STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

(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 at the facility from 04/07/2025 through 04/10/2025. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F580, F656, F684, F690, F761, and F812. The facility had a census of 47 and was licensed for 60 beds.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		5/5/25

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

Electronically Signed | 05/05/2025

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and the facility policy review, the facility failed to notify the physician of a resident with no documented bowel movement for six (6) consecutive days, which resulted in the resident being hospitalized on 1/30/25 for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident #25 Cross Reference F684, F656 Findings include: A record review of the facility's policy "Notification of Changes in a Resident's Conditions or Status",	F 580	* Resident #25 was reviewed 04/10/25 through the Alert listing report by Director of Nursing and Medical Records with no alerts noted. Physician was notified by the Director of Nursing of residents status. * All Residents have the potential to be affected by this practice. * 100% audit of "Facility Alert Listing Report" on bowl movements was completed by Director of Nursing on 04/11/25. All concerns were addressed by Registered Nurse with no adverse	

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F 580	Continued From page 2 undated, revealed, " ... It is the policy of this facility to ...consult with his or her physician ...changes in the resident's condition and/or status ...Procedure 1. Nursing services shall be responsible for notifying the resident's attending physician when ...d. There is a need to alter the resident's treatment significantly ..." A record review of the statement provided via the Administrator on facility letterhead dated 4/10/25 revealed the facility did not have a policy regarding constipation or bowel movements. On 04/07/25 at 02:38 PM, during a phone interview with a family member, she explained Resident #25 had been hospitalized in January because she did not have a bowel movement (BM) for a week. On 04/08/25 at 03:20 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained the Certified Nurse Aides (CNAs) are to notify them if a resident does not have a BM for three (3) consecutive days and the electronic health record (EHR) will trigger an alert for anyone with 3 days of no BM. She reported that the facility has standing physician's orders for medications to give if needed for residents with no BM. She confirmed that the physician is not always notified of no bowel movements unless the medications are not effective. On 04/08/25 at 04:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident#25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered to stop	F 580	findings. Physician was notified there were no concerns identified. In-service was given by Director of Nursing on 04/10/25 regarding notification of Physician for any changes including all Activity of Daily Living Changes. * The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Director of Nursing and/or Registered Nurse will check alerts including Bowel movements daily beginning 04/11/25 and will bring report to stand-up meeting with clinical team each morning. Registered Nurse and/or Licensed Practical Nurse will follow up with Certified Nurse Aide and resident about alert including Bowl Movement. Registered nurse and/or Licensed Practical Nurse will follow standing orders and care plan to resolve alert. At the end of each shift, the Registered Nurse will check to make sure the alert is completed. Director of Nursing is to follow up every 72 hours for eight weeks beginning 04/11/25 and ending 06/06/25.	

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F 580	Continued From page 3	F 580		

it. The CNAs are to notify the nurse if there are no BMs in 3 consecutive days and then the nurse is to give the resident medications and notify the physician if there are no changes. She confirmed she was not aware the resident was not having BMs, and explained the physician did see the resident prior to the hospital admission in January.

On 04/09/2025 at 10:45 AM, during a follow up interview with the DON, she acknowledged there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25.

On 04/10/25 at 12:45 PM, during a phone interview with Resident #25's Physician, he explained he is familiar with the resident and explained the resident has had irritable bowels, with alternating patterns of diarrhea and constipation. He confirmed Resident #25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for 6 consecutive days prior to being sent to the hospital. The facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.

A record review of Resident #25's "Admission Record" revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with

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F 580	Continued From page 4	F 580		

an onset date of 2/5/2025 included Hemorrhage Of Anus And Rectum and Fecal Impaction.

A record review of Resident #25's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Resident dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder.

A record review of the facility's "Documentation Survey Report" for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There was also no bowel movement documented on January 23, 24, and 28.

A record review of the medical record revealed there was no documentation of nursing interventions, assessments, or physician notification to address Resident #25's ongoing constipation or lack of consecutive days with no BM during the month of January 2025.

A record review of an acute hospital "Summary of Care Document" confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.

