurse had left for her to take later today. On 5/20/25 at 8:45 AM, an interview with the Licensed Practical Nurse (LPN) #1 confirmed that she had left medication in a medicine cup for Resident #5 on her bedside table for her to take later. She acknowledged that this practice was inappropriate, as it posed a risk that another	F 761	Plan of Correction F761 Resident number five was found with a medication cup left at the bedside, and Resident number fifty-six had liquid potassium remaining at the bedside after not consuming the full dose. Licensed Practical Nurse number one, who was responsible for both incidents, was educated on proper medication administration and the requirement that medications are not to be left unattended at the bedside. This education was provided by the Director of Nursing on May 23, 2025. Residents #5 and #56 were assessed by the Director of Nursing on May 23, 2025 and found to have experienced no adverse effects. The attending medical doctor was notified of both occurrences involving Resident number five and Resident number fifty-six. No new orders were received. All residents receiving medications have the potential to be affected by improper medication storage practices. A facility-wide audit of medication administration practices was conducted on 06/03/25 by Medical Records Registered Nurse. The audit did not identify any additional instances of unattended medications.	

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F 761	Continued From page 25 resident could mistakenly take the medication. A record review of Resident #5's Order Summary Report dated 5/20/25, revealed, " ...Simethicone Capsule 125 MG Give one (1) capsule by mouth three times a day for bloating, gas ..." On 5/22/25 at 9:00 AM, an interview with the Director of Nursing (DON) confirmed that medication should never be left at the bedside for a resident to take later. She stated that this practice puts other residents at risk because anyone could come into the room and take the medication that was not prescribed for them, or the resident could wait too late to take it and she has another dose upcoming at noon. A record review of Resident #5's Admission Record revealed the resident was admitted to the facility on 3/27/24, with diagnoses that included Unspecified Dementia. A record review of Resident #5's Minimum Data Set (MDS) revealed an Assessment Reference Date (ARD) of 4/1/25 under Section C, a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. Resident #56 During an observation of the medication administration pass for Resident #56 on 5/20/25 at 10:30 AM, LPN #1 prepared medications for administration. The resident had an order for Potassium Chloride Liquid 20 MEQ (milliequivalent) per 15 ml (milliliters) give 10 MEQ by mouth - Directions mix 7.5 ml (10 MEQ) in 120 ml of water and give by mouth one time a day. LPN #1 mixed the Potassium Chloride	F 761	Education completed for all licensed nursing staff was completed on 06/03/2025 by the Director of Nursing on medication administration practices and proper storage of medications. This includes requiring nurses to remain with residents until all medications are fully consumed or properly disposed of. Visual observations of medication carts are now performed daily by the nurse supervisor to ensure compliance or medications storage. A visual reminder was posted on all medication carts and treatment rooms stating, Do Not Leave Medications at the Bedside. This protocol was rolled out during the facility-wide in-service conducted on 06/03/2025 by the Director of Nursing and will be completed by June 15, 2025. The Director of Nursing will conduct medication pass observations, beginning 06/03/2025, 5 times a week for four weeks, followed by two times per week for an additional two weeks and one time a week for six weeks. Any deviations from proper medication storage or administration procedures will be addressed immediately. All findings will be reviewed during the monthly Quality Assurance and Performance Improvement committee meetings for a duration of three months with the first meeting being held 06/19/2025 to evaluate compliance and determine if further interventions are needed.	

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Liquid into 120 ml of thickened water and took this with the other medications into the resident's room. The resident drank part of the medication/water mixture and did not want the remainder, and the nurse told her she would leave it at the bedside, and she would try again later. LPN #1 left the room with the medication on the resident's overbed table and pushed the medication cart down the hall to the next resident's room. When asked about leaving the medication at bedside, LPN #1 acknowledged it was not safe to leave medications unattended since another resident could take it. She acknowledged that potassium was a medication that could be dangerous for a resident not needing extra potassium and should not have been left at bedside. She then went into the room and discarded the medication. She confirmed she had been in-serviced on not leaving medication at bedside.

An interview with the facility's Pharmacist on 5/20/25 at 10:40 AM, revealed the facility nurses are not to leave medication unattended at a resident's bedside and this was discussed during the most recent in-service.

