STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A380	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC NURSING HOME	176 SOUTH MAIN STREET , PONTOTOC, Mississippi, 38863

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI) MS #505265, at the facility from 7/21/25-7/24/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F 584, F 656, F677 and F 686. There were no deficiencies cited for CI MS# 29409 related to resident-on-resident abuse. The census at the time of the survey was 42 and the facility is licensed for 44 beds.	F0000		08/07/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and 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;	F0584	F0584 Corrective action: On 7/22/2025 at 10:52am Resident #4's wheelchair was replaced with a new facility wheelchair while he awaits the arrival of his new personal electric wheelchair which was special ordered and fitted by physical therapy. The wheelchair with the peeling vinyl armrests was disposed of on 7/22/2025 at 10:52am. Identifying other residents: All resident wheelchairs were visualized on 7/22/2025 by the Administrator finding no other resident being affected. Measures put into place: The facility staff will submit a workorder request through our electronic Biomed Workorder System for facility maintenance personnel to replace armrests or dispose of wheelchairs with torn vinyl. Facility Staff received the following education provided verbally and in writing by 8/12/2025. Education provided verbally and in writing for all direct care staff. The following content was included:	08/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0584 SS = D	Continued from page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to address resident equipment in disrepair, resulting in a resident continuing to use an unsafe and uncomfortable wheelchair for approximately one month for one (1) of 31 residents utilizing wheelchairs reviewed. Resident #4 Record review of the facility policy titled, “Medical Equipment Management Program Medical Equipment Repair” with a revision date of 4/22 revealed “Policy: The Biomedical-Clinical Services Department is responsible for providing safe, effective and timely repair of all Medical Equipment...” Record review of “(Proper Name) Biomed” record from 10/02/24 to 6/20/25 revealed no documentation regarding repair or replacement of Resident #4’s wheelchair. An observation and interview on 7/22/2025 at 8:55 AM, revealed Resident #4 sitting in a wheelchair in his room. The bilateral vinyl armrests were noted to be torn and tattered. Resident #4 stated, “The armrests are uncomfortable on my arms.” During an interview on 7/22/2025 at 10:40 AM, Certified Nurse Aide (CNA) #4 revealed that whenever resident equipment needs to be repaired or replaced, we put in a work order on the computer. The work order is called Biomed and goes to the maintenance department. After review of the Biomed work order for the past several months, she revealed that there was no order for the	F0584	Continued from page 1 During daily care, wheelchairs should be visualized for tears or maintenance issues. Upon identification of tears or maintenance issues, a workorder should be placed in the facilities Biomed Workorder System. If you need assistance submitting a work order, report your findings to the unit coordinator. The Unit Coordinator will be auditing monthly for any wheelchairs found with torn vinyl or in need of maintenance. The Unit Coordinator will also be auditing for work orders placed for wheelchairs found with tears or in disrepair. The audit results will be reviewed monthly by the Quality Assurance Performance Improvement committee monthly. Attachment 1: Wheelchair maintenance education (pg. 1) signatures of attendance (pgs. 5-8) Monitoring for sustained solutions: On 7/22/2025 The Administrator and Unit Coordinator visualized each resident wheelchair and determined all were without vinyl tears which will be considered the first audit of wheelchairs which will be monitored, audited, and reported to the QAPI committee on a monthly basis. The facility’s unit coordinator will perform a wheelchair monthly audit documenting any wheelchairs found with torn vinyl again on 8/7/2025 then monthly for 3 months then once quarterly for 1 year. Work orders will be placed for wheelchairs found with tears in the vinyl or the wheelchair will be disposed of. The monthly audit results will be reviewed by the facility’s Quality Assurance Performance Improvement (QAPI) committee to ensure the solutions are sustained at the next QAPI meeting on 8/12/2025 then monthly. Attachment 2: Wheelchair audit completed 8/7/2025	

