STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255229	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCARE CENTER	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI), a facility reported incident, CI MS #29326 at the facility from 6/16/25-6/19/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited, F550, F558, F584, F656, F677, F812, F880, and F925. The SA investigated CI MS #29326 and no deficiencies were cited related to the CI. The census at the time of the survey was 85 and the facility is licensed for 120 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 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	F 550		7/18/25

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

Electronically Signed | 07/01/2025

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F 550	Continued From page 1 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 interview, record review and facility policy review, the facility failed to ensure a resident's dignity was maintained as evidenced by a resident wearing a visibly soiled shirt and pants hanging below the hips, exposing undergarments for one (1) of 41 sampled residents. Resident #44 Findings Include: Review of the facility policy titled "Dignity," revised 2/2021, revealed under "Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem..." An observation of Resident #44 on 6/16/25 at 10:29 AM revealed he was sitting in his recliner in	F 550	Preparation and submission of this plan of correction by Holly Springs Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F550 Facility failed to ensure dignity was maintained for 1 of 41 sampled residents as evidenced by a soiled shirt and pants	

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F 550	Continued From page 2 his room with the door open. He was wearing a soiled shirt with yellow orange smeared food and five circular stains the size of nickels and quarters, resembling spilled liquids. His pants were pulled down past his hips, exposing his protective underwear. A staff member was observed changing the resident's linen but did not interact with or provide care to the resident. During an observation and interview with Licensed Practical Nurse (LPN) #4 on 6/16/25 at 10:41 AM, she confirmed that Resident #44's shirt was soiled, and his underwear was exposed. She stated, "Yes, it looks bad." She acknowledged this was a dignity issue and stated the resident's clothes should be changed when soiled. An interview with Certified Nurse Aide (CNA) #3 on 6/16/25 at 10:50 AM, she revealed she was assigned to Resident #44 and was aware his shirt was soiled. She stated, "I saw it after breakfast, but I got busy with another resident and never returned." CNA #3 acknowledged this was a dignity concern. An interview with the Administrator on 6/19/25 at 8:50 AM revealed his expectation was that staff should address Resident #44's needs as soon as they were identified. Record review of the "Admission Record" revealed the facility admitted Resident #44 on 8/24/24 with a diagnosis of Unspecified Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/13/25 indicated in section C, a Brief	F 550	hanging below the hips, exposing residents brief. Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #3 addressed the observations made by the surveyor on 6/16/25. LPN #4 and CNA #3 were in-serviced by the Staff Development Coordinator on 6/20/2025. At the time of the survey, 83 residents had the potential to be affected by the deficient practice. Nurse Supervisors rounded to ensure compliance with the dignity policy 6/19/25. No negative findings were noted. Administrator, Director of Nursing (DON), and Staff Development Coordinator (SDC) reviewed the Dignity Policy 6/19/25 to ensure accuracy. No negative findings were noted. SDC initiated staff in-services on 6/17/25 that includes maintaining the dignity of residents. These will be completed for current staff by 7/17/25 and will be ongoing for new staff members during orientation. Starting 6/23/25 the Nurse Supervisors, DON, Assistant Director of Nursing (ADON), and SDC will begin observing Resident #44 for soiled clothing and to ensure the clothes fit properly. A sample of (10) ten other residents will be observed for soiled and properly fitting clothing. This will occur (3) three times per week for (4) four weeks and (1) one time monthly thereafter for (3) three months. Negative findings will be addressed immediately, and results of the audits will be brought to two quarterly Quality Assurance Meetings by DON, SDC,	

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F 550	Continued From page 3 Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.	F 550	ADON or Nurse Supervisors, beginning on 7/10/25.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure that resident call lights were within reach, which limited a resident's ability to request assistance (Residents #39, #44, #48 and #82) and failed to ensure adequate mattress size needed (Resident #45) for five (5) of 83 residents residing in the facility. Findings include: Review of the facility policy dated October 2022 titled "Resident Call System" revealed, "Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation..." Resident #39 An observation on 6/16/25 at 11:00 AM and again on 6/17/25 at 11:08 AM revealed Resident #39's call light was not within reach. On 6/16/25 at 11:00 AM the observation revealed the call light	F 558	The facility failed to ensure call lights were within reach for 4 of 83 residents and failed to ensure adequate mattress size for 1 of 83 residents. Resident 39s call light was placed within reach on 6/18/25 by LPN #5. Resident #44s call light was placed within reach by Licensed Practical Nurse (LPN) #4 on 6/16/25. Resident #82s call light was placed within by LPN #4 on 6/16/25. Resident #48s call light was placed within reach by Certified Nursing Assistant (CNA) #4 on 6/17/25. The maintenance Director placed an extension cushion at the foot of Resident #45s bed on 6/17/25. A new mattress was ordered by the Maintenance Director on 6/27/25 to replace the mattress extension. At the time of survey, 83 residents had the potential to be affected by call lights not being in reach. Nurse Supervisors rounded on 6/18/25 to ensure call lights were in reach and all of them had clips. Negative findings were addressed	7/18/25

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F 558	Continued From page 4 was wrapped around the back of the bed and out of reach. And on 6/17/25 at 11:08 AM, the call light was observed on the floor, behind the bed, out of reach. During an observation and interview with Licensed Practical Nurse (LPN) #5 on 6/18/25 at 11:18 AM she confirmed the Resident #39's call light was out of reach and on the floor. She stated, "The call light should always be in reach so that the resident can call us if needed, it should not be on the floor out of reach." During an interview with the Director of Nursing (DON) on 6/18/25 at 11:45 AM, she stated, "The call light should be within reach of Resident #39, the call light is the resident's voice." Record review of Resident #39's "Admission Record" revealed the resident was admitted 1/08/2025 with diagnosis of Unspecified Dementia. Record review of Resident #39's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 4/17/2025, revealed a Brief Interview for Mental Status (BIMS) score of 6 indicating the resident was severely cognitively impaired. Resident #45 On 6/16/25 at 11:00 AM, 1:00 PM, and 2:30 PM Resident #45 was observed lying in bed with his feet hanging off the end of the mattress. He was positioned with his head at the head of the bed but both feet were extended past the end of the mattress with no support.	F 558	immediately. Maintenance replaced missing clips that were identified on 6/18/25. Six residents had bed extensions at the time of the survey. Resident #45 was the only one affected by deficient practice. Staff Development Coordinator (SDC) initiated in-services to direct care staff and administrative and support staff 6/23/25 on Reasonable Accommodations Needs and Preferences which include ensuring the call lights are in reach and the mattresses fit the bed appropriately. Resident room rounds will be conducted by Nurse Supervisors daily and discussed during morning meetings to address any negative findings related to deficient practice beginning 6/23/25. Beginning 6/23/25, Nurse Supervisor, DON, ADON, SDC will observe Residents #39, #44, #48, and #82 to ensure call lights are in reach. A sample of 10 other residents will be chosen to monitor call lights in reach. This will occur (3) three times per week for (4) four weeks and (1) one time monthly thereafter for (3) three months. Nurse Supervisor, Director of Nursing (DON), Assistant Director of Nursing (ADON), SDC will observe Resident #45 to ensure mattresses fit the bed appropriately. A sample of (10) ten residents will be observed to ensure compliance. This will occur (3) three times per week for (4) four weeks and (1)	

