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	255217	A. BUILDING _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and Complaint Investigations (CI) MS #28032, MS #28486, MS #28842 and MS #29061 at the facility from 6/3/25 through 6/5/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies at F550, F552, F584, F640, F656, F677, F684, F687, F689, F699, F838 and F880. The SA found the facility not to be in compliance with CI MS #28032 regarding sexual abuse and cited F600. The SA investigated CI MS#28486, MS #28842 and #29061 with no deficiencies cited for these CIs. The facility had a census of 57 at the time of survey and was licensed for 60 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		7/3/25

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

Electronically Signed | 06/19/2025

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to provide dignity to a resident, as evidenced by leaving an indwelling urinary catheter bag and tubing uncovered for one (1) of three (3) residents with a catheter reviewed. Resident #55 Findings include: A review of the facility policy, "Dignity" with a revision date of February 2021, revealed " ...12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents;	F 550	1. On June 04, 2025 when discovered Resident #55 did not have a dignity bag, a dignity bag was immediately provided to Resident #55 by the Director of Nursing to cover his urinary bag and tubing. 2. All residents with indwelling urinary catheter bags have the potential to be affected by this deficient practice. 3. On June 05, 2025 the Director of Nursing provided an in-service to all Certified Nursing Assistant (CNA) staff on the facility's "Dignity" policy to ensure	

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F 550	Continued From page 2 for example: ... a. helping the resident to keep urinary catheter bags covered ..." An observation on 06/03/25 at 7:49 AM, and again at 9:08 AM, revealed Resident #55 lying in his bed in his room. A urinary catheter bag containing 200 milliliters of yellow urine was hanging on his bed and visible from the hall, with no privacy bag in place. During an interview on 6/04/25 at 10:05 AM with Certified Nurse Aide (CNA) #4 and CNA #6, CNA #4 revealed that all urinary catheters are supposed to be kept inside a privacy bag, so the resident's urine is not visible to anyone else; it's a dignity issue. CNA #6 (lead CNA) revealed that the catheter is always supposed to be kept inside the privacy bag and confirmed that the urinary catheter bag was uncovered the previous morning, stating, "We are doing much better today, looking at that." In an interview on 6/4/2025 at 2:42 PM, the Director of Nurses (DON) revealed that it is our expectation that if a resident has a urinary catheter, it should be placed inside a privacy bag so that the urinary contents are not visible to anyone else. She revealed that if it were not inside a privacy bag, then it would be a dignity issue. Record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 4/15/2025 with medical diagnoses that included Multiple Sclerosis, and Neuromuscular dysfunction of the Bladder. Record review of Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date	F 550	resident's rights to dignity is being honored. A 100 percent audit on all residents with catheters was performed by the Director of Nursing on June 05,2025. One (1) of Three (3) residents was noted not having a genitourinary drainage bag. The resident was provided a dignity bag on June 05, 2025. 4. Beginning on June 05,2025, the Assistant Director of Nursing and/or the Lead Certified Nursing Assistant (CNA) will monitor all residents with catheters (three) 3 times a week for (twelve) 12 weeks to ensure residents requiring a catheter has a dignity bag is in place. Beginning on June 05, 2025 the Director of Nursing will make rounds three (3) times a week for (twelve) 12 results to ensure each resident has a dignity bag in place. Result of findings will be reported to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 550	Continued From page 3 (ARD) of 4/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that the resident had moderate cognitive impairment.	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to notify a resident representative of the risk and benefits for the initiation of a new psychotropic medication for one (1) of two (2) residents reviewed for psychotropic medication use. Resident #31 Findings Include: Review of the facility policy titled "Psychotropic	F 552	1. On June 05, 2025 Resident #31 was provided a consent form related to the use of psycho-trophic medication use risk and benefits. 2. All residents who receive anti-psychotic medication have the potential to be affected by this deficient practice. 3. On June 05, 2025 an in-service was	7/3/25

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F 552	Continued From page 4 Medication Use" with a revision date of 2/2025 revealed under, "Informed consent or refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: ... b. the indications and rationale for the recommendation; c. the potential risk and benefits (including possible side effects, adverse consequences, and the black box warning); and d. the resident's/representative's right to accept or decline the treatment." Record review of Resident #31's "Psych Progress Note" dated 11/8/24 revealed, "Facility request visit due to recent combative behavior. Staff report that a resident is displaying combative behaviors ... Resident is often noted to be reaching for things or pulling at blankets and fidgety often. However, staff reported that the resident has now become combative with staff. Behaviors have been monitored for approximately 1 week and seem to be worsening." Additionally reveled under, "Recommendations: Initiate Rexulti 0.5 mg (milligram) q (every) pm (evening)" for a diagnosis of Alzheimer's disease. Record review of Resident #31's "Progress Notes" dated 11/08/24 revealed, "Psych (psychiatric) NP (nurse practitioner) gave recommendation for Rexulti. The proper name of RR (resident representative) called to make her aware of the new order. Explained med (medication) is for Alzheimer's and also treats agitation. The proper name of RR said she believed the agitation was related to her not being able to visit lately." There was no documentation that the representative was informed of the risk	F 552	provided by the Corporate Nurse Educator to the Director of Nursing on the facility's "Pharmacy Overview" policy. On June 05, 2025 the Director of Nursing provided an in-service to all nursing staff on the facility's "Pharmacy Overview" policy. A 100% audit was performed by the Corporate Nurse Educator on all residents receiving anti-psychotic medication to ensure consent forms were provided. Findings were submitted to the Director of Nursing on June 05, 2025. The Director of Nursing in return provided the resident's Responsible Representative (RR) consent forms relating to the use of psycho-trophic medications use risks and benefits. 4. Beginning on June 05, 2025 the Assistant Director of Nursing and/or Medical records will review medication orders daily to ensure residents with new orders that are anti-psychotic medications have consent forms explaining risks and benefits (three) 3 times a week for (twelve) 12 weeks. Any concerns will be immediately addressed by the Director of Nursing. The Director of Nursing will submit results of findings to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 552	Continued From page 5 and benefits of the antipsychotic medication Rexulti, nor that alternative treatments were discussed or that informed consent was obtained. During an interview on 6/4/25 at 2:24 PM, the Director of Nursing (DON) confirmed that staff contacted the resident representative of Resident #31 to inform her of the new medication. However, the representative was not informed of alternative treatment options, potential risks and benefits, or provided the opportunity to consent or refuse treatment. The DON acknowledged the representative should have received this information to make an informed decision. Record review of the "Admission Record" revealed the facility admitted Resident #31 on 10/15/21 with diagnoses that included Dysphagia following Cerebral Infarction and Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score was not conducted because Resident #31 was rarely/never understood.	F 552		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		7/3/25