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F0584 SS = D	Continued from page 2 repair of Resident #4's wheelchair. An observation and interview on 7/22/2025 at 10:52 AM, the Administrator (ADM) confirmed that Resident #4's vinyl on both wheelchair armrests was tattered and torn. She stated, " He has a new wheelchair that has been ordered. Resident #4 stated, “I’ve been waiting for a month for the new wheelchair." The Administrator confirmed that the wheelchair had been on order for about a month and revealed she would get him a new wheelchair right now. During an interview on 7/23/2025 at 8:30 AM, Maintenance worker #1 confirmed that he receives his work orders through a system called Biomed and checks the system several times throughout the day for any new work orders. He revealed that yesterday was the first time he was made aware that Resident #4's wheelchair needed to be replaced due to the armrest vinyl being torn. Record review of Resident #4's "Demographics" revealed the resident was admitted to the facility on 10/26/22 with medical diagnoses that included Type 2 diabetes with peripheral neuropathy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #4 was cognitively intact.	F0584		
F0656 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	F0656	Corrective action: Resident #1 was shaved on 7/23/2025 at 08:01 am leaving his mustache per his request. Nail care including cleaning, trimming and filing was performed for Resident #17 per her request on 07/23/2025. Resident #30 was shaved on 7/23/2025 by the CLPN upon his request leaving a mustache and goatee. The facility was unable to accomplish a corrective action for Resident #6 as the finding occurred in the past. Identifying other residents: All residents were identified as having the potential	08/12/2025

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F0656 SS = G	Continued from page 3 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 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 implement Activity of Daily Living (ADL) care plans for Residents #1, #17, and #30 and failed to implement a pressure ulcer care plan for Resident # 6 for (4) four of 16 resident care plans reviewed. Findings Include: Review of the facility policy titled, “Plan of Care,” last revised 06/27/24, revealed, "Policy: It is the policy of “Proper Name” to properly provide patient care planning… Procedure:.. 2.) “An interdisciplinary collaborative manner as appropriate to the needs of the patient should be utilized to develop and implement the care plan..." Resident #1	F0656	Continued from page 3 to be affected. Measures put into place: Measure put into place to ensure resident care plans for shaving are implemented. All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. The Director of Nursing (DON), Administrator and Administrative Assistant provided shaving education and communicated documentation instructions and responsibilities to all direct care staff. The shaving education and documentation communication included the following: Resident’s ADL needs are included in their plan of care. Each resident’s plan of care can be found at the nurses’ desk available to all caregivers. Each resident’s plan of care is individualized. During resident’s Bath times, male residents should be offered shaving. This usually occurs three times weekly as communicated by each resident and care planned accordingly. It is important and your responsibility to document bathing and shaving in a resident’s medical recorded especially if a resident refuses care. If a resident does have a preference which differs from their plan of care the nurse should be notified for care plan updates. Shaving documentation should occur on the resident’s flowsheet. Access the Daily Cares flowsheet Open Hygiene tab Shower needs- click in the time column space giving you a shaving selection. Upon selecting shaving, click the comments icon and type refused in the comments section.	