A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil (antidiarrheal medication) three (3) times daily despite the documented days of no BM.

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F 580	Continued From page 5 Additionally, no medications were administered for constipation, including Miralax (type of laxative medication) that was ordered to be administered PRN (as needed).	F 580		
F 656 SS=G	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. (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	F 656		5/5/25

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F 656	Continued From page 6 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 interviews, record review, and the facility policy review, the facility failed to implement comprehensive person-centered care plan interventions for a resident with constipation and no documented bowel movements for consecutive days, which resulted in a Resident being hospitalized on 1/30/25 for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident#25 Cross Reference F580, F684 Findings include: A review of the facility's policy "Care Plans, Comprehensive Person-Centered," reviewed 10/2022 revealed, " ... 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. Policy Interpretation and Implementation... 7. The comprehensive, person-centered care plan: ... e. reflects currently recognized standards of practice for problem	F 656	* On 04/10/25 the Director of Nursing ensured Resident #25 had a bowel movement within the guidelines of the comprehensive care plan. * All residents have the potential to be affected by this practice. * The Director of Nursing and /or Registered Nurse provided education to all Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides beginning on 04/10/25 and ending on 05/05/25. This included the Certified Nursing Assistants notifying the Registered Nurse or Licensed Practical Nurse of any changes of Activities of Daily Living care (ADL care) including bowel movements. 100% Audit beginning 04/10/25 was conducted for all residents by MDS Nurse and/or Director of Nursing that alerted for no bowel movement to assure that care plan was in place.	

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F 656	Continued From page 7 areas and conditions ... 10. When possible, interventions address the underlying source (s) of the problem area (s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change ..." A record review of the "Care Plan Report" revealed Resident #25 had a comprehensive care plan with a "Focus" of "(Proper Name of Resident #25) is at risk for constipation r/t (related to) polypharmacy. The "Goal" that was initiated on 10/4/2023 revealed, "(Proper Name of Resident) will have a normal bowel movement at least every 3 (three) days ..." Interventions included "Follow orders for bowel management", "Glycolax powder ...as needed for constipation", and "Observe for/document/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of complications related to constipation ...fecal compaction ..." A record review of Resident #25's "Admission Record" revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage of Anus and Rectum and Fecal Impaction. A record review of Resident #25's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Further review revealed Resident #25 is dependent on staff for toileting hygiene and frequently incontinent of bowel and bladder.	F 656	*The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Care Plans will be audited with each alert by MDS Nurse and /or Director of Nursing daily beginning 04/11/25 times thirty days then every three days times four weeks then weekly times three months ending 09/11/25.	

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F 656	Continued From page 8	F 656		

A record review of the facility's "Documentation Survey Report" for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There was also no bowel movement documented on January 23, 24, and 28.

A record review of an acute hospital "Summary of Care Document" confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction.

A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil three (3) times daily despite the documented days of no BM. Additionally, MiralAX (type of laxative) was ordered PRN (as needed) and was not administered.

In a phone interview, on 04/07/25 at 02:38 PM, Resident #25's daughter explained that her mother had been hospitalized in January because she did not have a bowel movement (BM) for a week. She had to be transferred to an acute hospital in another state and was there for almost a week because her bowels were impacted.

In an interview on 04/08/25 at 04:00 PM, the Director of Nursing (DON) confirmed Resident#25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered. She confirmed

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Resident#25 was receiving Lomotil (antidiarrheal medication) three (3) times a day prior to the hospitalization. The CNAs are to notify the nurse if a resident goes three (3) consecutive days without a BM and the nurse should give medications and notify the physician if there are no changes. She reported she was not aware Resident #25 was not having BMs, and explained the physician did see the resident prior to the hospital admission in January. She also advised the physician after she was informed by the hospital that the resident had a fecal impaction in January.

In a follow up interview with the DON on 04/09/2025 at 10:45 AM, she acknowledged there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25.

In a phone interview with the physician on 04/10/25 at 12:45 PM, he confirmed Resident#25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for six (6) consecutive days prior to being sent to the hospital. He stated that the facility has standing orders to follow if a resident has no BM. He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.