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F 558	Continued From page 5 During an observation and interview with the DON on 6/17/25 at 8:30 AM, she confirmed that Resident #45's mattress was too short and that he needed a mattress extender. She stated, "His feet hanging off of the mattress could result in an injury to his feet." Record review of Resident #45's "Admission Record" revealed the resident was admitted 6/20/2023 with diagnoses of Other Reduction Deformities of Brain. Record review of Resident #45's MDS, Section C, with an ARD of 4/30/2025, revealed a BIMS score of 7, indicating that the resident is severely cognitively impaired. Resident #44 An observation of Resident #44 on 6/16/25 at 10:30 AM revealed he was sitting in his recliner in his room. His call light was out of reach, hanging from the wall outlet box onto the floor. An observation and interview with LPN #4 on 6/16/25 at 10:41 AM confirmed Resident #44's call light was tangled on the floor and out of his reach. She stated the resident knew how to use the call light and confirmed it should be within reach for safety, so he could alert staff if needed. She revealed that all staff were responsible for ensuring call lights were accessible. Record review of the "Admission Record" revealed the facility admitted Resident #44 on 8/24/24 with a diagnosis of Unspecified Dementia. Record review of the Quarterly Minimum Data Set	F 558	one time monthly thereafter for (3) three months. Results will be brought to two quarterly Quality Assurance meetings by the DON, ADON, and Nurse Supervisors beginning 7/10/25.	

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F 558	Continued From page 6	F 558		

(MDS) with an Assessment Reference Date (ARD) of 5/13/25 indicated in section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.

Resident #82

An observation and interview with Resident #82 on 6/16/25 at 10:55 AM revealed he was lying in bed, and his call light was not visible. He stated, "It's in the floor over there somewhere," while pointing toward the center of the room. He explained this happens often and, if he needed something, he had to wait for staff to come in and check on him. The call light was observed lying on the floor and not accessible to the resident.

An observation and interview with LPN #4 on 6/16/25 at 11:05 AM confirmed Resident #82's call light was not accessible and was located on the floor. She stated the resident should have his call light within reach in case he needed help and acknowledged it was a safety concern, as he might try to get up alone with no way to call for assistance.

Record review of the "Admission Record" revealed the facility admitted Resident #82 on 4/18/25 with a medical diagnosis of other Specified Diseases of the Biliary Tract.

Record review of the MDS with an ARD of 4/25/25 revealed under section C, a BIMS summary score of 15, which indicated Resident #82 was cognitively intact.

Resident #48

Observations on 6/17/25 at 8:25 AM and 10:45

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F 558	Continued From page 7 AM revealed that Resident #48 was in bed with the call light hanging down behind the bed and inaccessible to the resident. An observation and interview on 6/17/25 at 3:05 PM revealed Resident #48 lying in bed, the call light remains hanging down behind the bed and inaccessible to the resident. Resident #48 acknowledged that she was unable to reach her call light. During an observation and interview on 6/17/25 3:20 PM, Certified Nurse Aide (CNA) #4 revealed she is responsible for the resident today. She confirmed the call light was hanging down behind the bed, lying on the floor, and inaccessible to the resident. She revealed I must have forgotten to attach it to her pillow. CNA #4 revealed the call light is supposed to be attached to the resident's pillow so she can call if she needs anything. During an interview on 6/17/25 at 3:30 PM the DON confirmed that staff are expected to ensure call lights are always within residents' reach. She revealed they should always have access to their call lights to request assistance. Record review of the "Admission Record" revealed that Resident #48 was admitted to the facility on 08/04/2022 with diagnoses that included Alcoholic Polyneuropathy, repeated falls, and Schizophrenia. Record review of the MDS with an ARD of 04/18/2025 for Resident #48 revealed a BIMS score of 14, indicating that the resident is cognitively intact.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584		7/18/25

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F 584	Continued From page 8 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident 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	F 584		

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F 584	Continued From page 9 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record reviews, and facility policy reviews, the facility failed to provide a safe, clean, and homelike environment for five (5) of the 83 residents residing in the facility. (Residents #9, #20, #50, #55, and #82). Findings include: Review of the facility policy titled, "Statement of Resident Rights" undated revealed, "You have a right to:...2. Safe, decent and clean conditions." Review of the facility policy titled "Cleaning Cubicle Curtains" revised 9/05/17 revealed under, "Training &(and) Method:... If the curtain is stained, remove immediately." The facility provided a statement on facility letterhead that read, "Currently, we do not have a specific policy in place which is implemented on keeping and maintaining equipment." Resident #9 An observation of the footrests of Resident #9's motorized wheelchair on 6/16/25 at 11:35 AM revealed they were covered with dirt and crumbs. There was also the presence of a fly in the resident's room. During an interview on 6/19/25 at 11:30 AM, Resident #9 stated that his wheelchair had not been cleaned since he received it approximately	F 584	Facility failed to ensure a Safe/Clean/Comfortable/Homelike Environment for five of eighty-three residents. Resident #9s wheelchair was cleaned on 6/19/25 by CNA. Resident #20s wheelchair was taken by Maintenance on 6/17/25 to be pressure washed and the arm pads were replaced by maintenance. Resident #50s dresser was repaired by Maintenance on 6/16/25. Resident #55s curtain was taken down and replaced by Housekeeping Supervisor on 6/18/25. Resident #82 had a broken chair in the room exposing a screw. It was removed by Maintenance on 6/17/25. On 6/18/25 Maintenance checked the facilitys fly devices throughout the building to ensure they were baited and the lights worked correctly. The exterior door fans were also checked to ensure they were operating correctly. No negative findings were noted. On 6/18/25 the Maintenance Director notified the pest control company of the flies and scheduled another treatment. Pest control treated the building on 6/23/25. 83 residents had the potential to be affected at the time of the survey. Maintenance made rounds 6/17/25 to	