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F0656 SS = G	Continued from page 4 Record review of the "Care Plan" for Resident #1 revealed under, "Problem/Need: I require assistance w/ (with) ADLs (activities of daily living) r/t (related to) weakness, debility, and dementia." Also revealed under, "Approaches: Personal Hygiene- Limited-Extensive x (times) 1 (one). During an observation and interview on 7/21/2025 at 11:18 AM, Resident #1 was sitting in his wheelchair in his room. He was unshaven, with black and gray facial hair approximately 1/4 (one-fourth) inch in length. The resident stated he wanted to be shaved but preferred to keep his mustache. On 7/22/2025 at 10:36 AM, an interview with Certified Nurse Aide (CNA) #5 confirmed Resident #1 needed shaving. An interview with the Minimum Data Set (MDS) Nurse on 7/24/25 at 9:15 AM revealed the purpose of the care plan was to give staff instruction and paint a picture of the residents care to be provided. She confirmed Resident #1's care plan was not followed for shaving. Record review of the “Demographics” revealed the facility admitted Resident #1 on 4/14/25 with a medical diagnosis of Unspecified Dementia. Record review of Resident #1’s “Flowsheet History” dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident was severely cognitively impaired. Resident #6 Review of the “Care Plan” for Resident #6 revealed under, “Approaches: Observe for s/sx (signs/symptoms) of new skin breakdown during daily care document and report as indicated..." An interview with the Director of Nursing (DON) on 7/24/25 at 9:20 AM revealed Resident #6 transferred to the hospital on 3/1/25 and returned on 3/9/25. Record review of Resident #6’s hospital stay “Integumentary Flowsheet History” revealed documentation on 3/7/25 of deep tissue injury (DTI) left heel. Record review of the “Nursing Note” for Resident #6, dated 3/9/25 revealed, “Resident returned from "proper name" of hospital around 10 AM.” There was no documentation regarding any skin concerns.	F0656	Continued from page 4 All Education was completed by 8/12/2025. Signatures were required for proof of attendance. Measures in place to ensure resident care plans for nail care are implemented. The Director of Nursing (DON), Administrator and Administrative Assistant provided education and communicated documentation responsibilities to all licensed staff referencing the facility’s Nail Care Policy (Attachment 3) The education and communication included the following: Nail Care policy and procedure (Attachment# 3) reviewed for licensed staff responsibilities. Nail Trimming, Nail filing should be scheduled in the electronic medical record in the Worklist Tasks tab. The responsible licensed staff member should complete the task then document the task accurately. If a resident should refuse nail care or a family member provides nail care this should be documented in a nurse’s note. All measures put into place and education completed 8/12/2025. Measures in place to ensure resident care plans for skin assessment and pressure ulcer prevention are implemented. Measure 1: Review of Facility Policy On 7/24/2025, the Administrator and Director of Nursing reviewed the following facility policies and determined the facility does have assessment, intervention, and documentation policies consistent with professional standards of practice to prevent pressure ulcers: Assessment and Reassessment Documentation: Resident Care Pressure Ulcer Prevention and Intervention. Measure 2: Staff Education: The following policies	

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F0656 SS = G	Continued from page 5 Record review of Resident #6's body audits conducted on 3/9/25, 3/10/25, 3/13/25, 3/14/25, 3/15/25 revealed scattered bruising, no abrasion, no blister, no excoriation. There was no documentation regarding the left heel. Record review of Resident #6's body audit conducted on 3/16/25 revealed, "Unstageable pressure injury to left posterior heel, dark purple, dry, hard, closed, without pain. Measures 4.5 x 2.2 x 0." Record review of Resident #6's "Integumentary Flowsheet History" dated 7/15/25 revealed, "Redness to buttocks." Record review of Resident #6's "Wound History" dated 7/17/25 revealed, "Sacrum stage III pressure wound, red, slightly moist measuring 1.8 cm (centimeters) x 0.5 cm (centimeters) x 0.1 cm (centimeters) full thickness tissue loss with slough. On 7/23/25 at 11:12 AM, an interview with the DON confirmed Resident #6 developed a pressure injury to her left heel while in the hospital, and the wound was not identified in the facility until eight days later. Additionally, she revealed that after the resident's body audit conducted on 7/15/25 identified redness to her buttocks, there was no documentation to show the skin concern was addressed. She confirmed the plan of care was not followed. On 7/24/25 at 8:30 AM, an interview with Registered Nurse (RN) #2 reconfirmed that on 7/15/25, she assessed the resident's skin and noted redness to the buttocks. She revealed that she applied "pink" cream and a bandage to the area but did not document it or initiate wound care orders. An interview with the MDS Nurse on 7/24/25 at 9:00 AM confirmed Resident #6's skin care plan was not followed. Record review of the "Demographics" revealed the facility admitted Resident #6 on 2/13/25 with diagnoses including Dementia with Anxiety. Record review of