In an interview on 04/10/25 at 1:30 PM, LPN #3/Care Plan Nurse explained the facility has

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F 656	Continued From page 10 working care plans and are updated daily. She described the purpose of the care plan as providing the staff with a guideline to care for each individual resident. She expects staff to follow the care plans to provide care for the residents. In an interview on 04/10/25 at 1:40 PM, the DON explained she expects the staff to follow care plans to provide the highest quality of care for each resident, to follow standing orders related to no bowel movements, and to notify her and the physician of any changes in any resident. She reported there was miscommunication with the staff and the physician. In an interview on 04/10/25 at 1:50 PM, the Administrator explained the facility wants to provide each resident care as planned and to notify the DON and the physician of any changes.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and the facility policy review, the facility failed to identify or respond to a clinically relevant pattern of constipation, which resulted in a resident being	F 684	*The Director of Nursing evaluated Resident #25 04/08/25 with no new adverse findings. No complaints of pain. Abdomen is soft, non distended and non	5/5/25

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F 684	Continued From page 11 hospitalized on 1/30/25 for evaluation that included findings consistent with fecal impaction for one (1) of 14 sampled residents. Resident #25 Cross Reference F580, F656 Findings include: A record review of the statement provided via the Administrator on facility letterhead dated 4/10/25 revealed, " ... (Proper Name of Facility) does not have a policy for constipation or bowel movements." During a phone interview, on 04/07/25 at 02:38 PM, Resident #25's daughter explained that her mother had been hospitalized in January because she did not have a bowel movement (BM) for a week. She had to be transferred to an acute hospital in another state and was there for almost a week because her bowels were impacted. During an interview on 04/08/25 at 03:20 PM, Licensed Practical Nurse (LPN) #1 explained that the CNAs advise if there is a problem with a resident's BMs and the nurses receive an alert on the computer if a resident goes three (3) consecutive days without a BM. She further explained that the facility has standing orders for medications to give if a resident needs it for no BM or constipation. Usually, the nurse will administer oral medications related to constipation and if there are no results, they will use a suppository and rarely use an enema. If the medications are not effective, then the physician is notified. During an interview on 04/08/25 at 04:00 PM, the	F 684	tinder to touch. Bowl sounds active times four quadrants. * All Residents have the potential to be affected by this practice. * 100% audit of "Facility Alert Listing Report" on bowel movements was completed by Director of Nursing on 04/11/25. All concerns were addressed by Registered Nurse with no adverse findings. Physician was notified there were no changes or concerns identified. * The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Beginning 04/11/25 Director of Nursing and/or Registered Nurse will check "Alert Listing Report" for changes including Bowel movements daily. They will bring report to stand-up meeting with clinical team each morning. Registered Nurse and/or Licensed Practical Nurse will follow up with Certified Nurse Aide and resident about the " Alert Listing Report" for changes including Bowl Movements. Registered nurse and/or Licensed Practical Nurse will follow standing orders and care plan to resolve alert. Director of Nursing is to follow up every 72 hours for	

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	255262	A. BUILDING _____ B. WING _____	04/10/2025

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F 684	Continued From page 12 Director of Nursing (DON) confirmed Resident #25 was hospitalized with a fecal impaction several months ago. She explained the resident had a history of diarrhea and constipation and when she experienced diarrhea, medications were administered. She confirmed Resident#25 was receiving Lomotil (antidiarrheal medication) three (3) times a day prior to the hospitalization. The CNAs are to notify the nurse if a resident goes three (3) consecutive days without a BM and the nurse should give medications and notify the physician if there are no changes. She reported she was not aware Resident #25 was not having BMs, and explained the physician did see the resident prior to the hospital admission in January. She also advised the physician after she was informed by the hospital that the resident had a fecal impaction in January. During a follow up interview with the DON on 04/09/2025 at 10:45 AM, she confirmed there was no documentation of nursing interventions, constipation medications administered, or provider notification regarding the gaps in bowel movements prior to the hospitalization for Resident #25. During a phone interview with the physician on 04/10/25 at 12:45 PM, he explained Resident #25 had irritable bowels, with alternating patterns of diarrhea and constipation. He confirmed Resident#25 was on Lomotil for diarrhea and reported he was aware the resident was admitted to the hospital several months ago for a fecal impaction. However, he was not informed that the resident had no BMs or documentation of no BM for six (6) consecutive days prior to being sent to the hospital. He stated that the facility has standing orders to follow if a resident has no BM.	F 684	eight weeks ending 06/06/25	