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F 584	Continued From page 10 six months ago. During an observation and interview on 6/19/25 at 11:42 AM with the Housekeeping Manager confirmed that Resident # 9's motorized wheelchair was indeed dirty and required cleaning. She also confirmed that the Certified Nursing Assistants (CNAs) were responsible for cleaning the wheelchairs. Record review of the "Admission Record" revealed Resident #9 was admitted to the facility on 12/4/24. Record review of the Minimum (MDS) with an Assessment Reference Date (ARD) of 3/14/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #20 An observation and interview on 6/16/25 at 11:33 AM, revealed Resident #20 sitting in his wheelchair. The right armrest was noted to have 95% of the vinyl missing from the top, exposing the padding, and the remaining vinyl was tattered. The left arm rest revealed tattered and torn vinyl. The wheelchair frame and spokes of the wheels were covered in a thick, gray substance. The resident revealed he wasn't sure why his wheelchair looked like this and wasn't sure when it would be cleaned. An observation and interview on 6/17/25, at 3:25 PM with the Administrator (ADM) revealed that Resident #20's wheelchair remained in need of repair and cleaning, with the frame and spokes of the wheels covered in a thick, gray substance.	F 584	identify broken furniture, wheelchairs that needed cleaning or repaired, and pest control issues. The Housekeeping Supervisor made rounds to identify any privacy curtains that needed to be changed. Negative findings were addressed immediately. Staff Development Coordinator (SDC) initiated in-services 6/18/25 on maintaining a safe/homelike environment and reporting broken equipment on our internal notification platform as well as reporting pests. Maintenance will monitor the internal notification platform daily beginning 6/23/25 to identify broken equipment or notification of pests. Beginning 6/23/25 Maintenance will be rounding (3) three times weekly for (4) four weeks and (1) one time monthly thereafter for (3) three months to identify pest issues and ensure the devices have bait and are working appropriately. Beginning 6/23/25 Housekeeping Supervisor will inspect (20) twenty resident rooms privacy curtains (3) three times per week for (4) four weeks and (1) one time monthly thereafter for (3) three months until compliance is achieved. Nurse Supervisor, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) will observe cleanliness and will ensure the armrests of wheelchairs are in good repair (3) three times per week for (4) four weeks and (1) one time monthly for (3) three months thereafter. The Administrator, DON, Maintenance Director	

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The Administrator confirmed the wheelchair was dirty and needed to be cleaned, and the armrests were tattered and needed to be replaced. He revealed he did not know which staff member was responsible for cleaning the wheelchairs, but dirty and disrepaired equipment was not acceptable.

In an interview on 6/17/25 at 4:25 PM, the Director of Nurses (DON) revealed that wheelchairs are supposed to be cleaned during the night shift, and the resident's wheelchair should have been cleaned.

During an interview on 6/17/25 at 4:31 PM the Maintenance Director revealed he was unaware that the arm rests were so tattered, with missing vinyl exposing the padding. He revealed that the staff should have either notified him or put it in the TELS system. He revealed that replacing the armrest was an easy fix, and it should have already been taken care of.

Record review of Resident #20's "Admission Record" revealed the resident was admitted 01/07/2019.

Record review of Resident #20's MDS, Section C, with an ARD of 3/28/2025, revealed a BIMS score of 15, indicating the resident is cognitively intact.

Resident #50
An observation of Resident #50's room on 6/16/25 at 10:21 AM revealed a 4-drawer dresser with the fourth drawer broken and missing, leaving the contents inside visible. Several flies were observed flying around inside the room.

Resident #55

and Housekeeping Supervisor will present the results of monitoring to the quarterly Quality Assurance meeting beginning 7/10/25 for two quarters.

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An observation of Resident #55's room on 6/17/25 at 2:46 PM revealed the lower portion of the privacy curtain had eight circular dark brown stains of various sizes, the largest approximately the size of a nickel.

Resident #82
On 6/16/25 at 10:55 AM, an observation of Resident #82's room revealed a straight chair located beside the bed with the right armrest broken and hanging down, exposing a silver screw.

An observation and interview with Maintenance Director on 6/17/25 at 3:51 PM confirmed Resident #82's room had a chair with its right arm broken hanging down. Maintenance stated he had not been made aware of the issue and confirmed that a resident or visitor could be injured if they sat in it. He also confirmed Resident #50's dresser drawer was broken and remarked, "That's an easy fix, if someone would have let me know." He acknowledged residents should have a homelike environment with furniture in good condition and added, "This is their home." He explained that nurses and aides, who are constantly in and out of the rooms, were responsible for reporting such concerns so they could be entered into TELS (the work order platform) for repair.

An observation and interview with the Housekeeping Supervisor on 6/18/25 at 3:25 PM revealed that housekeepers were responsible for daily room cleaning and, during that time, were expected to check privacy curtains for cleanliness and condition. She stated she was responsible for replacing them when needed. She confirmed Resident #55's privacy curtain was soiled with a

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F 584	Continued From page 13 dark brown substance and stated, "It needs to be changed." She added that residents should have a clean and healthy living environment and that a clean room makes them feel better. An interview with the ADM on 6/17/25 at 9:05 AM revealed staff were assigned to make daily rounds of the residents' rooms and were supposed to report any repair concerns. Record review of the "Proper Name of Pest Control Work Order" revealed a visit date of 6/9/25 which targeted flies.	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/18/25

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F 656	Continued From page 14 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this 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, resident and staff interview, record review, and facility policy review, the facility failed to: 1) develop a care plan for dementia care (Resident #70) and 2) failed to implement an Activities of Daily Living (ADL) care plan for dependent residents (Resident #11, #30, #41, #43 and #78) for six (6) of 30 resident care plans reviewed. The scope of this deficiency was increased to "E" due to F656 cited on the last annual recertification survey. Findings Include:	F 656	Facility failed to develop a dementia care plan for Resident #70. Minimum Data Set (MDS) Nurse updated Resident #70s care plan for dementia care on 6/18/25. Resident #11 was observed with a brown substance underneath fingernails and toenails were observed to be long. The nurse Supervisor cleaned fingernails and trimmed toenails 6/17/25. Resident also received a shower on 6/17/25. Resident #30 was observed with long fingernails on 6/16/25. Nurse Supervisor trimmed nails on 6/17/25. Resident #41 was observed with half an inch of facial hair on his chin, cheeks, and upper lip. On 6/17/25 the	

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F 656	Continued From page 15 Review of the facility's policy titled, "Care Plan, Comprehensive Person-Centered" with a revision date of 6/02/25, revealed under "Policy Statement: A comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #11 Record review of the Care Plan Report for Resident #11 revealed: "The resident has an ADL self-care performance deficit r/t Activity Intolerance, Limited Mobility... Interventions... requires total assistance of staff for shower/ bath three times weekly and as necessary ...requires substantial- maximum assistance by staff with personal hygiene..." An observation and interview with Resident #11 on 6/17/25 at 8:15 AM, revealed that he had not received a bath or shower since his admission. He stated, "It's been a month since I've had a bath or shower." A dark brown substance was noted underneath all of the residents fingernails. An observation and interview on 6/17/25 at 1:30 PM, Resident #11 stated he had received his first bath earlier that day and that it was the first since admission. An observation revealed a dark brown substance remained under his fingernails and his toenails were observed to be long, with a brown substance under them. The resident stated he would like his fingernails and toenails trimmed and cleaned. An interview with Registered Nurse (RN) #1 at	F 656	shower aid showered and shaved the resident. Resident #78 was observed with curly, course, and chin hair. On 6/17/25 a Certified Nursing Assistant (CNA) shaved and showered Resident #78. 83 residents had the potential to be affected by the deficient practice at the time of the survey. On 6/17/25 Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Supervisor made rounds on residents to identify ADL concerns that needed to be addressed. Any findings were immediately corrected. 6/18/25 MDS performed an audit to ensure residents with dementia diagnosis had a comprehensive care plan in place. No other negative findings were noted. Staff Development Coordinator (SDC) initiated in-services for nursing staff on following Activities of Daily Living (ADL) care plan for dependent residents on 6/18/25. Social Services and MDS were in-serviced on developing comprehensive person-centered care plans for each resident, consistent with the residents' rights on 6/23/25 by Administrator. Nurse Supervisor, DON, ADON will monitor ADL care on residents #11, #30, #41, and number #78, plus a sample of 10 other residents (3) three times per week for (4) four weeks and once monthly for (3) three months to ensure compliance. MDS and Social Services will monitor new orders to identify and develop comprehensive person-centered care plans for any resident with a new	