the "Flowsheet Data" dated 5/16/25 revealed a BIMS summary score of 6, indicating Resident #6 was severely cognitively impaired. Resident# 17 During an observation on 7/22/25 at 10:30 AM, with Registered Charge Nurse #1, it was confirmed that	F0656	Continued from page 5 included in staff education: Assessment and Reassessment (Attachment 6) Documentation: Resident Care (Attachment 7) Pressure Ulcer Prevention and Intervention. (Attachment 8) Licensed staff education provided by the Director of Nursing started on 8/8/2025 to be completed by 8/12/2025. Measure 3: Staff Education: Professional standards of practice Licensed staff education addressing professional standards of practice assessment and documentation responsibilities. Licensed staff education provided by the Director of Nursing starting on 8/8/2025 to be completed by 8/12/2025. Brief Description of Education: American Nurses Association (ANA) Principles for Nursing Documentation ANA Scope and Standards of Practice Legalities of Nursing Documentation Attachment 10: Nursing Assessment and Documentation Responsibilities Education Monitoring for sustained solutions: Care plan Shaving and Nail care monitoring: The Director of Nursing or Charge Nurse will perform monthly audits for completion of shaving and nail care to ensure solutions are sustained. The audits will occur monthly for year 2025 then quarterly for year 2026 will include the following: Visualization of 10 random residents monthly auditing for care plan intervention:	

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F0656 SS = G	Continued from page 6 Resident #17's nails were long and jagged and needed to be trimmed. She stated it was her responsibility to trim the nails but confirmed she had not gotten around to it. Record review of the ADL care plan for Resident #17, last revised 7/11/25, revealed the problem: "I require assistance with ADLs … Approaches: Nail care as indicated. … Personal hygiene – limited to extensive assistance..." During an interview with the MDS nurse, on 7/22/25 at 11:30 AM, she confirmed that if staff had not trimmed Resident #17's nails, they did not implement the resident's ADL care plan. She revealed the purpose of the comprehensive care plan is to give staff a description of the type of care the residents require. Review of the "Demographic Report" for Resident #17 revealed the facility admitted the resident on 1/15/22 with a diagnosis of Hemiplegia affecting the left side as a late effect of Cerebrovascular Accident. Record review of Resident #17's BIMS, dated 7/11/25, revealed a score of 15, indicating the resident was cognitively intact. Resident #30 Record review of the Care Plan with a problem onset of 6/21/23 revealed, "Problem/Need: ADL's" I require assistance with my ADLs r/t Parkinson's...Approaches: Assistn with shaving as desired..." On 7/21/2025 at 12:23 PM during an observation and interview with Resident #30 revealed that he had facial hair measuring one-half to one inch on his cheeks, chin, upper lip, and neck. During the interview, Resident #30 stated, "I cannot shave myself and I would like to be shaved." During an interview with the MDS Coordinator at 12:41 PM on 7/22/25, confirmed that while Resident #30 was capable of taking showers independently with supervision, he has not been shaved in quite some time. She further confirmed there was no documentation indicating that Resident #30 had refused to be shaved. During an interview on 7/24/2025 at 9:37 AM, the MDS Coordinator confirmed that the ADL Care Plan, which includes assistance with shaving as desired, was not implemented. She verbalized that the purpose of this care plan was to serve as a guide for all staff involved in providing ADL care, ensuring consistency	F0656	Continued from page 6 Shaving completed during bathing Shaving documentation accuracy Nail care performance including cleaning, trimming, and filing Accuracy of nail care performance All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. The Director of Nursing (DON) will complete the next audit on 8/8/2025. The completed monthly audit will be reported to the QAPI committee starting on 8/12/2025 continuing to be reported monthly to the committee throughout 2025 and 2026. Attachment 4: Nail Care/Shaving Audit Care plan monitoring for skin assessment and pressure ulcer prevention intervention implementation. The Director of Nursing or Charge Nurse will monitor upon hospital return nurse assessment and documentation compliance within 1 day of return/readmission to ensure the skin assessment, identification of skin breakdown, accurate documentation, intervention, and treatment planning are complete starting 7/25/2025. If not completed by the Director of Nursing, the charge nurse will provide this monitoring in writing to the Director of Nursing immediately upon completion. The Director of Nursing will provide this monitoring to the QAPI committee monthly throughout 2025 and 2026 to ensure nursing assessment, treatment and documentation compliance has been sustained. The Director of Nursing will perform monitoring of the licensed staff weekly body audits to ensure treatments have been initiated as needed and upon each resident's hospital return for the presence of: Skin assessment completed Skin assessment documented accurately If wound identified: wound description, treatment initiation, Care Plan revision all documented accurately.	