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F 584	Continued From page 6 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to provide a safe, homelike environment as evidenced by an unsanitary bathroom for one (1) of the thirty resident shared bathrooms observed. Room #133, and Room #135	F 584	1. On June 04, 2025 resident bathroom #133 and #135 revealed a urine odor. On June 5, 2025 resident bathroom #133 and #135 received a complete room cleaning by the Housekeeping Supervisor. On June 06, 2025 the Maintenance Director	

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F 584	Continued From page 7 Findings include: Review of the facility policy titled "Safe environment", undated, revealed, "The facility must provide- (1) A safe, clean, comfortable, and homelike environment ....(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior ... " Review of the facility policy titled "Bathrooms," undated, revealed that "Bathrooms shall be maintained in a clean and sanitary manner and shall be cleaned on a daily basis." Record review of "Grand Rounds" for room #135 dated 5/27/25, 5/28/25, 5/29/25, 6/2/25, and 6/3/25 revealed that, under "Free from urine odors, and bathroom cleaned" it was documented No (N). An observation on 6/3/25 at 2:40 PM revealed a strong urine odor in the shared bathroom of Rooms #133 and #135. A thick black substance was around the base of the toilet. An observation on 6/4/25 at 8:55 AM, and again at 1:25 PM, revealed a strong urine odor in the shared bathroom of Rooms #133 and #135. The thick black substance remained around the base of the toilet. During an observation and interview on 6/04/25 at 3:55 PM, Registered Nurse (RN) #1 revealed that the bathroom shared by Room #133 and Room #135 has been a work in progress for quite some time. He revealed that four men share that bathroom, and maintenance has changed out the toilet several times. He confirmed the room had a	F 584	replaced the tile in resident bathroom #133 and #135. On June 09, 2025 resident bathroom #133 and #135 received another complete room cleaning by the Housekeeping Supervisor. Residents noted in bathroom #133 and #135 revealed no ill effects from staff failure to maintain a safe, clean, comfortable, and homelike environment. 2. All residents have the potential to be affected by this deficient practice. 3. On June 04, 2025 an in-service was provided by the Administrator to the Environmental staff on the long-term care regulation "Resident's Rights" policy ensuring a safe, clean, comfortable, and homelike environment. On June 05, 2025, the Administrator provided an in-service to the Housekeeping Supervisor and the Maintenance Director on ensuring complete room cleanings are documented and environmental issues are documented in the maintenance log. 4. Beginning on June 06, 2025, the Housekeeping Supervisor and/or the Lead Certified Nursing Assistant will conduct room rounds checking bathrooms for urine odors and tile replacement or commode replacement on (five) 5 residents (three) 3 times a week for twelve (12) weeks to ensure a safe and homelike environment for residents. Beginning on June 06, 2025 the results of the room rounds will be submitted to the Administrator weekly times (twelve) 12	

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F 584	Continued From page 8 strong urine smell, and there was a black substance around the base. An observation and interview on 6/04/25 at 4:17 PM with the Maintenance Assistant revealed that he wasn't aware of the significant amount of black corrosion around the base of the toilet and stated, "That's on us. I'll let my maintenance director know." He confirmed the bathroom had a strong urine smell. During an interview on 6/04/25 at 4:30 PM, the Housekeeping Director revealed he was aware of the strong urine smell in the resident's bathroom. He revealed that four males share it, and we are cleaning that room more frequently because the men are missing the toilet; it is just a constant battle. During an interview on 06/04/25 at 4:52 PM, the Maintenance Director revealed the department heads make rounds to each resident's rooms and bathrooms each morning and report anything that may be in disrepair or need cleaning during the stand-up meeting. He revealed that he was not aware of the black corrosion around the base of the toilet until his Maintenance Assistant took him into the bathroom a few minutes ago to show him. He confirmed that the toilet had black corrosion around its base, and the strong urine smell was because the tile needed to be replaced. During an interview and observation on 6/04/25 at 5:06 PM, the Administrator revealed that department heads conduct "Grand Rounds" each morning in each resident room, which includes their bathroom, and discuss any issues found during the stand-up meeting. She confirmed that	F 584	weeks for accuracy and completeness and maintained in the Administrator's office. The Administrator will present results to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 584	Continued From page 9 there was a strong urine odor in the bathroom that rooms #133 and #135 shared. She acknowledged there was a black corrosion around the base of the toilet and stated, "We will replace the tile, but until then, a little bleach and Pine-Sol would do a lot of good." During an interview on 6/04/25 at 5:13 PM, Medical Records revealed she is responsible for the morning Grand Round for the shared bathroom of rooms #133 and #135. She revealed that "Every day, I go in there. Honestly, it has a strong odor of urine, and the bathroom is dirty. I always put it down on the sheet and notify housekeeping in the hallway, and I also address it during our morning stand-up meeting." She revealed this has been a constant issue.	F 584		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the	F 640		7/3/25

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F 640	Continued From page 10 CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews and facility policy review, the facility failed to timely submit the quarterly Minimum Data Set (MDS) assessment for one (1) of 22 resident MDS assessments reviewed for timely submissions: Resident #17. Findings include:	F 640	1. Resident #17 Minimum Data Set (MDS) quarterly assessment was submitted and completed on June 05, 2025 by the Minimum Data Set (MDS) Nurse. On June 05,2025 the Director of Nursing in-serviced the Minimum Data Set (MDS) Nurse on the importance of timely scheduling and completing quarterly MDS	