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F 684	Continued From page 13	F 684		

He confirmed that if he had been notified that Resident #25 had no BMs for consecutive days, he would have implemented orders for constipation.

A record review of Resident #25's "Admission Record" revealed the facility originally admitted the resident on 03/01/2022 and she had a diagnosis of Constipation. Diagnoses added with an onset date of 2/5/2025 included Hemorrhage Of Anus And Rectum and Fecal Impaction.

A record review of Resident #25's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated she was cognitively intact. Section GG revealed Resident #25 was dependent on staff for toileting hygiene and Section H revealed she was frequently incontinent of bowel and bladder.

A record review of the facility's "Documentation Survey Report" for January 2025 revealed Resident #1 experienced multiple days without a documented bowel movement. Specifically, there was no documented bowel movement on January 1, 2, 3, and 5, and again on January 14, 15, 16, 17, 18, and 19, which was six (6) consecutive days. There were also no bowel movement documented on January 23, 24, and 28.

A record review of the medical record revealed there was no documentation of nursing interventions, assessments, or physician notification to address Resident #25's ongoing constipation or lack of consecutive days with no BM during the month of January 2025.

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F 684	Continued From page 14 A record review of an acute hospital "Summary of Care Document" confirmed that Resident #1 was hospitalized from 01/30/2025 through 02/04/2025 with multiple medical issues, including a diagnosed fecal impaction. A record review of the Resident's Medication Administration Record (MAR) for January 2025 revealed Resident #25 continued to receive Lomotil three (3) times daily despite the documented days of no BM. Additionally, MiralAX (type of laxative) was ordered PRN (as needed) and was not administered. A record review of the Resident's "Physician's Progress Notes" dated 01/30/25 revealed, "pt (patient) with decreased LOC (Level of Consciousness), pt noncompliant with therapy, pt with no dysuria, ... good BS (bowel sounds) ..." A record review of the Resident's "Physician's Progress Notes" dated 02/06/25 revealed, "pt with GI (Gastrointestinal) bleed ..."	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		5/5/25

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F 690	Continued From page 15 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate incontinence care was provided, as evidenced by the failure to cleanse the skin during a brief change for one (1) of two (2) residents observed for incontinence care (Resident #13). Findings included: A review of the facility's policy titled, "Perineal Care," revised 8/25/2014, revealed, "...Procedure ...5. Clean perineal area well with soap and warm water taking care to clean from front to back using a clean washcloth or clean area of the cloth	F 690	*Resident #13 was evaluated with no adverse findings. The Certified Nurse Aide was educated 04/08/25 by the Director of Nursing on Proper perineal Care for resident # 13. * All residents have the potential to be affected by this practice. *The Director of Nursing provided education to all Certified Nursing Assistants beginning on 04/10/25 and ending on 05/06/25. Skills checks will be preformed on all Certified Nursing Assistants by 05/06/25.	