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F0656 SS = G	Continued from page 7 and quality across all shifts and personnel. A record review of Resident #30's Demographics revealed that the resident was admitted to the facility on 9/4/23, with diagnoses that included Parkinson's Disease. A record review of Resident #30's Flowsheet History revealed a BIMS Summary Score of 13 with an Assessment Reference Date (ARD) of 5/30/25, which indicated that the resident was cognitively intact.	F0656	Continued from page 7 Each audit completed upon every hospital return starting 7/25/2025 will be reported monthly to the facility's Quality Assurance Performance Improvement committee monthly starting on 8/12/2025 to ensure sustained compliance. Weekly body audits will be monitored to ensure treatment is initiated starting on 7/25/2025 and will continue weekly for 2025 and then by auditing 100% of weekly audits identifying a wound monthly for year 2026. The Director of Nursing performed the first skin assessment, wound identification, and documentation audit on 7/30/2025 after a resident's hospital return on 7/29/2025.	
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care for three (3) of 42 residents observed during the initial tour related to nail care for Resident #17 and failed to shave Residents #1 and #30. Findings Include: The facility provided a statement on letterhead signed by the Director of Nursing that revealed, "(Proper name) of the facility does not have a personal hygiene policy." Review of the facility policy titled, "Nails, Care of," last revised 08/06/24, revealed: "Policy: It is the policy of 'Proper Name' Nursing Home that nails should be properly cared for..." Resident #1 On 7/21/2025 at 11:18 AM, an observation and interview with Resident #1 revealed he had black and gray facial hair approximately 1/4 (one-fourth) inch in length and stated he wanted to be shaved but preferred to keep his mustache.	F0677	Corrective action: Resident #1 was shaved on 7/23/2025 at 08:01 am leaving his mustache per his request. Nail care including cleaning, trimming and filing was performed for Resident #17 per her request on 07/23/2025. Resident #30 was shaved on 7/23/2025 by the CLPN upon his request leaving a mustache and goatee. All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. Identifying other residents: All other dependent residents were found to have the potential to be affected. Measures put into place: All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. The Director of Nursing (DON), Administrator and Administrative Assistant provided shaving education and communicated documentation instructions and responsibilities to all direct care staff. The shaving education and documentation communication included the	08/12/2025

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F0677 SS = D	Continued from page 8 An interview with Certified Nurse Aide (CNA) #5 on 7/22/2025 at 10:36 AM revealed Resident #1 should be shaved every time he received a bath. She stated it was the shower aide's responsibility to ensure this was done and confirmed the resident needed shaving. An interview with the Director of Nursing (DON) on 7/22/2025 at 10:40 AM revealed that male residents were to be shaved once weekly or as requested. She confirmed that Resident #1 was unshaven and acknowledged that this gave him an untidy appearance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/25 revealed Resident #1 required substantial/maximal assistance with personal hygiene, including shaving. Record review of the "Demographics" revealed the facility admitted Resident #1 on 4/14/25 with a medical diagnoses including Unspecified Dementia. Record review of Resident #1's "Flowsheet History" dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident was severely cognitively impaired. Resident #17 An observation on 7/21/25 at 10:30 AM revealed Resident #17's nails were approximately 1/2 inch long and jagged in appearance. Resident #17 stated she could not remember the last time her nails were trimmed but stated she would like them trimmed. An observation of Resident #17's nails with CNA #1 on 7/22/25 at 10:28 AM revealed the resident's nails were long and jagged. CNA #1 confirmed the nails needed to be trimmed. An observation on 7/22/25 at 10:30 AM with Registered Charge Nurse #1 revealed Resident #17's nails were long and jagged and needed to be trimmed. She stated it was her responsibility to trim the nails but confirmed she had not gotten around to it. She stated a concern with the resident's nails not being trimmed was that the resident could scratch herself. Record review of the "Demographics" for Resident #17 revealed the facility admitted the resident on 1/15/22 with a diagnosis of hemiplegia affecting the left side as a late effect of cerebrovascular accident. Record review of Resident #17's BIMS, dated 7/11/25, revealed a score of 15, indicating the resident was	F0677	Continued from page 8 following: Resident's ADL needs are included in their plan of care. Each resident's plan of care can be found at the nurses' desk available to all caregivers. Each