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F 640	Continued From page 11 Record review of the facility policy titled "MDS Completion and Submission Timeframes," with revision date July 2017, revealed the following policy statement: "Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes ..." Record review of Resident #17's Quarterly MDS assessment with Assessment Reference Date (ARD) of 10/21/2024 revealed, "Section Z0500 ...B. Date Registered Nurse (RN) Assessment Coordinator signed assessment as complete: 11/14/2024 ..." Record review of Resident #17's Quarterly MDS assessment with of ARD 4/18/2025 revealed, "Section Z0500 ...B. Date Registered Nurse (RN) Assessment Coordinator signed assessment as complete: 6/4/2025 ..." During an interview on 6/4/25 at 1:18 PM with the MDS Nurse, she confirmed quarterly MDS assessments for Resident #17 with ARD dates 10/21/2024 and 4/18/2025 were both submitted after the 14-day timeframe. She explained that in October 2024, she missed a significant amount of work due to a family illness, and in April 2025, she was out for surgery. She further stated that no one filled in for her during her absence, resulting in delays in submitting assessments. During an interview on 6/5/25 at 1:47 PM with the Director of Nursing (DON), she confirmed her expectation that MDS assessments to be submitted timely. Record review of the Admission Record revealed	F 640	assessments. 2. All residents have the potential to affected. 3. On June 05, 2025 an in-service was initiated and completed by the Director of Nursing for the MDS Coordinator on ensuring resident MDS assessments are scheduled and completed timely. A 100% assessment review dates (ARD) was performed on June 09, 2025 and will be ongoing weekly by the MDS Coordinator to ensure all MDS are scheduled timely 4. Beginning on June 06, 2025, the Minimum Data Set Coordinator/and or the Assistant Director of Nursing will conduct audits (five) 5 times a week and will continue onward with MDS assessments are completed timely. Beginning on June 05, 2025, the MDS Coordinator will submit results to the Administrator weekly times (twelve) 12 weeks to audit for accuracy and completeness. Findings will be reported to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 640	Continued From page 12 Resident #17 was admitted to the facility on 1/24/24, with medical diagnoses that included Epilepsy and Vascular Dementia. Record review of the quarterly MDS with an ARD of 4/18/25 indicated, under Section C, a Brief Interview for Mental Statue (BIMS) score of 7, which indicated the resident had moderate cognitive impairment.	F 640		
F 656 SS=D	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 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		7/3/25

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F 656	Continued From page 13 (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 observation, staff and resident interview, record review and facility policy review, the facility failed to implement care plans: 1) related to Activities of Daily Living (ADL) assistance (Resident #1, #7, and #17); 2)trauma informed care (Resident #44), 3)prevention of accidents/positioning (Resident #15); and 4) assistance with feeding (Resident #49). This was for six (6) of 22 resident's care plans reviewed. Findings Include	F 656	1. Resident #1 received oral care on June 04, 2025 by the Certified Nursing Assistant (CNA) staff. Resident #1 care plan was updated by the Care Plan Nurse on June 04, 2025 to reflect oral care. Resident #7 received fingernail and toenail care by the Certified Nursing Assistant (CNA) staff on June 04, 2025. On June 04, 2025 Resident #7 care plan was updated by the Care Plan Nurse to reflect fingernail and toenail care. On June 04, 2025 Resident #17 was provided finger nail care, oral care, and a shave by the Certified Nursing Assistant (CNA) staff. On June 04, 2025 Resident #17 care plan was updated by the Care Plan Nurse to reflect finger nail care, oral, and a shave. On June 04, 2025 Resident #44 was provided an updated trauma informed	

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F 656	Continued From page 14 Review of the facility policy titled, "Care Plan, Comprehensive Person-Centered" with a revision date of March 2022 revealed under the "Policy Statement...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". Resident #1 Record review of Resident #1's Activities of Daily Living (ADL) care plan, with no date, revealed, " ...oral hygiene assist daily and as needed ..." On 6/3/25 at 8:22 AM and again at 1:54 PM, observations and interviews with Resident #1 revealed he had visible thick, brownish-yellow discoloration and buildup on the upper and lower front teeth. Resident #1 revealed that it had been a while since anyone had brushed his teeth for him. He stated he would not refuse mouth care if someone offered it. He mentioned that sometimes staff performed mouth care, but not often. Review of Resident #1's ADL care plan on 6/4/25 at 12:37 PM with the Care Plan nurse revealed the ADL care plan was fully developed and included oral care on the Kardex for the aide's instruction. She confirmed that the care plan was not implemented by the staff. She further stated that the care plans were individualized for each resident and provided treatment and goals tailored to each resident. Record review of the "Admission Record" that Resident #1 was admitted to the facility on 8/30/24, with medical diagnoses that included	F 656	care assessment by Social Services. Resident #44 care plan was updated by the Care Plan Nurse on June 04, 2025 to reflect accurate trauma informed care assessment. On June 04, 2025 Resident #15 fall mat was placed at bedside to prevent injury by Lead Certified Nursing Assistant. On June 10, 2025 Resident #15 physician order to obtain wedge between thighs was discontinued. On June 04, 2025 Resident #49 breakfast tray was left on the bedside table by Certified Nursing Assistant (CNA) staff. On June 04, 2025 Certified Nursing Assistant (CNA) staff received corrective counseling. 2. All residents have the potential to be affected. 3. On June 04, 2025 an in-service was initiated and completed by the Director of Nursing to all nursing staff on the facility's "Care Plan" policy and following the care guide to ensure resident's plan of care are followed at all times. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect oral, nail, shave, trauma informed care, accident prevention, and assistance with feeding. Two (2) of Fifty-nine (59) residents care plan was updated regarding oral care by the Care Plan Nurse on June 04, 2025. Two (2) of Fifty-nine residents care plan was updated regarding toenail and fingernail care by the Care Plan Nurse on June 04, 2025.	

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F 656	Continued From page 15 Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other lack of coordination, need for assistance with personal care, contracture of muscle right hand, contracture of muscle left hand, and muscle weakness (generalized). Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating that the resident had moderate cognitive impairment. Resident #15 Record review of Resident #15's care plan, "Fall Risk related to history of falls, impaired mobility", date initiated 7/10/2018 revealed, " ...floor mat to floor at bedside to prevent injury from falls ...apply wedge between thighs ..." On 6/03/25 at 10:18 AM and again at 2:00 PM, during observations revealed Resident #15 lying in bed without wedge cushion placed between thighs, and a fall mat was folded up and leaning against the wall. Review of Resident #15's Fall care plan with Care Plan Nurse on 6/04/25 at 12:45 PM confirmed the fall care plan was fully developed and included the placement of the fall mat at the bedside and the wedge between the resident's thighs. She acknowledged that the care plan had not been implemented by the staff. Additionally, she confirmed that the care plans were individualized for each resident and provided specific treatment and goals tailored to each resident's needs.	F 656	One (1) of 59 resident care plan was updated regarding shaving by the Care Plan Nurse on June 04, 2025. One (1) of 59 resident care plan was updated by the Care Plan Nurse regarding trauma informed care on June 04, 2025. One (1) of 59 resident care plan was updated regarding accident prevention. 4. Beginning on June 05,2025, the Lead Certified Nursing Assistant and/or the Care Plan Nurse will make observation rounds (three) 3 times per week for twelve (12) weeks to ensure care plan implementations are followed for residents. Beginning June 05, 2025, results of the observation rounds will be submitted to the Director of Nursing to monitor for accuracy and completeness. The Administrator will be forwarded to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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Record review of the "Admission Record" that Resident #15 was admitted to the facility on 7/10/18 with medical diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and unspecified convulsions.