During an interview on 5/21/25 at 10:10 AM, the Director of Nursing acknowledged that for the safety of the residents as well as other people in the facility, medications should be stored properly and should not be left unattended at the bedside. She stated another resident could have taken the medication which could have led to health problems for them, especially with potassium. She confirmed the facility failed to properly store medications.

Record review of in-service by the DON and

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F 761	Continued From page 27 Pharmacist titled, "Med Pass - General" dated 4/10/25, revealed LPN #1's signature on the sign-in sheet which indicated she attended the training. The in-service consisted of "Med Pass Points" which included, "Meds are never to be left at the bedside for the resident to take later". Record review of Resident #56's "Order Summary Report" revealed an order dated 12/2/24 for Potassium Chloride Liquid 20 MEQ per 15 ml (10%) - give 10 MEQ by mouth one time a day related to Hypokalemia. Directions: Mix 7.5 ml (10 MEQ) in 120 ml of water and give by mouth one time a day. Record review of Resident #56's "Admission Record" revealed she was admitted by the facility on 8/7/24. Her diagnoses included Alzheimer's Disease and Chronic Kidney Disease. Record review of Resident #56's MDS with ARD of 4/17/25 revealed the resident had a BIMS score of three (3) which indicated the resident had severe cognitive impairment.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		6/20/25

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 29 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to utilize standard precautions with glove use during medication administration for Resident #35 and failed to use Enhanced Barrier Precautions (EBP) during catheter care for Resident #55 for two (2) of six (6) resident care areas observed. The scope for F 880 was increased to "E" due to a prior citation on the last annual recertification survey on 2/20/24, which represents a pattern of deficiency. Findings include: Record review of facility policy titled, "Medication Administration - General Guidelines" dated 8/25/14, revealed, "...Hand hygiene is performed and gloves are used in accordance with standard precautions for medication administration...". Record review of facility policy titled, "Infection	F 880	Plan of Correction-F880 The facility addressed both incidents upon discovery. For Resident number thirty-five, it was observed that Licensed Practical Nurse number one used an ungloved finger to hold a tablet during splitting, then returned the touched half to the medication bottle and administered the other half to the resident. The remaining medication in the bottle was discarded on May 20, 2025, by Licensed Practical Nurse number one, to prevent future contamination. The resident was assessed by the Director of Nursing for any clinical concerns and by the Director of Social Services on May 22, 2025, for any psychosocial distress. No medical or emotional concerns were identified. The resident was offered education and reassurance regarding safe medication handling and provided the opportunity to ask questions or express concerns by the	

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F 880	Continued From page 30 Prevention and Control Program Overview", dated 10/6/17, revealed, "The goals of the infection prevention and control program are to: A. decrease the risk of infection to residents and personnel...". Resident #35 During observation of the medication administration pass for Resident #35 on 5/20/25 at 10:10 AM, Licensed Practical Nurse (LPN) #1 prepared medications for administration. The resident had an order for Vitamin B12 250 micrograms (mcg) and a 500 mcg Vitamin B12 was available. LPN #1 used the pill splitter to half the tablet. She placed her ungloved finger on half of the tablet to hold it in the pill splitter, and she dropped the other half into the resident's medication cup. She then picked up the other half of tablet in the pill splitter with her bare finger and placed it back into the medication bottle. During an interview with LPN #1, she confirmed for infection control purposes, she should have disposed of the tablet or worn gloves so her bare hands would not contaminate the medications in the bottle. She stated she had been in-serviced on infection control during medication pass. During an interview on 5/20/25 at 10:40 AM, the facility's Pharmacist stated the facility's nursing staff had been in-serviced on infection control during medication administration. During an interview on 5/21/25 at 10:10 AM, the Director of Nursing (DON) revealed infection control measures were to be used during medication administration. She confirmed the facility failed to ensure safe practices were used to decrease the likelihood of the spread of	F 880	Director of Nursing on May 22, 2025. For Resident number fifty-five, catheter care was observed to be completed without adherence to evidence-based infection prevention protocols. The resident was re-cleaned using proper technique on May 21, 2025, by the certified nursing assistant assigned to his care, and the resident was observed by the Director of Nursing for signs and symptoms of infection through May 22, 2025. The Director of Social Services met with the resident on May 22, 2025, to address any potential psychosocial impact. No adverse outcomes or concerns were reported, and the resident was informed of the steps taken to prevent recurrence and promote their safety. All residents have the potential to be affected by lapses in infection prevention. A facility-wide audit was conducted on June 2, 2025, by the Infection Preventionist. This audit included a review of all residents on isolation or identified as high-risk for multidrug-resistant organisms to ensure that Enhanced Barrier Precautions were appropriately implemented and maintained, including Personal Protective Equipment availability and staff adherence. Medication administration practices will be audited by the Medical Records Registered Nurse starting June 3, 2025, to be completed by June 15, 2025, for all licensed nursing staff, focusing on hand hygiene, use of gloves, and prevention of direct hand contact with medications. No additional concerns were identified during the audit.	