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F 656	Continued From page 16 6/17/25 at 2:03 PM, she confirmed that Resident #11 had not had a bath, shower, or nail care since being admitted because he refuses every time. Record reviews do not reveal any progress notes or documentation of Resident #11 refusing a bath, shower, or nail care. During an interview with the Minimum Data Set (MDS) Coordinator on 6/19/25 at 3:08 PM, she stated, "Care Plans are in place so that staff know how to provide care." She further stated, "when staff do not follow the plan of care, it's failure for them to follow the plan of care and residents are not receiving the care they deserve." Record review of Resident #11's "Admission Record" revealed the resident was admitted 5/09/2025 with diagnosis of End Stage Renal Disease. Record review of Resident #11's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 5/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident is cognitively intact. Resident #30 A record review of Resident #30's "Care Plan" revealed that the resident is resistant to care as evidenced by refusing showers, refusing to get out of bed ..... Interventions that included: If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed-upon time. On 6/16/25 at 11:17 AM an observation and interview revealed that Resident #30's fingernails	F 656	diagnosis of dementia (3) three times per week for (4) four weeks and once monthly thereafter for (3) three months. DON and MDS will bring the results of the audits to the quarterly quality assurance meeting beginning 7/10/25 for two quarters.	

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were approximately three-fourths (3/4) of an inch long past the tip of the fingers, with a jagged appearance. Resident #30 stated, "I don't like my nails this long and I want them cut." He revealed I don't know when the last time they were trimmed, but I know it's been a while.

In an interview on 6/17/25 at 2:58 PM, the Director of Nurses (DON) revealed that the resident has, at times, refused to have his fingernails trimmed. However, we are still responsible for assessing the resident's fingernails each month and documenting his nail care, as well as any refusals. She confirmed that his long and jagged fingernails could cause skin breakdown.

During an interview on 6/19/25 at 11:07 AM, the MDS nurse revealed that she and the MDS Coordinator are responsible for developing individualized care plans for each resident. She revealed that even if Resident #30 has at times refused his baths, his nail care should still be addressed and his ADL's should always be offered. She revealed that his intervention needs to be followed, regarding negotiating a time for ADLs, so that the resident participates and is more willing. She revealed that if his hygiene, which includes nail care, had not been addressed, then his plan of care was not being followed.

A record review of the "Admission Record" for Resident #30 revealed he was admitted to the facility on 9/6/2024 with diagnoses that included Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis following Cerebral Infarction affecting the Left Non-Dominant side.

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A record review of the MDS with an ARD of 3/31/25, revealed Resident #30 had a BIMS score of 15, indicating the resident was cognitively intact.

Resident #41

Record review of Resident #41's ADL Care Plan revealed the resident has an "ADL self-care performance deficit related to (r/t) Activity intolerance, Limited Mobility...Interventions...Bathing/Showering: The resident requires Substantial/Max assistance by staff with bathing/showering (Q) every Tues-Thurs-Sat and as necessary..."

On 6/16/25 at 11:22 AM during an observation and interview Resident # 41 was noted to have approximately half an inch of facial hair on his chin, cheeks and upper lip. He expressed a desire to be clean shaven and indicated he needed a shower, stating, "I don't remember for sure the last time I got a shower, but it has been a long time."

On 6/17/25 at 3:00 PM during a follow-up observation and interview with Certified Nursing Assistant (CNA) #2, confirmed that Resident #41 needed both shaving and a shower. She stated that he often refuses personal care but typically gets shaved when he takes a shower. CNA #2 emphasized the staff's responsibility to ensure that residents are maintained in a neat and clean condition, describing it as a "dignity issue."

Record review of Resident #41's personal hygiene tasks record indicated that he only refused care three (3) times in the past 30 days.

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During an interview on 6/19/25 at 3:08 PM with the MDS Coordinator, she confirmed that care plans were established to guide staff in providing necessary care. She pointed out that when the staff do not adhere to these care plans, it results in residents not receiving the care they deserve.

Record review of the "Admission Record" revealed the facility admitted Resident #41 on 7/24/24 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified.

Record review of the MDS with an ARD of 4/24/25 revealed, under Section C revealed, a BIMS score of 12, which indicated the resident had moderate cognitive impairment.

Resident #78

Record review of Resident #78's care plans revealed the resident had an "ADL self-care performance deficit r/t Dementia, Impaired balance, Limited Mobility with Interventions that include...The resident requires substantial/max assistance from staff with personal hygiene..."

On 6/16/25 at 11:33 AM during an observation with Resident # 78 revealed the resident had curly, coarse chin hair.

An observation and interview with Registered Nurse (RN) #1 on 6/17/25 at 1:16 PM, revealed, "She (Resident #78) refuses, she will not let us shave her."

Record review of Resident #78'S task for personal hygiene revealed the resident only

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refused care one (1) time in the past 30 day look back.

During an interview on 6/19/25 at 3:08 PM the MDS Coordinator confirmed that care plans are put in place so that the staff know how to provide care for their residents. She further stated that when the staff does not follow the care plan, "that's failure for them to follow the care plan" and residents are not receiving the care they deserve.

Record review of the "Admission Record" revealed Resident #78 was admitted to the facility on 3/3/25 with medical diagnoses that included Dementia.

Record review of the MDS with an ARD of 5/22/25 revealed, under Section C revealed, a BIMS score of 00, which indicated the resident had severe cognitive impairment.
Resident #70

Record review of Resident #70's Care Plans revealed a care plan was not developed for dementia care.

Record review of Resident #70's "Admission Record" revealed a new diagnosis of Dementia Unspecified Severity with other Behavioral Disturbance was added on 12/27/24.

During an interview on 6/18/25 at 9:05 AM, with the MDS Coordinator, she confirmed Resident #70 did not have a dementia care plan and stated the resident should have one so that the staff knew he had dementia and how to provide appropriate care for him.

