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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with complaint investigations (CI MS #18572 and CI MS #18185) from 4/4/2022 through 4/7/2022. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #8572 for Quality of Care for resident not being groomed adequately and Residents Rights for resident not treated with dignity and cited F550 and F677. The SA did not substantiate CI MS #18185 for employee to resident abuse. The SA also cited F645, F646, F656, F676, F689, F693, F812, F880, F888, and F919. The facility had a census of 54 and held a license for 60 beds at the time of survey.	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,	F 550		5/31/22

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

Electronically Signed | 04/29/2022

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 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.

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interviews, record review, and facility policy review, the facility failed to ensure that each resident was treated with dignity as evidenced by failure to provide verbal communication to residents during care, knock on resident's door before entering, cover a resident and close door during care, and failure to provide a privacy bag for a catheter for 4 of 24 residents observed. Resident #19, #27, #42, #43. Findings Include Resident #27	F 550	On 4/7/2022, certified nursing assistants were inserviced on promoting/maintaining resident dignity related to resident #27 and #43 including knocking before entering room introducing self, explaining care, and interacting with resident during care. On 4/7/22, Certified nursing assistants were inserviced on keeping resident covered and door closed during care including resident #19. On 4/7/22, resident #42 foley catheter bag was placed in a privacy bag. All residents have the potential to be affected by this deficient practice.	

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F 550	Continued From page 2 Review of the facility policy titled, "Promoting/Maintaining Resident Dignity" with a revision date of 1-19, revealed, " It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. " Under "Compliance Guidelines." #1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights...#5. When interacting with a resident, pay attention to the resident as an individual... #7. Explain care or procedures to the resident before initiating the activity. #8. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused, and resident centered...#12. Maintain resident privacy." An observation on 04/04/22 at 11:59 AM, revealed Certified Nurse Assistant (CNA) #7 yelled from Resident #27's room to CNA #6 who was in the hall and asked her to come help pull the resident up in the bed. State Agency (SA) observed CNA #6 enter Resident #27's room without knocking and assisted CNA #7 to pull the resident up in the bed. Observed that neither CNA spoke to the resident while performing the task and before leaving the resident's room. An interview on 4/5/22 at 3:30 PM, with CNA #5 revealed that when staff enters a resident's room the staff member should knock on the door, speak to them, and let them know why they are entering their room. She revealed that not speaking to a resident while performing care	F 550	On 4/7/2022 the Director of Nursing began inservicing all certified nursing assistants and nurses on promoting and maintaining residents' dignity. Inservice complete on 4/28/2022. On 4/6/2022, all residents with Foley catheters were provided a fig leaf bag or privacy bag by registered nurse Supervisor and Director of Nursing began inservicing all nurses and certified nursing assistants on providing all residents with a foley catheter a privacy bag or fig leaf bag to maintain dignity. Inservice complete on 4/28/2022. The Staff Development Coordinator or Director of Nursing will conduct three (3) observations for providing dignity, privacy with foley catheter bag beginning 5/5/22 per week for the next three (3) months to ensure staff are promoting and maintaining resident dignity in accordance with our facility's practice guidelines and regulatory requirements. Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.	

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would be rude and a dignity issue. She revealed that it is all about how you approach people when providing care.

An interview on 4/5/22 at 4:30 PM, with CNA #8 revealed that the staff should always knock and tell the resident their name and what you are needing to do when entering their room.

An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed she did not remember not speaking to Resident #27 while helping pull her up in the bed. She revealed that she feels like sometimes the staff gets in a hurry and busy trying to complete the task and forget we need to socialize with them more.

An interview on 4/7/22 at 10:00 AM, with the Director of Nursing (DON) revealed that staff should knock on the resident's door and introduce themselves if the resident does not know them, explain the care that needs to be performed and just socialize with them. She revealed that she is not sure if it would be a dignity issue or just non-sociable when a staff member does not speak to a resident while performing care

An interview on 4/7/22 at 12:15 AM, with Resident #27 revealed that most of the time the staff does not speak to her when they come in to do

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something. She revealed that the staff will talk to each other in front of her, sometimes they have their blue-tooth headphones on and take personal phone calls on their cell phones. She revealed that she does not care if they want to ignore her, but it would be nice to be included.

Record review of Resident #27's Admission Record revealed an admission date of 10/09/15 with medical diagnoses that include Type 2 Diabetes Mellitus and Major Depressive Disorder.

Record review of the residents Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/22 revealed a Brief Interview of Mental Status (BIMS) of 15, which indicates the resident is cognitively intact.

Resident #43

An observation on 04/04/22 at 10:40 AM, revealed Resident #43 lying in bed, awake, alert and with speech that is hard to understand due to a Cerebrovascular Disease with an onset date of 10/15/13. An observation of CNA #7 enter the resident's room with a fresh glass of water and sit it on the resident's over-bed table. Observed CNA #7 point to the two glasses of water that were already on his over-bed table without speaking. Observed the resident speak to CNA #7, pull one of the glasses toward him and pushed the other glass toward the CNA #7. CNA #7 took the glass of water that the resident pushed toward her and left the room without speaking to the resident.

An observation on 4/4/22 at 12:25 PM, revealed Resident #43 lying in bed, awake and alert. Observed CNA #6 enter Resident #43's room

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with his lunch tray, set it up on his over-bed table and leave the room without speaking to the resident.