Resident #17

Record review of Resident #17's ADL care plan, with no date, revealed, " ...staff to provide ADL care every (Q) day as appropriate ..."

During an observation on 6/3/25 at 7:37 AM it was revealed Resident #17's bilateral fingernails were approximately three-fourths (3/4") of an inch long and jagged, extending past the tips of fingers; a brown substance was noted under each nail. Additionally, facial hair was approximately one-half (1/2") inch long and was observed on the cheeks, chin, and above the resident's lip.

Review of Resident #17's ADL care plan with Care Plan Nurse on 6/4/25 at 12:41 PM confirmed that the ADL care plan was fully developed and included oral care on the Kardex for the aide's instruction. She acknowledged that the care plan had not been implemented by the staff. Furthermore, she confirmed that the care plans were individualized for each resident, providing specific treatment and goals tailored to each resident's needs.

Record review of the "Admission Record" revealed Resident #17 was admitted to the facility on 1/24/24, with medical diagnoses that included Epilepsy and Vascular Dementia.

Record review of the quarterly MDS with an ARD

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of 4/18/25 indicated, under Section C, a BIMS score of 7, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #17 was dependent on staff with personal hygiene.

Resident #7

Record review of Resident #7's "Activities of Daily Living (ADL) Care Plan" revealed under, "Focus: Alteration in ADL's" and additionally revealed under, "Interventions: May provide fingernail and toenail care as needed."

On 6/03/25 at 10:28 AM, an observation and interview with Resident #7 revealed her toenails needed cutting. An observation revealed the residents toenails on both feet were excessively thick and long extending approximately 8 millimeters (mm) past the tips of the toes.

An observation and interview with the Wound Care Nurse on 6/04/25 at 10:21 AM confirmed Resident #7's toenails needed care.

An interview with the MDS Nurse on 6/05/24 at 8:50 AM revealed the purpose of the care plan was to have an individual resident centered care plan to meet the resident needs. She explained it was a road map for resident care. The MDS Nurse acknowledged the care pan was not followed for Resident #7's nail care.

Record review of "Admission Record" revealed the facility admitted Resident #7 on 5/08/20 with medical diagnoses that included Cornes and

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Callosities, Unspecified Intellectual Disabilities and Paranoid Schizophrenia.

Record review of the MDS with an ARD of 2/11/25 revealed under section C, a BIMS summary score of 15, which indicated Resident #7 was cognitively intact.

Resident #44

Record review of Resident #44's "Care Plan Report" revealed under, "Focus: Risk for psychosocial complications R/T (related to) diagnosis of PTSD (Post-Traumatic Stress Disorder." Also revealed under, "Interventions: Assess for anxiety and triggers contributing to PTSD."

During an interview with Resident #44 on 6/04/25 at 1:42 PM, he revealed he was a United States Marine in the military for 5 years and was a sniper during wartime. He stated that he does suffer from post-traumatic stress disorder and has nightmares on and off. The resident explained that when a helicopter passes over the facility, it bothers him (triggers). The resident additionally revealed he was run over by an automobile before coming to the facility and had numerous broken bones and head trauma that required surgery.

Record review of Resident #44's "Trauma Informed Care Assessment-Post Traumatic Stress Disorder (PTSD)" dated 5/19/25 revealed under, "PTSD Screen: Sometimes things happen that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire* a physical or sexual assault or abuse* an earthquake or flood* a war* seeing

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someone killed or seriously injured* having a loved one die through homicide or suicide ... 1. Have you ever experienced this kind of event? No" was documented.

On 6/04/25 at 1:50 PM an interview with Social Services #1 confirmed Resident #44's trauma assessment was completed inaccurately, and as a result, the facility failed to identify his symptoms (nightmares) and potential triggers.

An interview with MDS Nurse on 6/05/25 at 8:50 AM confirmed Resident #44's trauma informed care assessment was inaccurate; therefore, the care plan was not followed to identify resident triggers contributing to his diagnosis of PTSD.

Record review of the "Admission Record" revealed the facility admitted Resident #44 on 11/30/23 with medical diagnoses that included Encounter for Surgical Aftercare Following Surgery on the Nervous System and Post-Traumatic Stress Disorder.

Record review of the MDS with an ARD of 2/12/25 revealed, under section C, a BIMS summary score of 15, which indicated Resident #44 was cognitively intact.

Resident #49

Record review of Resident #49's care plans revealed an alteration in ADL's related to general weakness , impaired mobility dated 12/26/23 with an intervention of "Total Assist times one (1) staff with eating."

On 6/3/25 at 7:30 AM an observation revealed

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F 656	Continued From page 20 Resident #49's breakfast tray was sitting on her bedside table. The resident was lying in bed with her head covered and continued observation revealed that no staff entered the room to assist the resident or set tray up until 8:00 AM. On 6/3/25 at 8:00 AM during interview with CNA #1 she verified that Resident #49 had to be assisted by staff during meals. Interview with Licensed Practical Nurse (LPN) #1 on 6/3/25 at 8:05 AM she confirmed that Resident #49 should have been assisted with breakfast when the tray was delivered. An interview with the Care Plan Nurse at 8:53 AM on 6/5/25 she verified that the care plan should have been followed but wasn't. Record review of the "Admission Record" revealed the facility admitted Resident #49 on 12/20/23 with a diagnosis of Diffuse Traumatic Brain Injury Record review of the MDS with an ARD of 12/19/24 for Resident #49 revealed a BIMS score of 11, indicating the resident is moderately cognitively impaired.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 677	1. Resident #1 received oral care on	7/3/25