An interview with Social Services #1 on 6/18/25 at

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F 656	Continued From page 21 9:22 AM, she confirmed that Resident #70 should have a care plan in place for dementia so that the staff knew what care to provide. Record review of the "Admission Record" revealed the facility admitted Resident #70 on 6/26/24 with a diagnosis of Post Traumatic Seizures. Record review of the MDS with an ARD of 3/24/25 revealed under section C, a BIMS score of 9, which indicated Resident #70 was moderately cognitively impaired.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record reviews, and facility policy review, the facility failed to provide activities of daily living (ADL) care for residents who are dependent on staff assistance for five (5) of 83 residents reviewed for ADLs. (Residents #11, #30, #41, #43, and #78) The scope for this deficiency was increased to "E" due to a previous citation of F677 on the last annual recertification survey completed on 1/4/24. Findings include: Review of the facility policy titled "Activities of Daily Living (ADL) with a revision date of March	F 677	Resident #11 was observed with a brown substance underneath fingernails and toenails were observed to be long. The nurse Supervisor cleaned fingernails and trimmed toenails 6/17/25. Resident #11 also received a shower on 6/17/25. Resident #43 was observed 6/16/25 with long fingernails and a brown substance underneath. 6/17/25, the Nurse Supervisor trimmed resident #43 nails, and a shower aide gave resident a shower. On 6/16/25 Resident #30 was observed with long jagged and dirty fingernails. The Nursing Supervisor trimmed and cleaned resident #30 fingernails on 6/17/25. Resident #41 was	7/18/25

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F 677	Continued From page 22 2018, revealed the following: "Policy Statement: 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 ...4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate..." Resident #11 On 6/17/25 at 8:15 AM, an observation and interview with Resident #11 revealed that he had dirty fingernails with a brown substance under each nail bed. Resident #11 stated had not received a bath since his admission and thought it had been a month. On 6/17/25 at 1:30 PM, an observation and interview with Resident #11 revealed he had received a bath today for the first time since he got to the facility, but an observation of his fingernails revealed no change in appearance and his toenails were long with a brown substance underneath them. During an interview with Registered Nurse (RN) #1 at 6/17/25 at 2:03 PM, she confirmed that Resident #11 had not had a bath, shower, or nail care since being admitted. She stated he has not had these things because he always refuses. Record reviews do not reveal any progress notes or documentation of Resident #11 refusing a bath, shower, or nail care.	F 677	observed 6/16/25 to have hair on his chin, cheeks, and upper lip. On 6/17/25 the shower aid shaved and showered resident #41. Resident #78 was observed on 6/16/25 to have hair on her chin. On 6/17/25 the shower aide showered and shaved Resident #78. 83 residents had the potential to be affected at the time of survey. 6/17/25 Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Supervisor made rounds on residents to identify Activities of Daily Living (ADL) concerns that needed to be addressed. Any findings were immediately corrected. Staff Development Coordinator (SDC) initiated in-services for nursing staff on following Activities of Daily Living (ADL) care plan for dependent residents on 6/18/25. Resident refusals will be monitored in the daily Stand-Up meetings beginning 6/23/25 by Nurse Supervisors, DON, and ADON. Residents who refuse will be discussed to determine a different approach to achieving ADL care. DON, ADON, Nurse Supervisors will make walking rounds to ensure ADL care has been completed on (30) thirty residents (3) three times per week for (4) four weeks and (1) one time monthly for (3) three months thereafter to ensure compliance with ADLs. Results of the audits will be brought to the quarterly quality assurance meeting by DON beginning 7/10/25 for two quarters.	

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During an interview with the Director of Nursing (DON), she stated that the residents should get a bath and have their nails cleaned and trimmed. She confirmed that not being clean would increase the risk of infection in Resident # 11.

Record review of Resident #11's "Admission Record" revealed the resident was admitted 5/09/2025 with diagnosis of End Stage Renal Disease.

Record review of Resident #11's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 5/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #11 is cognitively intact.

Resident #43

On 6/16/25 at 10:45 AM, an observation and interview with Resident #43 revealed long fingernails and a brown substance underneath. When asked if she wanted her nails trimmed, the resident states, "Yes, I would like them trimmed."

During an interview with Licensed Practical Nurse (LPN) #1 at Resident #43's bedside, on 6/17/25 at 1:48 PM, she confirmed that the resident's fingernails were long and had a brown substance under them and stated, "Her fingernails should be cleaned and trimmed."

During an interview on 6/17/25 at 2:04 PM with RN #1, she stated that her (Resident #43) fingernails should be kept clean and trimmed. If she had a break in her skin, her dirty nails could lead to an infection.

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During an interview with the DON on 6/17/25 at 3:00 PM, she stated that, "The expectation is that a resident's nails be kept clean and trimmed.

Record review of Resident #43's "Admission Record" revealed the resident was admitted 4/01/2025 with diagnoses of Chronic Systolic (Congestive) Heart Failure and Dementia.

Record review of Resident #43's MDS, Section C, with an ARD of 4/11/2025, revealed a BIMS score of 9, which indicates the resident is severely cognitively impaired.
Resident #30

An observation and interview on 6/16/25 at 11:17 AM with Resident #30 revealed his fingernails were long and jagged. Resident #30 recalled that it had been a while since anyone had provided nail care. He then admitted that he does not like his nails this long.

An interview and observation on 6/17/25 at 9:25 AM, Resident #30 revealed that no one had come to do his fingernails and stated that he wanted them cut. His fingernails remain long and jagged, measuring approximately three-fourths (3/4) inch past the tips of the fingers.

During an observation and interview on 6/17/25 at 2:23 PM, RN #1 confirmed Resident #30's fingernails were long and jagged and needed to be cut. She revealed that with his fingernails being this long and jagged, he could scratch himself and create a skin tear. RN #1 asked Resident #30 if he wanted his fingernails cut, and Resident #30 replied, "Yes."

On 6/17/25 at 2:58 PM, the DON revealed that

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the resident (Resident #30) sometimes refuses to have his fingernails trimmed, but we are still responsible for assessing the resident's fingernails each month and documenting his nail care, as well as any refusals. She confirmed that his long and jagged fingernails could cause skin breakdown.

A record review of the "Admission Record" for Resident #30 revealed he was admitted to the facility on 9/6/2024 with diagnoses that included Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis following Cerebral Infarction affecting the Left Non-Dominant side.

A record review of the MDS with an ARD of March 31, 2025, revealed Resident #30 had a BIMS score of 15, indicating the resident was cognitively intact.

Resident #41

During an observation on 6/16/25 at 11:22 AM, Resident # 41 was noted to have approximately half an inch of facial hair on his chin, cheeks and upper lip. In an interview, he expressed a desire to be shaved and indicated he needed a shower. He stated that he did not remember for sure the last time he got a shower but knows that it has been a long time.