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F 880	Continued From page 31 infection by placing a medication that had been in the nurse's ungloved hands back into the medication bottle. Record review of in-service by the DON and pharmacist titled, "Med Pass - General" dated 4/10/25, revealed LPN #1's signature on the sign-in sheet which indicated she attended the training. The in-service consisted of "Med Pass Points" which included, "Infection Control ... Never touch any medication with your bare hands". Record review of Resident #35's "Order Summary Report" revealed an order dated 2/27/25 for Cyanocobalamin Tablet 250 micrograms by mouth daily for B12 deficiency. Record review of Resident #35's "Admission Record" revealed she was admitted to the facility on 11/19/20, with diagnoses that included Alzheimer's Disease, Hypertension, and Osteoporosis. Record review of Resident #35's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/1/25 revealed a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident had a severe cognitive impairment. Resident #55 Review of facility policy titled, "Enhanced Barrier Precautions" with no date revealed, "Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation...3. Examples of high-contact resident care activities requiring	F 880	All licensed nursing staff received education on infection prevention protocols on June 3, 2025, by the Infection Preventionist and will be completed by June 15th, 2025. Training covered proper hand hygiene, glove use, safe medication handling, and evidence-based practices for catheter care. A new protocol was implemented requiring the use of gloves and staff were reminded that medications must never be touched with bare hands. Visual reminders were posted on all medication carts and in treatment areas. For Enhanced Barrier Precautions, PPE stations were reviewed and reorganized to ensure full accessibility, and signage was verified for all applicable residents by the Infection Preventionist on June 3, 2025. Staff competency for both areas was reviewed by staff competency check offs started June 3, 2025, to be completed by June 15, 2025, by the infection preventionist. The Infection Preventionist or Director of Nursing will conduct weekly audits beginnng 06/03/2025 focused on infection control compliance related to medication administration and Enhanced Barrier Precautions. Five observations will be conducted weekly for five weeks, followed by three observations weekly for four weeks and one observation for three weeks. Results will be reviewed during the monthly Quality Assurance and Performance Improvement committee meetings for a period of three months with	

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F 880	Continued From page 32 the use of gown and gloves for EPBs include: ...g. device care ...urinary catheter..." During an observation on 5/21/25 at 9:28 AM of catheter care for Resident # 55 with Certified Nursing Assistants (CNAs) #1 and #2, it was revealed that both CNAs failed to use Enhanced Barrier Precautions (EBP) during catheter care. On 5/21/25 at 9:36 AM, an interview with CNAs #1 and #2 revealed that neither CNA was aware that EBP should have been used during catheter care. CNA #1 stated that EBP are used to prevent the spread of infection between the resident and staff and/or from resident to resident. Additionally, she confirmed that not adhering to the EPB could cause an infection for Resident #55. On 5/21/25 at 9:54 AM, an interview with the DON confirmed that EBP should have been used during catheter care and that the CNAs were trained to do so. She verbalized that EBP were put into place to help prevent the spread of infection and failing to utilize EBP could place Resident #55 at an increased risk for infection. Record review of Order Summary Report for Resident #55 dated 5/21/25, revealed, " ...Catheter care using soap and warm water or wipes every shift ..." Record review of Admission Record for Resident #55 revealed the resident was admitted to the facility on 6/29/24 with diagnoses which included Neuromuscular Dysfunction of Bladder. A record review of Resident #55's MDS with an ARD of 3/1/25, and in Section C, Resident #55 has a BIMS score of 13 which indicates that the	F 880	the first meeting being 06/19/25. Any noncompliance will result in immediate corrective action and additional training as needed to ensure sustained adherence to infection prevention protocols.	

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F 880	Continued From page 33 resident is cognitively intact.	F 880		