resident's plan of care is individualized. During resident's Bath times, male residents should be offered shaving. This usually occurs three times weekly as communicated by each resident and care planned accordingly. It is important and your responsibility to document bathing and shaving in a resident's medical recorded especially if a resident refuses care. If a resident does have a preference which differs from their plan of care the nurse should be notified for care plan updates. For instance: If Mr X is scheduled a bath three times a week and usually only wants to be shaved on Wednesdays, you should still offer shaving on all bath days and document "refused" as it applies. Shaving documentation should occur on the resident's flowsheet. Access the Daily Cares flowsheet Open Hygiene tab Shower needs- click in the time column space giving you a shaving selection. Upon selecting shaving, click the comments icon and type refused in the comments section. All Education was completed by 8/12/2025. Signatures were required for proof of attendance. Attachment 1: ADL performance and documentation education (pg. 2-4) The Director of Nursing (DON), Administrator and Administrative Assistant provided education and communicated documentation responsibilities to all licensed staff referencing the facility's Nail Care	

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F0677 SS = D	Continued from page 9 cognitively intact. Review of Section GG of the MDS – Functional Abilities, dated 7/11/25, revealed a code of 03 which indicated Resident #17 required partial/moderate assistance for personal hygiene. Resident #30 During an observation and interview on 7/21/2025 at 12:23 PM with Resident #30 revealed that he had facial hair measuring one-half to one inch on his cheeks, chin, upper lip, and neck. During the interview, Resident #30 stated, "I cannot shave myself and I would like to be shaved, but (Proper Name of CNA#3) doesn't work here anymore, and she was the one who always shaved me." When asked if he would allow someone else to shave him, he agreed that he would. During an interview with CNA#2 on 7/22/25 at 10:43 AM concerning Resident #30, she confirmed that residents are typically shaved on their designated shower days, which for Resident #30 are Tuesday, Thursday, and Saturday nights. However, when the medical record was reviewed with CNA #2, it was noted that there was no documentation regarding personal hygiene, specifically shaving, for Resident #30. During an interview on 7/22/25 at 11:00 AM with the DON, she validated that it is standard practice for residents to be shaved during shower days. An interview with the MDS Coordinator at 12:41 PM on 7/22/25 confirmed that while Resident #30 was capable of taking showers independently with supervision, he has not been shaved in quite some time. The MDS Coordinator acknowledged that CNA#3 typically performed the shaving tasks but is currently on educational leave. She stated that the CNA's responsible for showering residents should have offered to shave Resident #30 during those times. She further confirmed there was no documentation indicating that Resident #30 had refused to be shaved. A record review of Resident #30's Demographics revealed that the resident was admitted to the facility on 6/9/23, with diagnoses that included Parkinson's Disease. A record review of Resident #30's Flowsheet History revealed a BIMS Summary Score of 13 dated 5/30/25, which indicated that the resident was cognitively intact.	F0677	Continued from page 9 Policy (Attachment 3) The education and communication included the following: Nail Care policy and procedure (Attachment# 3) reviewed for licensed staff responsibilities. Nail Trimming, Nail filing should be scheduled in the electronic medical record in the Worklist Tasks tab. The responsible licensed staff member should complete the task then document the task accurately. If a resident should refuse nail care or a family member provides nail care this should be documented in a nurse's note. All measures put into place and education completed 8/12/2025. Attachment 3: Nail Care Policy Attachment 5: Nail Care Responsibilities Monitoring for sustained solutions: The Director of Nursing or Charge Nurse will perform monthly audits for completion of shaving and nail care to ensure solutions are sustained. The audits will occur monthly for year 2025 then quarterly for year 2026 will include the following: Visualization of 10 random residents monthly auditing for: Shaving completed during bathing Shaving documentation accuracy Nail care performance including cleaning, trimming, and filing Accuracy of nail care performance All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for	

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F0677 SS = D		F0677	Continued from page 10 shaving and nail care on 7/23/2025. The Director of Nursing (DON) will complete the next audit on 8/8/2025. The completed monthly audit will be reported to the QA Attachment 4: Nail Care/Shaving Audit PI committee starting on 8/12/2025 continuing to be reported monthly to the committee throughout 2025 and 2026.	