During a follow-up observation and interview on 6/17/25 at 3:00 PM with Certified Nursing Assistant (CNA) #2, she confirmed that Resident #41 needed both shaving and a shower. She stated that he often refuses personal care but typically gets shaved when he takes a shower. CNA #2 emphasized the staff's responsibility to ensure that residents are maintained in a neat

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and clean condition. She also expressed concern that neglecting personal care could lead to a decline in the residents' health.

Record review of Resident #41's personal hygiene tasks record indicated that he only refused care three (3) times in the past 30 days.

Record review of the "Admission Record" revealed Resident #41 was admitted to the facility on 7/24/24 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified.

Record review of the MDS with an ARD of 4/24/25 revealed, under Section C revealed Resident #41 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.

Resident #78

During an observation on 6/16/25 at 11:33 AM for Resident #78, the resident was noted to have curly, coarse hair on her chin.

On 6/17/25 at 1:16 PM, an observation and interview with RN #1, revealed that Resident #78 often refuses to allow staff to shave her.

Record review of Resident #78's personal hygiene tasks record indicated that Resident #78 only refused care once in the past 30 days.

During an interview on 6/17/25 at 4:22 PM with the DON expressed her expectations for residents to be shaved, if needed, during their showers. She emphasized the importance of

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F 677	Continued From page 27 maintaining personal grooming, particularly for female residents, noting that having facial hair can significantly affect a resident's dignity and may lead to feeling of embarrassment and lower self-esteem. She acknowledged that the resident may not fully understand the implications of having facial hair but underscored that this does not lessen the importance of addressing the issue. Record review of the "Admission Record" revealed Resident #78 was admitted to the facility on 3/3/25 with medical diagnoses that included Dementia. Record review of the MDS with an ARD of 5/22/25 revealed, under Section C revealed, a BIMS score of 00, which indicated the resident had severe cognitive impairment.	F 677		
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 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.	F 812		7/18/25

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F 812	Continued From page 28 §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 observations, staff interviews, record review, and facility policy review, the facility failed to: 1) label and store food properly and maintain the kitchen and the equipment in a clean and sanitary condition for two (2) of three (3) kitchen tours, and 2) prevent the potential for foodborne illness as evidenced by meal trays left in rooms for a prolonged time (Resident #24, #52, #68, #83) for one (1) of four (4) survey days. Findings Include: Review of facility policy titled, "Food Storage: Dry Goods" dated 2/2023 revealed, "...All packaged and canned food items will be kept clean, dry, and properly sealed..." Review of facility policy titled, "Food Storage: Cold Foods" dated 2/2023 revealed, "...All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination..." Review of facility policy titled, "Environment" revised date 9/2017 revealed, "Policy Statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition..." Review of facility policy titled, "Environment" revised date 9/2017 revealed, "Policy Statement: All foodservice equipment will be clean, sanitary,	F 812	Facility failed to label and store food properly and maintain the kitchen equipment in clean and sanitary condition. The Dietary Manager disposed of all unlabeled items noted by surveyor on 6/16/25. The Dietary Manager, Cooks, and Maintenance assistant cleaned dirty equipment noted by surveyor on 6/16/25. Maintenance was informed of broken frier in kitchen by Administrator on 6/16/25. Maintenance Director called local repair company to repair fryer 6/18/25. Depending on the diagnosis it will either be repaired or removed by 7/18/25 by Maintenance Director. Flies were exterminated by Maintenance Staff and Kitchen staff 6/16/25. Maintenance Director checked the fly bait station and light in kitchen on 6/17/25 to ensure it was working correctly. No negative findings were noted. Pest Control came to spray for flies on 6/23/25. 83 residents had the potential to be affected at the time of the survey. Dietary Manager and kitchen staff were in-serviced on 6/16/25 by the District Dietary Manager on maintaining a clean/sanitary environment, following infection control practices with glove usage and washing hands, testing and documenting dish machine temperatures to ensure they're in normal range, and	

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F 812	Continued From page 29 and in proper working order..." Review of facility training titled, "Glove Usage - Term 2 - 2025" revealed, "Our policy requires kitchen staff to be educated on proper glove usage including how to properly put on gloves, activities where gloves are required, when to change gloves, and how to properly remove gloves..." Review of facility training titled, "Glove Usage In-service" revealed, "...When to change or remove your gloves: When they are dirty, torn, damaged, discolored or contaminated; Before taking ONE STEP away from your work area..." During the initial kitchen tour with the Dietary Manager (DM) on 6/16/25 at 10:14 AM, several observations were made regarding food storage practices. In the reach-in cooler number one (1), several items, including orange juice, tomato juice, ham, shredded cheddar cheese, bell peppers, sliced tomatoes, tomato paste, spaghetti sauce, lettuce, a sliced onion, cold slaw, sliced pears, parmesan cheese, and BBQ sauce were present without dates indicating when they were opened or when they expired. The prep table located next to the reach-in cooler revealed multiple seasonings with open lids, an open cup of salt with no lid, an open bag of bacon bits without an "opened" date, a five (5) pound container of peanut butter, a container of mixed peanut butter and jelly sitting out, without a date indicating when it was made or when it would expire. An additional prep table in the middle of the workspace area contained a cardboard box on the bottom shelf with gnats flying around inside it. Upon further investigation, several potatoes were found inside the box. The DM	F 812	storing and labeling foods. Staff Development Coordinator (SDC) initiated in-services to staff 6/18/25 on picking trays up in a timely manner and returning them back to the kitchen for processing. SDC initiated in-services to nursing and support staff on 6/23/25 on how to input maintenance concerns, broken items and pests, in the internal notification system. The Administrator, Dietary Manager, Cooks, and District Dietary Manager will conduct audits in the kitchen to ensure items are labeled correctly, equipment clean and in good working condition, proper infection control practices with handwashing and wearing gloves are enforced, dishwashing temperatures are in normal range, trays are returned timely and fly prevention. These audits will occur (3) three times per week for (4) four weeks and once monthly for (3) three months thereafter until compliance is achieved. Dietary manager and Administrator will bring results of the audits to the Quarterly Quality Assurance Committee meeting beginning 7/10/2025 for two quarters.	

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remarked, "That box is garbage because the garbage can was full and overflowing." Furthermore, flies were observed flying around in the kitchen prep and cook area. The return vent located to the left of the stove was heavily covered with dust. Additionally, five (5) lids for the steam table containers located on the bottom shelf of the steam table that were covered with grease and food crumbs. Three (3) fry baskets on top of the deep fryer contained old grease and crumbs.