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F 677	Continued From page 21 interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene (Resident #1 and #17) and failure to provide timely assistance with meals (Resident #49) for three (3) of 57 residents in the facility. Findings include: Review of facility policy titled, "Activities of Daily Living (ADL) Supporting" with revision date March 2018, revealed, " ...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ..." Resident #1 During observations and interviews on 6/3/25 at 8:22 AM and again at 1:54 PM, Resident #1 had a buildup of a thick brown/yellow substance on his teeth. This buildup was observed on both the upper and lower teeth. The resident stated he would like to have his teeth cleaned and it had been a while since anyone had offered. He verified he would not decline if they offered. During an observation and interview on 6/4/25 at 12:20 PM with Certified Nursing Assistant (CNA) #2, she confirmed the resident's teeth had buildup and should have been brushed. She revealed that not receiving daily oral care could lead to gum disease and/or cavities. During an observation and interview with the Director of Nursing (DON) on 6/4/25 at 12:26 PM, she confirmed that Resident #1 was in need of oral care and that the CNAs were responsible for providing that daily. She further revealed that	F 677	June 04, 2025 by the Certified Nursing Assistant (CNA) staff. Resident #1 care plan was updated by the Care Plan Nurse on June 04, 2025 to reflect oral care. On June 04, 2025 Resident #17 was provided finger nail care, oral care, and a shave by the Certified Nursing Assistant (CNA) staff. On June 04, 2025 Resident #17 care plan was updated by the Care Plan Nurse to reflect finger nail care, oral, and a shave. On June 04, 2025 Resident #49 breakfast tray was left on the bedside table by Certified Nursing Assistant (CNA) staff. On June 04, 2025 Certified Nursing Assistant staff received corrective counseling. 2. All residents have the potential to be affected. 3. On June 04, 2025 an in-service was initiated and completed by the Director of Nursing to all nursing staff on the facility's "Care Plan" policy and following the care guide to ensure resident's plan of care are followed at all times. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect oral care, finger nail care, shave, and assistance with feeding. Two (2) of Fifty-nine (59) residents care plan was updated regarding oral care by the Care Plan Nurse on June 04, 2025. Two (2) of Fifty-nine residents care plan was updated regarding toenail and fingernail care by the Care Plan Nurse on June 04, 2025. One (1) of 59 resident care plan was	

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F 677	Continued From page 22 lack of oral care could lead to dental caries. Record review of the "Admission Record" revealed that Resident #1 was admitted to the facility on 8/30/24, with medical diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other lack of coordination, need for assistance with personal care, contracture of muscle right hand, contracture of muscle left hand, and muscle weakness (generalized). Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating that the resident had moderate cognitive impairment. Resident #17 An observation on 6/3/25 at 7:37 AM revealed Resident #17's fingernails on both hands had a brown substance under each nail bed, was jagged and long extending approximately three-fourths (3/4") of an inch long past the tips of fingers; facial hair was visible on the resident's cheeks, chin and upper lip that was approximately one-half (1/2") inch long. During an observation and interview on 6/4/25 at 12:14 PM with CNA #2, she confirmed Resident #17 had 1/2" facial hair to his face and upper lip and that his fingernails were very long and dirty as well. She verbalized that he should be clean shaven, and his fingernails should also be trimmed. She confirmed that having long fingernails and long facial hair could be a source for bacteria to grow. Additionally, he could cause a skin tear with his long nails.	F 677	updated regarding shaving by the Care Plan Nurse on June 04, 2025. One (1) of 59 residents care plan was updated regarding assistance with feeding. 4. Beginning on June 05,2025, the Lead Certified Nursing Assistant and/or the Care Plan Nurse will make observation rounds (three) 3 times per week for twelve (12) weeks to ensure care plan implementations are followed for residents. Beginning June 05, 2025, results of the observation rounds will be submitted to the Director of Nursing to monitor for accuracy and completeness. The Administrator will be forwarded to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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	255217	A. BUILDING _____ B. WING _____	06/05/2025

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F 677	Continued From page 23 During an observation and interview on 6/4/25 at 12:20 PM with Licensed Practical Nurse (LPN) #2, she confirmed that Resident #17, "scratches and digs," with his fingernails, however they should be kept trimmed and clean. She also confirmed that his facial hair was several days old and should have been shaved off. She verbalized that he could scratch himself with his long nails and cause infection. During an interview with the DON on 6/4/25 at 12:26 PM, she confirmed that fingernails should be trimmed and cleaned as needed and that Resident #17 should have already been shaved. She confirmed he could cause a skin tear and/or infection with long, jagged nails. Record review of the "Admission Record" revealed Resident #17 was admitted to the facility on 1/24/24, with medical diagnoses that included Epilepsy and Vascular Dementia. Record review of the quarterly MDS with an ARD of 4/18/25 indicated, under Section C, a BIMS score of 7, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #17 was dependent on staff for personal hygiene. Resident #49 An observation on 6/3/25 at 7:30 AM revealed Resident #49's breakfast tray sitting on her bedside table, not opened or set up. The resident was in bed with her head covered with a blanket. Continued observation revealed that staff finally came in to assist the resident with breakfast at 8:00 AM.	F 677		

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F 677	Continued From page 24	F 677		

An interview with CNA #1 on 6/3/25 at 8:00 AM verified that Resident #49 has to be assisted with meals. She revealed that staff know they are not supposed to leave trays in the rooms of residents that need assistance, if they cannot feed them at that time. She stated that if a resident needs to be fed you are supposed to sit down and feed the resident when you bring the tray into the room. She stated that the tray should have been left on the cart until she was available to assist the resident. She verified that the food could get cold and that residents may not want to eat it.

An interview with CNA #2 on 6/3/25 at 8:03 AM confirmed that when a meal tray is placed in the room you are to assist the resident at that time and not leave the tray sitting in the room.

An interview with LPN #1 on 6/3/25 at 8:05 AM confirmed that if a resident requires assistance with meals they are to be assisted when the tray is taken into the room and Resident #49 should have been assisted with breakfast when the tray was delivered.

An interview with the Administrator on 6/4/25 at 11:00 AM stated that she expected the staff to assist residents with their meals when they bring their tray to their rooms.

Record review of the "Admission Record" revealed the facility admitted Resident #49 on 12/26/23 with a diagnoses including DiffuseTraumatic Brain Injury.

Record review of the MDS with an ARD of 12/19/24 for Resident #49 revealed a BIMS score of 11, indicating the resident is moderately cognitively impaired.