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to assess and implement timely interventions to address skin integrity concerns, resulting in progression of a pressure injury and delayed wound healing for one (1) of three (3) residents reviewed for pressure ulcers. (Resident #6) Findings include: Review of the facility policy titled “Assessment and Reassessment of Patients” with a revision date of 5/12/25 revealed under, “Policy: It is the policy of (proper name of facility) that patients should be properly assessed and reassessed.” Also revealed under, “Procedure: … 6. Wound assessments and measurements should be performed at start of care, resumption of care, and recommended weekly. Reassessment should be performed any time there is a significant change noted...” Record review of Resident #6’s hospital “Integumentary	F0686	Corrective action: The facility was unable to accomplish a corrective action for Resident #6 as the finding occurred in the past. On 7/24/2025 the Administrator, the Director of Nursing, the Charge Nurse, and MDS Coordinator completed a skin Audit for each resident assessing for the presence of skin breakdown, previous identification of skin breakdown, accurate documentation, wound treatment intervention, and care planning. Identifying other residents: Dependent bed-bound residents were identified as having the potential to be affected upon hospital return. Measures put into place: Measure 1: Review of Facility Policy On 7/24/2025, the Administrator and Director of Nursing reviewed the following facility policies and determined the facility does have assessment, intervention, and documentation policies consistent with professional standards of practice to prevent pressure ulcers: Assessment and Reassessment Documentation: Resident Care Pressure Ulcer Prevention and Intervention. Measure 2: Staff Education: The following policies included in staff education: Assessment and Reassessment (Attachment 6) Documentation: Resident Care (Attachment 7)	08/12/2025

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F0686 SS = G	Continued from page 11 Flowsheet History" revealed documentation on 3/7/25 of deep tissue injury (DTI) left heel. An interview with the Director of Nursing (DON) on 7/24/25 at 9:20 AM revealed Resident #6 transferred to the hospital on 3/1/25 and returned on 3/9/25. Record review of the "Nursing Note" for Resident #6, dated 3/9/25 revealed, "Resident returned from "proper name" of hospital around 10 AM." There was no documentation regarding any skin concerns. Record review of Resident #6's body audits conducted on 3/9/25, 3/10/25, 3/13/25, 3/14/25, 3/15/25 revealed scattered bruising, no abrasion, no blister, no excoriation. There was no documentation on the left heel. Record review of Resident #6's body audit conducted on 3/16/25 revealed, "Unstageable pressure injury to left posterior heel, dark purple, dry, hard, closed, without pain. Measures 4.5 x 2.2 x 0." Record review of Resident #6's wound care "Work List Task Details" revealed an order dated 3/16/25, "Unstageable pressure injury to left, posterior heel. Clean with betadine and leave OTA (open to air) daily at 10:00 AM." Record review of Resident #6's "Integumentary Flowsheet History" dated 7/15/25 revealed, "Redness to buttocks." Record review of Resident #6's "Wound History" dated 7/17/25 revealed, "Sacrum stage III pressure wound, red, slightly moist measuring 1.8 cm (centimeters) x 0.5 cm (centimeters) x 0.1 cm (centimeters) full thickness tissue loss with slough. Record review of Resident #6's wound care "Work List Task Details" revealed an order dated 7/17/25, "Cleanse stage III pressure ulcer to sacral area with NS (normal saline) or DWC (dermal wound cleanser), pat dry with 4 x 4 gauze, apply collagen with silver, cover with dry dressing. Change T (Tuesday)/Th (Thursday)/Sat (Saturday) and prn (as needed)." An interview with the Director of Nursing (DON) on 7/23/25 at 11:12 AM confirmed Resident #6 developed a pressure injury on her left heel while in the hospital, and the wound was not identified in the facility until eight days later, at which point it had progressed to an unstageable pressure injury. She revealed it would have been the charge nurse's responsibility to assess the resident's skin on readmission and then