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F 690	Continued From page 16 for each stroke. 6. Rinse perineal area, moving from front to back using a clean area of the washcloth or towelette or use another clean washcloth or towelette for each stroke. (Note: Not all products require rinsing. Follow product instructions). 7. Dry perineal area moving from front to back. Use a blotting motion with towel. 8. Turn resident on side. 9. Clean, rinse (as applicable) and dry buttocks and perianal area without contaminating perineal area. 10. Remove wet incontinent pad or protective linen. Change gloves and perform hand hygiene ..." On 4/8/25 at 2:20 PM, during an observation of incontinence care, and interview with Certified Nurse Aide (CNA) #1, she explained that Resident #13 was dependent on staff for activities of daily living (ADLs) and was incontinent of bowel and bladder. Resident #13 was lying in bed, and his brief was soiled with urine. Disposable wipes were noted on the bedside table. CNA #1 removed the soiled brief and applied a clean one without cleansing or rinsing the perineal area or buttocks. The CNA repositioned the resident and covered him with a blanket. On 4/8/25 at 2:50 PM, during a follow-up interview with CNA #1, she confirmed she changed Resident #13's soiled brief and did not provide perineal care. She stated she was nervous during the observation and forgot, but she knew the appropriate procedure. She acknowledged that failing to cleanse the resident could contribute to urinary tract infections and skin breakdown. On 4/9/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she stated her	F 690	*The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Audits of perineal care will be completed by Director of Nursing and/or Registered Nurse beginning 04/10/25. This audit will include two Certified Nursing Assistants preforming hands on demonstration of perineal care two times weekly beginning 04/10/25 for four weeks and will be validated by the Director of Nursing and/or Registered Nurse. Perineal audit forms will be reviewed with the Administrator and Director of Nursing weekly times four weeks, then monthly times three months. Any deficient practice will be brought to the Quality Assurance Performance Improvement Committee for correction action plan.	

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F 690	Continued From page 17 expectation is for staff to always provide proper incontinence care to prevent infections or skin breakdown. A record review of the "Admission Record" revealed the facility admitted Resident #13 on 3/10/25 with diagnoses including Metabolic Encephalopathy. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired. Further review revealed he was frequently incontinent of bowel and bladder and dependent on staff for toileting hygiene.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		5/5/25

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F 761	Continued From page 18 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure medications were secured when a wound care treatment cart was left unlocked and unattended in a hallway for one (1) of four (4) days of the survey. Findings included: A review of the facility's policy titled "Medication Administration Guidelines," revised August 25, 2014, revealed, " ...Procedure ...2. Administration ...m. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by..." On 4/9/25 at 2:14 PM, during an observation on the North Hall, a wound care treatment cart was unlocked. The cart was left unattended by Registered Nurse (RN) #1, who had entered a resident's room to perform wound care. RN #1 remained in the room with the door closed until 2:34 PM. When she exited the room, she confirmed the treatment cart had been left	F 761	*The wound care cart was locked immediately by the Registered Nurse on 04/09/25. *All residents in the area of the wound care cart have the potential to be affected. * All Medication and Wound Care carts were checked 04/09/25 by Director of Nursing to assure all carts were locked and secured. One on One in-service was given 04/09/25 by Director of Nursing to the Registered Nurse. All medications and dressings were checked by Director of Nursing on 04/09/25 and accounted for. *The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Rounds will be made beginning 04/11/25	

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F 761	Continued From page 19 unlocked and unattended. On 4/9/25 at 2:38 PM, during a follow up interview with RN #1, she confirmed the cart had been left unlocked and unattended for approximately 20 minutes. She stated that the cart should have been locked to prevent resident access. RN #1 opened the cart and demonstrated the contents, which included bactericidal isopropyl alcohol-based sanitizer wipes, Santyl ointment (used for tissue removal and debridement), normal saline, betadine, and nail clippers. She explained that these items could pose risks to residents, including gastrointestinal distress or requiring emergency care, if consumed. On 4/10/25 at 12:10 PM, during an interview with the Director of Nursing (DON), she confirmed that it was her expectation for staff to keep carts locked and not leave them unattended. She stated the risks of leaving wound carts unsecured included possible resident poisoning from substances such as betadine or Santyl, and unauthorized access by staff without proper training, which could result in theft or misuse of supplies. She confirmed that RN #1 should have locked the cart while it was unattended per facility policy.	F 761	and ending 09/06/25, to check all medication carts, and wound care carts to assure they are locked and secured twice Weekly times four weeks then every week times four weeks, then monthly times three months.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		5/5/25