During an interview on 6/16/25 at 10:30 AM with the DM, she confirmed that no open food items should be stored without an open date. She further emphasized that this practice is unacceptable as it could lead to foodborne illnesses. Additionally, she confirmed the maintenance supervisor was supposed to clean the return vent every other weekend and that it could cause food contamination when it is that dirty. Concerning the lids for the steam table, the DM stated, "those were from last night." She further stated that the three (3) fry baskets were used yesterday to cook lunch and that they were supposed to be cleaned daily, if used. The DM verbalized that one of the deep fryers didn't work and hasn't been in working condition for two to three months now. She confirmed that she submitted a work order with TELS (maintenance work request program) two to three months ago.

During a second observation of the kitchen on 6/16/25 at 2:41 PM, two (2) half gallon pitchers of tea and lemonade were revealed sitting out on the drink station without a date. Additionally, the stove top was covered with old grease and food buildup.

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During an interview on 6/16/25 at 2:52 PM, the District Dietary Manager confirmed that the facility policy mandates that all open food items be labeled with an open date for safety and organization.

An interview with the District Dietary Manager and the Administrator on 6/16/25 at 3:34 PM revealed that no entries had been made in the TELS system regarding the deep fryer that was out of order.

During an observation on 6/18/25 at 11:02 AM with DM focused on dish washing and sanitation practices, the low-temp dishwasher temperature reading was 110 degrees Fahrenheit, which is below the acceptable range of 120 to 140 degrees Fahrenheit necessary for effective sanitation.

Review of facility's "Dish Machine Log" dated June 25 revealed "Wash and Rinse" temperatures for Lunch were not documented for June 1-16 and they were not documented for Dinner for June 2-17.

An observation on 6/18/25 at 11:10 AM noted that the dietary cook walked away from her station and into the office, where she placed her hands in her personal bag. She then returned to the steam table to perform temperature checks without changing her gloves or washing her hands.

An interview on 6/18/25 at 11:15 AM with the DM confirmed that gloves should be changed any time staff leave the line, get dirty or become torn, and emphasized the importance of washing hands and re-gloving to maintain hygiene standards.

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During an interview with the District Dietary Manager on 6/18/25 at 1:00 PM, she confirmed that the dishwasher temperatures should be checked during each meal cleanup, affirming that these records had not been documented. She stressed that maintaining proper temperature readings is essential to ensure that dishes are sanitized effectively.

Record review of the facility's infection log revealed no indications of any food-borne illnesses.

Resident #24, #52, #68, and #83 Meal Trays

The facility provided a statement on letterhead that read, "Currently, we do not have a specific policy in place which is implemented on time frames for picking up food trays."

An observation of Resident #24 on 6/16/25 at 10:24 AM revealed she was lying in bed, verbal, and confused. Her breakfast tray was in front of her on an overbed table and contained grits, a sausage patty, and French toast. The resident was not eating and stated she was done.

On 6/16/25 at 11:18 AM, an observation and interview with Resident # 83, who was found lying in bed with a breakfast tray placed on the bedside table. The tray contained a bowl of oatmeal, which the resident confirmed was from breakfast.

An observation of Resident #52 on 6/17/25 at 10:37 AM revealed he was lying in bed with his eyes closed. The breakfast tray had not been removed and was still sitting on the overbed table beside his bed.

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F 812	Continued From page 33	F 812		

An observation of Resident #68 on 6/17/25 at 12:11 PM revealed she was lying in bed, verbal, and confused. Her breakfast tray was placed on a chair beside the bed and contained leftovers of French toast and a sausage patty.

During an interview with the Infection Preventionist (IP) on 6/17/25 at 3:26 PM, she stated there was no excuse for the breakfast trays not to be picked up in a timely manner and certainly should not be left in the resident rooms until lunchtime. She confirmed leaving the breakfast tray out for long periods of time could make someone sick.

An interview with the Administrator on 6/19/25 at 8:56 AM revealed meal trays should be removed from the rooms when the residents were done eating and confirmed that someone could get sick from eating leftover food.

Record review of the "Admission Record" revealed the facility admitted Resident #24 on 5/02/25 with a medical diagnosis of Unspecified Dementia.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/12/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #24 was moderately cognitively impaired.

Record review of the "Admission Record" revealed the facility admitted Resident #52 on 5/08/25 with a medical diagnosis of Unspecified Dementia.

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F 812	Continued From page 34 Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score was not conducted for Resident #52 due to cognitive skills for daily decision making was severely impaired. Record review of the "Admission Record" revealed the facility admitted Resident #68 on 1/04/24 with a medical diagnosis of Major Depressive Disorder. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #68 was cognitively intact. Record review of the "Admission Record" revealed Resident #83 was admitted to the facility on 5/8/25 with medical diagnoses that included Dementia. Record review of the MDS with an ARD of 5/17/25 revealed, under Section C revealed, Resident #83 had a BIMS score of 6, which indicated severe cognitive impairment.	F 812		
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.	F 880		7/18/25

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F 880	Continued From page 35 §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; (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	F 880		

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F 880	Continued From page 36 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 observation, staff interviews, record review, and facility policy review, the facility failed to the spread of infection, as evidenced by failure to practice Enhanced Barrier Precautions (EBP) (Resident #32, #62, #64) during care for three (3) of four (4) resident care observations. Findings Include: Review of the facility policy titled "Infection Prevention and Control Program" with a revision date of 3/18/25 revealed under, "Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."	F 880	Facility failed to practice Enhanced Barrier Precautions (EBP) for three of four resident care observations. Licensed Practical Nurse (LPN) #3, Certified Nursing Assistant (CNA) #1, and Wound Care Nurse were in-serviced on the EBP policy 6/18/25 by Staff Development Coordinator (SDC)/Infection Preventionist. All residents had the potential to be affected by EBP during the survey. SDC/Infection Preventionist initiated in-services for the facility staff and Agency staff on EBP 6/18/25. 6/19/2025, Director of Nursing (DON) initiated a training binder for new Agency staff to utilize for training on EBP before taking the floor. New associates will be trained by	

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F 880	Continued From page 37 Record review of the facility policy "Enhanced Barrier Precautions" dated 4/1/2024, revealed "Enhanced Barrier Precautions", (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices ..." Resident #32 An observation on 6/18/25 at 9:05 AM revealed Licensed Practical Nurse (LPN) #3 entering Resident #32's room to provide medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube. Resident #32 had an EBP signage located on her door that instructed staff to wear a gown and gloves during high-contact resident care activities. LPN #3 administered the resident's medications through the PEG tube but did not wear a gown. During an interview on 6/18/25 at 9:30 AM, LPN #3 confirmed that Resident #32 was on EBP because she has a PEG tube. She further revealed that wearing the proper protective equipment is to protect both ourselves and the residents from the possible spread of infection. She confirmed that she did not wear a protective gown and revealed that she should have. Record review of the "Order Summary Report" for Resident #32 revealed an order for EBP related to Peg tube every shift with an order date of 04/14/2025. Record review of Resident #32's "Admission	F 880	SDC/Infection Preventionist on EBP policy during initial orientation. Agency staff will be trained by SDC/Infection Preventionist, DON, Assistant Director of Nursing (ADON), or Nurse Supervisor before taking on an assignment. Beginning 6/23/25 Nurse Supervisor, DON, ADON, SDC/Infection Preventionist will observe EBP practices on 10 residents that are on EBP, (3) three times per week for (4) four weeks and (1) one time monthly for (3) three months thereafter to ensure compliance. DON will present the results of the audits at the Quarterly Quality Assurance meeting beginning 7/10/25 for two quarters.	