weekly	F0686	Continued from page 11 Pressure Ulcer Prevention and Intervention. (Attachment 8) Licensed staff education provided by the Director of Nursing started on 8/8/2025 to be completed by 8/12/2025. Measure 3: Staff Education: Professional standards of practice Licensed staff education addressing professional standards of practice assessment and documentation responsibilities. Licensed staff education provided by the Director of Nursing starting on 8/8/2025 to be completed by 8/12/2025. Brief Description of Education: American Nurses Association (ANA) Principles for Nursing Documentation ANA Scope and Standards of Practice Legalities of Nursing Documentation Attachment 10: Nursing Assessment and Documentation Responsibilities Education Monitoring for sustained solutions: The Director of Nursing or Charge Nurse will monitor upon hospital return nurse assessment and documentation compliance within 1 day of return/readmission to ensure the skin assessment, identification of skin breakdown, accurate documentation, intervention, and treatment planning are complete starting 7/25/2025. If not completed by the Director of Nursing, the charge nurse will provide this monitoring in writing to the Director of Nursing immediately upon completion. The Director of Nursing will provide this monitoring to the QAPI committee monthly throughout 2025 and 2026 to ensure nursing assessment, treatment and documentation compliance has been sustained. The Director of Nursing will perform monitoring of the licensed staff weekly body audits to ensure treatments	

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F0686 SS = G	Continued from page 12 thereafter. She confirmed there were no interventions implemented when the resident returned to address the skin concern. The DON explained that after the body audit conducted on 7/15/25 identified redness to the resident's buttocks, no treatment was initiated. She confirmed interventions should have been implemented. She stated, "I thought we were better than that." She acknowledged that the lack of assessment and follow-through with treatment could have caused both wounds to progress and worsen. An interview with Registered Nurse (RN) #2 on 7/24/25 at 8:30 AM revealed she was the charge nurse working on 3/9/25 when Resident #6 returned from the hospital. She confirmed she did not perform a body audit on readmission and stated, "I don't remember doing one." She explained that on 7/15/25, she assessed the resident's skin and noted redness to the buttocks. She revealed that she applied "pink" cream and a bandage to the area but did not document it or initiate wound care orders. She stated, "As far as why I didn't, I get busy, and it just fell through the cracks." An observation on 7/24/25 at 9:50 AM with Resident #6 during wound care revealed the left heel (unstageable due to eschar) revealed a round eschar covered wound. The wound bed was black; peri wound intact with no redness or irritation. Edges were well defined. The sacral wound (stage III) was oval shaped, yellow adherent slough covered, edges well defined, peri wound without redness or irritation. Record review of the "Demographics" revealed the facility admitted Resident #6 on 2/13/25 with diagnoses including Dementia with Anxiety. Record review of the "Flowsheet Data" dated 5/16/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #6 was severely cognitively impaired.	F0686	Continued from page 12 have been initiated as needed and upon each resident's hospital return for the presence of: Skin assessment completed Skin assessment documented accurately If wound identified: wound description, treatment initiation, Care Plan revision all documented accurately. Each audit completed upon every hospital return starting 7/25/2025 will be reported monthly to the facility's Quality Assurance Performance Improvement committee monthly starting on 8/12/2025 to ensure sustained compliance. Weekly body audits will be monitored to ensure treatment is initiated starting on 7/25/2025 and will continue weekly for 2025 and then by auditing 100% of weekly audits identifying a wound monthly for year 2026. The Director of Nursing performed the first skin assessment, wound identification, and documentation audit on 7/30/2025 after a resident's hospital return on 7/29/2025.	