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F 812	Continued From page 20 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to maintain a sanitary and pest-free environment in the kitchen by not ensuring effective pest control measures were implemented and sustained for two (2) of three (3) kitchen observations. Findings included: A review of the facility's policy, "Sanitization" (undated), revealed, " ...The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1. All kitchens, kitchen areas shall be... protected from rodents, roaches, flies, and other insects." A review of the facility's "Pest Control Policy," dated 4/10/23, revealed, " ...Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents ...6. Maintenance services assist, when appropriate and necessary, in providing pest	F 812	*Food service area was cleaned completely on 04/11/25 by Dietary staff and Dietary Manager. All bagged goods and cereal were sealed in plastic containers and shelves were wiped down before placing containers back on shelves. All food carts were cleaned and sanitized to be ready for next meal service. * All residents can be affected by this practice. * Dietary staff was in-serviced 04/10/25 by Dietary Manager on their cleaning schedules and responsibilities to assure kitchen is clean and sanitary for preparation of meal service. Pest Control was directed on 04/18/25 by Administrator to come weekly for four weeks, then bi-weekly for three months, then monthly unless there were any signs of pest or rodents seen.	

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F 812	Continued From page 21 control services." On 4/7/25 at 10:02 AM, during the initial kitchen tour with the Dietary Manager, the dry goods storage area was observed. A cardboard box containing individually packaged cereal had small, black, rice-sized objects and shredded cardboard inside. The Dietary Manager confirmed the rice-sized objects appeared to be rat droppings. A glue trap with what appeared to be peanut butter smeared on top was observed on the floor of the pantry area. The Dietary Manager stated he was unaware of when the kitchen was last treated for rodents. He reported concern that rodents may be entering through a small gap beneath the kitchen's back door, which leads directly outside. On 4/9/25 at 8:50 AM, during a phone interview with the Registered Dietitian (RD), she explained she performs monthly kitchen tours at the end of each month. She stated she had not observed pest or rodent activity during those walk throughs. She stated her expectations were for dietary staff to maintain an effective pest control plan and adhere to sanitation standards. On 4/9/25 at 10:00 AM, during an interview with the Maintenance Supervisor, he stated he was unaware of rodent activity in the kitchen but acknowledged that rodents may have entered through a gap under the back door. He explained the rear kitchen area had a two-door system-a screen door and a solid, sealed door. He reported that staff had previously left the solid door open to allow air circulation when the air conditioning system was not functioning. He stated the air system was scheduled to be repaired that day.	F 812	* The Quality Assurance Performance Improvement (QAPI) team met and discussed the adverse event on 05/01/25. The team included Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, MDS Nurses, Medical Records, Therapy, Maintenance, Life Connections, Business office Manager, Dietary Manager and Social Services. The policy was reviewed and no changes were deemed necessary. Rounds will be made twice weekly for four weeks, then weekly for four weeks then monthly for 3 months beginning 04/10/25 and ending 09/05/25 by Dietary Manager and/or Administrator to check for cleanliness of the Kitchen.	

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F 812	Continued From page 22 On 4/9/25 at 11:04 AM, during an observation of the assembly line plating, a live roach was observed crawling across a resident's meal tray. The tray was immediately removed after confirmation by the Dietary Manager, Dietary Aide, Head Cook, and Maintenance Supervisor. On 4/10/25 at 9:10 AM, during observation of the low-temperature dishwasher, a live roach was observed crawling on top of the machine. On 4/10/25 at 1:10 PM, during an interview with the Administrator, she was informed of the pest-related concerns identified during two (2) of three (3) kitchen inspections. She stated she had been unaware of pest issues in the kitchen and acknowledged that high staff turnover had affected kitchen oversight. She emphasized that her expectations were for food to be prepared safely, the kitchen to be maintained in a clean and organized condition, and for pest infestations to be minimized. A record review of the facility's pest control logs revealed treatments for rodents and pests had occurred since December 2024. A review of the facility's pest control logs revealed the pest control company were targeting mice and roaches with roaches and rodent activity noted on visits during the monthly visits for the months of January, February, and March 2025.	F 812		