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F 880	Continued From page 38	F 880		

Record" revealed an admission date of 06/26/2024 with medical diagnoses that included Gastrostomy status.

Resident #64

On 6/17/25 at 1:30 PM, the Wound Care Nurse and Certified Nurse Aide (CNA) #1 were observed entering Resident #64's room to provide wound care. Resident #64 had an EBP signage located on his room door, instructing staff to wear a gown and gloves during high-contact resident care activities. The Wound Care Nurse and CNA #1 were observed performing hand hygiene. Then, CNA #1 assisted Resident #64 with the sit-to-stand lift, unfastened his brief, and then assisted the Wound Care Nurse during the provision of his wound care. The Wound Care Nurse and CNA #1 did not wear a gown.

A record review of the "Order Summary Report" for Resident #64 revealed an order for EBP related to chronic wound every shift with an order date 4/14/2025.

Record review of the "Admission Record" revealed the facility admitted Resident #63 on 6/26/2023.

Resident #62
During an observation and interview on 6/18/25 at 10:00 AM with the Wound Care Nurse during PEG site care for Resident #62, the Wound Care Nurse did not adhere to the EBP that was required for this procedure. There was appropriate signage posted outside of Resident #62's door indicating the need for EBP. A cart containing Personal Protective Equipment (PPE)

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F 880	Continued From page 39 supplies was readily available across the hall. While reading the EBP sign aloud during the observation, the nurse acknowledged that she should have worn a gown and gloves for the PEG site care. The nurse articulated the purpose of using EBP, which includes protecting both the resident and staff from infections and preventing the transfer of infection between residents. Record review of the "Admission Record" revealed Resident #62 was admitted to the facility on 1/17/25. Record review of the MDS with an ARD of 4/7/25 revealed, under Section C revealed, a BIMS score of 9, which indicated the resident had moderate cognitive impairment. During an interview on 6/18/25 at 10:17 AM, the Infection Preventionist (IP) revealed education has been provided to the nursing staff regarding EBP, and Personal Protective Equipment (PPE) is kept outside the resident's door. She confirmed that Residents #32, #62, and #64 were supposed to have EBP used, and the staff should have worn the protective equipment, which includes a gown. She revealed that wearing the PPE protects not only the staff but also the residents from the potential spread of any infections.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 925		7/18/25

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F 925	Continued From page 40 Based on observation, staff interview, and facility policy review, the facility failed to ensure they had an effective pest control as evidenced by multiple sightings of flies in resident's rooms and kitchen and gnats observed in the kitchen for two (2) of four (4) survey days. Findings include: The facility provided a statement on letterhead that read, "Currently, we do not have a specific policy in place which is implemented on Pest Control." Review of facility policy titled, "Environment" revised date 9/2017 revealed, "Policy Statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition..." During the initial kitchen tour with the Dietary Manager (DM) on 6/16/25 at 10:14 AM, a prep table in the middle of the workspace area contained a cardboard box on the bottom shelf with gnats flying around inside it. Upon further investigation, several potatoes were found inside the box. The DM remarked, "That box is garbage because the garbage can was full and overflowing." Furthermore, flies were observed flying around in the kitchen prep and cook area. Resident #15 An observation on 6/16/25 at 11:44 AM with Resident #15 revealed a fly in his room and a fly swatter on his bedside table. Resident #24 An observation of Resident #24 on 6/16/25 at 10:24 AM revealed she was lying in bed, verbal	F 925	1. On 6/18/25 Maintenance checked the facilitys fly devices throughout the building to ensure they were baited and the lights worked correctly. The exterior door fans were also checked to ensure they were operating correctly. No negative findings were noted. On 6/18/25 the Maintenance Director notified the pest control company of the flies and scheduled another treatment.Pest control treated the building for flies and insects 6/23/25. 2. 83 residents had the potential to be affected by the deficient practice at the time of survey. 3. Staff Development Coordinator (SDC) initiated in-services 6/23/25 on reporting pests to the Maintenance Director, keeping doors/windows closed, picking up food timely, and other interventions to decrease the amount of flies in the building. 6/19/25 Maintenance Director purchased fly traps from the local hardware store to install outside in high opportunity areas. 4. Maintenance Associates will monitor pest sightings (3) three times per week for (4) weeks and monthly for three months thereafter beginning 6/23/25. Maintenance Director will coordinate with Pest Control Service on extra treamtents if necessary. Maintenance Director will report findings to the quarterly Quality Assurance Committee beginning 7/10/25 for two quarters.	

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F 925	Continued From page 41	F 925		

but confused with two visible flies flying over her bed. Her overbed table was pulled across her bed with a remaining breakfast tray uncovered with left over food and the flies were attempting to land on the food tray.

Resident #52
An observation of Resident #52 on 6/17/25 at 10:37 AM revealed he was lying in bed with his eyes closed and two flies were flying around his bed and attempting to land on the table beside his bed that had a left over breakfast tray.

Resident #70
An observation of Resident #70 on 6/16/25 at 12:22 PM revealed he was lying in bed with multiple flies (3-5) flying around his room, circling over the resident and landing on his covers.

An interview with Maintenance on 6/17/25 at 3:51 PM confirmed flies had been a problem for months despite everything they had tried. He admitted that there is a pest control company that visits twice monthly. He revealed that flies could be entering residents opened windows because some screens were damaged. He stated he had been in the process of replacing the damaged screens.

An interview with the Administrator (ADM) on 6/17/25 at 9:05 AM confirmed that flies were a concern in the facility despite pest control coming to the facility even recently. He admitted he had not contacted anyone or explored additional pest control services. He additionally revealed leaving the meal trays in the residents' rooms could attract insects.

Review of the "Proper Name of Pest Control

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F 925	Continued From page 42	F 925		

Work Order" revealed a visit date of 6/9/25 which targeted flies.

Record review of the "Admission Record" revealed Resident #15 was admitted to the facility on 12/20/21 with medical diagnoses that included Complete Traumatic Amputation at Right Hip Joint, Subsequent and Adult Failure to Thrive.

Record review of the "Admission Record" revealed the facility admitted Resident #24 on 5/02/25 with a medical diagnosis of Unspecified Dementia.

Record review of the "Admission Record" revealed the facility admitted Resident #52 on 5/08/25 with a medical diagnosis of Unspecified Dementia.

Record review of the "Admission Record" revealed the facility admitted Resident #70 on 6/26/24 with a diagnosis of Post Traumatic Seizures.