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F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. 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 the necessary foot care to maintain skin integrity and prevent complications for one (1) of three (3) residents reviewed that needed assistance with foot care. Resident #7 Findings Include: Review of the facility policy titled "Foot Care" with a revision date of 10/2022 revealed under, "Policy Statement: Resident receive appropriate care and treatment in order to maintain mobility and foot health." Also revealed under, "Policy Interpretation and Implementation: 1. Residents are provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions." On 6/03/25 at 10:28 AM, during an observation	F 687	1. Resident #7 received fingernail and toenail care by the Certified Nursing Assistant (CNA) staff on June 04, 2025. On June 04, 2025 Resident #7 care plan was updated by the Care Plan Nurse to reflect fingernail and toenail care. On June 11, 2025 Resident #7 received foot care by the Podiatrist. Resident #7 is scheduled for another visit by the Podiatrist on August 13, 2025. 2. All residents have the potential to be affected by this deficient practice. 3. On June 04, 2025 an in-service was initiated and completed by the Director of Nursing to all nursing staff on the facility's "Care Plan" policy and following the care guide to ensure resident's plan of care are followed at all times. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans	7/3/25

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F 687	Continued From page 26 and interview with Resident #7 she stated, "Are you here to trim my toenails?" She revealed her toenails needed cutting and the podiatrist was here weeks ago, but she was told she was not on the list to be seen. The resident reported she was having left heel pain and explained she had told the nurse. An observation of the left heel revealed a circular area with excessively thick dry and peeling skin, with dark redness surrounding the area. There was a small open area inside the patch of dryness that measured approximately 0.8 centimeters (cm) x 0.5 centimeters (cm) and was V-shaped in appearance with no intact skin and dark purple outer edges. The resident stated she had been applying lotion to it every day, but the staff were not doing a treatment. She stated the area was painful to touch. Several calluses were observed on both feet and her toenails on both feet were excessively thick and long extending approximately eight (8) millimeters (mm) past the tips of the toes. Record review of Resident #7's "Progress Notes" revealed there was no documentation regarding a skin concern. Record review of Resident #7's June 2025 "Treatment Administration Record (TAR)" there were no orders to provide care to the left heel. Record review of Resident #7's "Skin Check" dated 6/03/25, 5/27/25, 5/20/25, and 5/13/25 revealed "No skin issues" was documented. An interview with the Wound Care Nurse on 6/04/25 at 10:21 AM revealed she worked weekends and helped some during the week with wound care. She explained Resident #7 did not have skin concerns other than some dry skin at	F 687	reflect nail care. One (1) of 59 residents reflected nail care. A 100% Head to Toe skin assessment audit was performed by the Registered Nurse on June 05, 2025. The results of the audit revealed no negative findings. 4. Beginning on June 05,2025, the Lead Certified Nursing Assistant and/or the Care Plan Nurse will make observation rounds (three) 3 times per week for twelve (12) weeks to ensure care plan implementations are followed for residents. Beginning June 05, 2025, results of the observation rounds will be submitted to the Director of Nursing to monitor for accuracy and completeness. The Administrator will be forwarded to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 687	Continued From page 27	F 687		

times. The Wound Nurse stated," She's complaining all the time that her feet felt like they were bursting." Following an observation of Resident #7's left heel with the Wound Nurse, she stated she was unaware of the wound. She described the area as dry, thick cracking skin with redness around the edges. The resident confirmed the area was tender to touch. The Wound Nurse provided measurements of the entire circumference of the wound that measured 9.5 centimeters (cm) x 3.5 centimeters (cm). She confirmed the resident had excessively long thick toenails that needed to be cut. She revealed this could cause skin concerns or injury to the resident. The Wound Nurse acknowledged the residents' foot concerns should have been discovered during routine weekly skin checks and stated early identification could prevent foot complications.

An observation and interview with the Assistant Director of Nursing (ADON) on 6/04/25 at 10:46 AM revealed the medication nurses were responsible for doing the weekly body audits. She revealed she was not aware of any skin concerns the resident had. After assessing Resident 7's left heel, she confirmed this should have been detected during the body audit done yesterday and a treatment initiated.

An interview with Licensed Practical Nurse (LPN) #2 on 6/04/25 at 2:10 PM revealed she conducted the skin audit on Resident #7 yesterday. She confirmed she did not document accurately to reflect the resident skin condition. LPN #2 stated she had been applying lotion to the area, but she did not have any documentation to prove she had been doing it. She explained the podiatrist was here last month and she thought

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F 687	Continued From page 28 he saw her and stated, "Maybe he didn't document it." Record review of Resident #7's "Foot Care Progress Note" dated 2/24/25 revealed the resident was seen for toenail care with recommendations of "Daily moisturizer twice daily and 60 day follow up" for corns and callus. An interview with the Director of Nursing (DON) on 6/05/25 at 8:15 AM confirmed Resident #7 had excessively long thick toenails. She revealed the resident was at risk for infection and ingrown toenails or injury. She confirmed the resident was last seen by the podiatrist in February 2025. Record review of "Admission Record" revealed the facility admitted Resident #7 on 5/08/20 with medical diagnoses that included Cornes and Callosities, Unspecified Intellectual Disabilities and Paranoid Schizophrenia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #7 was cognitively intact.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		7/3/25

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F 689	Continued From page 29 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to provides an environment that is free from accident hazards as evidenced by failure to implement interventions to reduce fall hazards for one (1) of 40 residents sampled, Resident #15. Findings include: Review of the facility policy titled, "Safety and Supervision of Residents" with a revision date of July 2017 revealed under, "Policy Statement...Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities...Resident Risk and Environment Hazards...c. Falls". During observations on 6/03/25 at 10:18 AM and again at 2:00 PM, revealed Resident #15 lying in bed with a fall mat folded up and leaning against the wall and without a wedge placed between his thighs. During an observation and interview on 6/4/25 at 11:03 AM, with Certified Nursing Assistant (CNA) #1, she confirmed that the fall mat was folded up and propped against the wall. She revealed that the fall mat was supposed to be laid out on the floor in case he fell. She further confirmed that should he fall out of bed without the fall mat in place, he could potentially break a bone or get seriously hurt. She confirmed he did not have a wedge between his thighs, nor did he even have a wedge in his room.	F 689	1. On June 06, 2025 Resident #15 was assessed by the Director of Nursing for any ill effects noted related to staff not following the care guide while making room rounds ensuring fall mat was placed at bedside and a wedge was placed between his thighs. Resident #15 had no noted effects noted. Resident #15 physician order to implement wedge was discontinued on June 10, 2025. 2. All residents have the potential to be affected by this deficient practice. 3. On June 05, 2025 an in-service was completed and completed by the Director of Nursing to all nursing staff on the facility's "Accident/Incident" policy to ensure accidents are prevented. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect accident prevention. One (1) of 59 resident care plan was updated by the Care Plan Nurse on June 04, 2025 regarding accident prevention. A 100% care guide audit was completed by the Assistant Director of Nursing to ensure care guide implementation of assistant devices are noted to prevent accidents. On June 09, 2025 the Director of Rehabilitation initiated and completed a 100% audit on residents receiving therapy to ensure residents have appropriate relieving devices documented. Results revealed (two) 2 of (ten) residents	

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F 689	Continued From page 30 During an observation and interview on 6/4/25 at 11:06 AM, with Licensed Practical Nurse (LPN) #1, she confirmed the fall mat was propped against the wall but should be on the floor beside his bed. She verbalized that the mat was there to help prevent injury should the resident fall out of bed. Additionally, she stated that he could break a bone if he fell out of bed without the mat in place. She confirmed that Resident #15 did not have a wedge between his thighs. She also could not find one in his room as well. During an interview on 6/4/25 at 11:10 AM, with the Director of Nursing (DON), she confirmed the fall mat should have been in place on the floor beside his bed and he should have the wedge cushion in place. She confirmed that the mat was put in place to help prevent a serious injury should he fall out of bed. Record review of the "Admission Record" that Resident #15 was admitted to the facility on 7/10/18 with medical diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and unspecified convulsions. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/25, under Section C for Resident #15, revealed, " ...resident is rarely/never understood ..."	F 689	receiving therapy wedge order was discontinued on June 10, 2025. 4. Beginning on June 05, 2025, the Assistant Director of Nursing will make observation audit rounds (three) 3 times a week for eight (8) weeks to ensure care guide implementation for residents and ensure resident environment remains free of accident hazards. Beginning June 05, 2025 the Director of Rehabilitation will monitor residents receiving therapy services (three) 3 times a week for (eight) 8 weeks to ensure appropriate relieving devices are documented. Results of audits will be submitted to the Administrator weekly times (eight) 8 weeks for accuracy and completeness. The Administrator will forward results to the Quality Assurance Committee meeting held on June 20, 2025,then monthly times (three) 3 months for review and further recommendations.	
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		7/3/25

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F 699	Continued From page 31 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure an accurate trauma-informed care assessment was completed for one (1) of two (2) residents reviewed for Post-Traumatic Stress Disorder (PTSD). Resident #44 Findings Include: Review of the facility policy titled "Trauma Informed Care and Culturally Competent Care" with a revision date of 8/2022 revealed under, "Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization." Also revealed under, "Resident Assessment: 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers..." An interview with Resident #44 on 6/04/25 at 1:42 PM revealed he was a United States Marine in the military for five (5) years and was a sniper during wartime. He stated that he does suffer from PTSD and has nightmares on and off. He explained that when a helicopter passes over the facility, it bothers him (triggers). The resident additionally revealed he was run over by an automobile before coming to the facility and had	F 699	1. On June 04, 2025 Resident #44 was provided an updated trauma informed care assessment by Social Services. Resident #44 care plan was updated by the Care Plan Nurse on June 04, 2025 to reflect accurate trauma informed care assessment. 2. All residents have the potential to be affected. 3. On June 04, 2025 Social Services was provided an in-service by the Administrator on the facility's "Trauma-Informed Care" policy to ensure accurate trauma-informed care assessments are performed on all residents requiring assessments. On June 05, 2025 Social Services performed 100% audit on all behavioral residents. Results revealed four (4) of (twenty) 20 behavioral residents received a trauma-informed care assessment. 4. Beginning on June 05,2025, Social Services/and or Assistant Director of Nursing will monitor (five) 5 noted behavioral residents weekly times (twelve) 12 weeks to ensure accurate trauma-informed care assessments are completed timely. Results of the monitoring will be submitted to the	

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F 699	Continued From page 32 numerous broken bones and head trauma that required surgery. Record review of Resident #44's "Trauma Informed Care Assessment-Post Traumatic Stress Disorder (PTSD)" dated 5/19/25 revealed under, "PTSD Screen: Sometimes things happen that are unusually or especially frightening, horrible, or traumatic. For example: *a serious accident or fire* a physical or sexual assault or abuse* an earthquake or flood* a war* seeing someone killed or seriously injured* having a loved one die through homicide or suicide ... 1. Have you ever experienced this kind of event? No" was documented. An interview with Social Services #1 on 6/04/25 at 1:50 PM revealed that all she knew regarding Resident #44's background she obtained from a family member, who mentioned that he was homeless and was hit by a car. SS #1 stated she was not aware that he was a marine and in a war. She confirmed being in a war and being hit by an automobile were both traumatic events. She stated, "He has never had an episode to make us think he had post-traumatic stress disorder." She acknowledged the trauma assessment was completed inaccurately, and as a result, the facility failed to identify his symptoms (nightmares) and potential triggers. An interview with Licensed Practical Nurse (LPN) #2 on 6/04/25 at 1:56 PM revealed she was assigned to Resident #44 but was unaware he had PTSD. She stated he had not reported any triggers to her. An interview with the Director of Nursing (DON) on 6/04/25 at 2:01 PM confirmed her	F 699	Director of Nursing. Any concerns will be immediately addressed by the Director of Nursing and forwarded to the Administrator. The Administrator will submit findings to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 699	Continued From page 33 expectations were for Resident #44 to have an accurate trauma-informed assessment completed so that staff could identify the resident triggers to prevent any potential re-trauma. Record review of the "Admission Record" revealed the facility admitted Resident #44 on 11/30/23 with medical diagnoses that included Encounter for Surgical Aftercare Following Surgery on the Nervous System and Post-Traumatic Stress Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #44 was cognitively intact.	F 699		
F 838 SS=D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population,	F 838		7/3/25

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F 838	Continued From page 34 including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding,	F 838		

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F 838	Continued From page 35	F 838		

or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for

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F 838	Continued From page 36 each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure the Facility Assessment was updated to include a comprehensive evaluation of the resident population and the necessary resources, including staffing levels and competencies, required to meet resident needs under both routine and emergency conditions for three (3) of three (3) survey days. Findings include: Review of the facility policy titled "Facility Assessment" with a revision date of December 2024 revealed Policy Statement: A facility assessment is conducted annually to determine and update the capacity to meet the needs of and	F 838	1. On June 05,2025 staffing related to the annual facility assessment was updated by the Administrator. 2. All residents have the potential to be affected by this deficient practice. 3. On June 05, 2025 the Chief Operating Officer provided the Administrator an in-service on the facility's "Facility Assessment" policy to ensure documentation of sufficient staffing. A 100% Facility Assessment audit was performed on June 05, 2025 by the Clinical Nurse Director. Results revealed no negative findings.	

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F 838	Continued From page 37 competently care for residents during day-to-day operations (including nights and weekends) and emergencies. ..." Facility Assessment ...4. The facility assessment is used to inform staffing decisions. ...A. The facility assessment is used to ensure there is enough staff with appropriate competencies and skill sets to meet the needs of the residents identified through the review of resident assessments and plans of care. ...(2) Staffing needs are considered for each shift, including day, evening, and night shifts, and adjusted as necessary based on changes in the resident population." A review of the Facility Assessment document revealed that under Section II ("Staffing, Training, Services & Personnel") and Section III ("Physical Environment, Technology, & Equipment"), the Sufficiency Analysis Categories were marked only as "Evaluated." The assessment lacked documentation of specific staffing levels required for each shift (day, evening, and night) and did not address the specific skills and competencies necessary for staff to provide care for the facility's current resident population. During an interview on June 5, 2025, at 12:05 PM, the Administrator revealed that she completes the facility Assessment using the (proper name)Program. She revealed that she has always answered those questions and marked either 'evaluated' or 'sufficient' for staff. She confirmed that she has always only documented in the facility assessment that the staffing was sufficient, but did not actually calculate or address the staffing and skills needed for specific shifts, including night shifts, weekends, and emergencies.	F 838	4. Beginning on June 05, 20225 the Administrator and/or the Director of Nursing will monitor all facility assessments (three) 3 times a week for (twelve) 12 weeks to ensure sufficient staffing documentation is updated on the facility's annual facility assessment. The Administrator will submit results of the monitoring to the Chief Operating Officer weekly times (twelve) 12 to ensure documentation of sufficient staffing. Results of the findings will be to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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F 880	Continued From page 38	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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;	F 880		7/3/25

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F 880	Continued From page 39 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to help prevent the possible transmission of infections when staff failed during medication administration to ensure a multi-use glucometer was properly cleaned and disinfected and failed to use Enhanced Barrier Precautions (EBP) during catheter care (Resident #55) for two (2) of three (3) infection control practices observed.	F 880	1. On June 04, 2025 the glucometer was cleaned per manufacture instructions for (two) 2 minutes then sit to dry for an additional (two) 2 minutes by the Licensed Practical Nurse (LPN) staff. The Director of Nursing educated all nursing staff on instructions of cleaning glucometers on June 04, 2025. On June 04, 2025 all Certified Nursing Assistant (CNA) staff	

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F 880	Continued From page 40 Findings include: Review of the policy titled, "Enhanced Barrier Precautions Checklist" with no revision date revealed "Staff shall apply Enhanced Barrier Precautions to the care of all residents in high contact care activities ...5. Barriers include gloves, gowns ... An observation of catheter care for Resident #55 on 6/4/25 at 10:05 AM revealed Enhanced Barrier Precautions (EBP) signage on the outside of the room door. Certified Nurse Aide (CNA) #4 entered the room, performed hand hygiene, applied clean gloves, and did not apply a gown for enhanced barrier precautions. The Lead CNA assisted CNA #4 with catheter care and washed her hands, applying gloves, but did not put on a gown. The Lead CNA was observed leaning into the residents' bed with her clothes touching the bed. During an interview on 6/4/2025, at 10:20 AM, CNA #4 confirmed that she failed to wear a gown while providing catheter care for Resident #55. The Lead CNA revealed the resident is on EBP because he has a urinary catheter, and we should have both worn a gown to protect ourselves and also the resident from any possible spread of infection. An interview on 6/04/25 at 1:20 PM, the Infection Preventionist confirmed that enhanced barrier precautions are supposed to be used when providing catheter care. She revealed that the staff is to wear their gowns and gloves to protect themselves and the residents from any possible transmission of infection.	F 880	was provided education on the facility's "Enhanced Barrier Precautions" policy to ensure staff wear personal protective equipment while providing care to resident with noted catheters. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Nursing educated all nursing staff on instructions of cleaning glucometers on June 04, 2025. On June 04, 2025 all Certified Nursing Assistant (CNA) staff was provided education on the facility's "Enhanced Barrier Precautions" policy to ensure staff wear personal protective equipment while providing care to resident with noted catheters. On June 05, 2025 the Administrator and the Director of Nursing completed a 100% walk through, observing staff to see if there are any staff that are not in compliance with the policies and procedures on Infection Control Standards. 4. Beginning on June 05, 2025, the Charge Nurse(s)/and or Lead Certified Nurse Assistant will monitor Certified Nursing Assistant (CNA) staff wearing proper protective equipment while performing care on residents with Enhanced Barrier Precautions signage (two) 2 times a week for (twelve) 12 weeks to ensure staff are in compliance into Infection Control standards. The Charge Nurse(s)/and or Lead Certified Nursing Assistant will report results to the	

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F 880	Continued From page 41 An interview on 6/04/25 at 2:49 PM, the Director of Nurses (DON) confirmed that Resident #55 was under enhanced barrier precautions due to having a urinary catheter. She revealed it is our expectation that the staff members providing catheter care should always wear a gown and gloves to help prevent the spread of infections. Record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 4/15/2025 with medical diagnoses that included Multiple Sclerosis, and Neuromuscular dysfunction of the bladder. Record review of Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that the resident had moderate cognitive impairment. Multi-Use Glucometer Review of facility policy titled, "Obtaining a Fingerstick Glucose Level" with no date, revealed, " ...clean and disinfect reusable equipment between uses according to the manufacturer's instructions ..." Review of manufacturer's "User Instruction Manual" with no date, revealed, "...PDI Super Sani-Cloth Germicidal Disposable Wipe...Contact time: two (2) minutes..." During an observation and interview in between glucose checks on 6/4/25 at 11:17 AM with Licensed Practical Nurse (LPN) #1 revealed she cleaned the glucometer with a Sani-wipe by	F 880	Assistant Director of Nursing beginning on June 05, 2025. The Director of Nursing and the Administrator will monitor Certified Nursing Assistant (CNA) staff daily during facility rounds beginning on June 05, 2025 (one) 1 time a week for (twelve) 12 weeks to ensure ongoing compliance. Results will be submitted to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations. .	

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F 880	Continued From page 42 wiping down the meter with the wipe for a few seconds, then proceeded to set her clock for two (2) minutes. She placed the glucometer on a clean surface and allowed it to dry for two (2) minutes before use. She verbalized they were taught to wipe it down and let it sit and dry for 2 minutes. She further stated, "We used to do it that way (have contact with the germicidal wipe for two (2) minutes), but then they said we were doing it wrong." She confirmed that not following the manufacturer's guidelines could result in the spread of infection. During an interview on 6/4/25 at 11:28 AM, with the Director of Nursing (DON), she confirmed they (nursing staff) were taught to wipe the glucometer and then let it dry for two (2) minutes. She stated, "We misunderstood the directions." Additionally, she verbalized that reusable equipment should be cleaned according to manufacturer's guidelines to prevent the spread of infection.	F 880		