An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed Resident #43 is hard to understand, but she did not remember, not speaking to him while setting his lunch tray up. She revealed that she feels like sometimes the staff get in a hurry and busy trying to complete the task and forget we need to socialize with them more.

An interview on 4/7/22 at 11:58 AM, with Resident #43 revealed the staff usually does not talk to him when they come in his room.

Record review of Resident #43's Admission Record revealed an initial admission date of 10/15/13 and medical diagnoses that include Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting right dominant side.

Record review of Resident #43's MDS with an ARD of 2/26/22 revealed a BIMS of 15, which indicates the resident is cognitively intact.

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Resident #19

On 04/04/22 at 10:18 AM, an observation of Resident #19 from the hallway, revealed the door was open, and Resident #19 was lying in bed with only a brief on. No top sheet or blanket was covering him.

On 04/05/22 at 08:51 AM, an observation of Resident #19 from the hallway, revealed him lying in bed exposed with only a brief on. Licensed Practical Nurse (LPN) #1 was in the room working on the resident's gastrostomy tube. The nurse exited the room leaving the door open with the resident remaining exposed with only a brief on. A Certified Nursing Assistant (CNA) entered the room closing the door behind her.

An interview on 04/06/22 at 03:02 PM, with Licensed Practical Nurse (LPN) #1 revealed that Resident #19 should be covered when the door is open. LPN #1 stated that it could embarrassing to him, and it is a dignity issue.

Record review of Resident #19's Admission Record revealed the resident was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Dysphagia, Convulsions, and a Personal History of Traumatic Brain Injury.

Record review of MDS with an ARD of 01/25/2022 revealed Resident #19 with a BIMS score of 03, which indicated the resident has severe cognitive impairment.

Resident #42

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F 550	Continued From page 7	F 550		

Review of facility policy titled, "Maintaining Privacy and Dignity For Residents with Foley Catheter Drainage Bags", with a revision date of 2/16 revealed, " It is the policy of this facility to provide privacy and dignity to all residents that have a urinary drainage bag in use. The procedure revealed the drainage bag will be maintained in a storage pouch to hide the contents and prevent embarrassment to the resident".

On 04/04/22 at 10:57 AM, 12:05 PM, and 03:05 PM, observations revealed Resident #42's urinary catheter bag was visible to the hallway. The catheter bag was on the right-hand side of the bed facing the entrance room door without a privacy bag. Urine was noted in urinary catheter bag.

On 04/05/22 at 8:50 AM, and again at 3:50 PM, observations revealed Resident #42's urinary catheter bag on the right side of the bed facing the entrance room door without a privacy bag and visible to the hallway.

During an observation on 04/06/22 at 09:33 AM , Resident #42's urinary catheter bag was on the right side of the bed without a privacy bag and facing the entrance room door. The catheter was visible from the hallway.

During an observation and interview, on 04/06/22 at 1:00 PM, with the Director of Nurses (DON), she confirmed the resident had a privacy bag on the back of his wheelchair, but he should have a privacy bag for his bed, and his catheter bag should not be visible to the hallway.

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F 550	Continued From page 8 A record review of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022 with diagnoses of Neuromuscular Dysfunction of the Bladder and Fracture of Left Femur. Record review of the MDS with an ARD of 02/22/2022, revealed Resident #42 had a BIMS score of 15, which indicated the resident was cognitively intact.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		5/31/22

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F 656	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review, the facility failed to develop and implement comprehensive care plans for three (3) of 24 residents reviewed for care plans, Resident #19, Resident #20 and Resident #42. Findings include: Resident #19 A record review of the facility Policy, Titled, "Care Plans-Comprehensive" with a revision date of 10/2016, revealed, "An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Under Policy interpretation and implementation. #3. Each resident's comprehensive care plan is designed to: (f) Identify the professional services that are	F 656	Resident #19 fingernails were cut and hair was brushed to remove fuzz on 4/6/22 by registered nurse supervisor. Placed resident #20 white board, dry erase marker, and eraser in reach on 4/6/22 by social services director. Resident #42 fingernails were cut and nail care was added to care plan on 4/6/22 by Minimum Data Set (MDS) nurse. Resident #42 was provided a privacy bag for foley catheter on 4/6/22 by registered nurse supervisor. All residents have the potential to be affected by this deficient practice. Director of Nursing inserviced the Minimum Data Set (MDS) nurse, certified nursing assistants and nurses beginning on 4/7/22 and completed 4/28/22 on "Develop/Implement Comprehensive Care plans including nail care, shampooing	

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F 656	Continued From page 10 responsible for each element of care. A record review of Resident #19's Comprehensive Care Plan initiated 10/26/2020 and reviewed on 02/04/2022 revealed, "Focus The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Huntington disease ...Interventions ... BATHING: Check nail length and trim and clean on bath day and as necessary ...." Observations on 04/04/22 at 10:44 AM and at 12:11 PM, revealed Resident #19 lying in bed, hair matted with white fuzz in it. Fingernails are long and jagged approximately one-half (1/2) inch past the tip of the fingers on each hand. An observation on 04/05/22 at 09:14 AM, revealed Resident #19 lying in bed, hair matted with white fuzz in it. Nails are long and jagged approximately 1/2 inch past the tip of the fingers on each hand. An observation on 04/06/22 at 11:12 AM, Resident #19 was lying in bed. Hair matted with white fuzz. Fingernails were long and jagged approximately 1/2 inch long past the tips of fingers on both hands. An interview and observation on 04/06/22 at 01:05 PM, with the Director of Nurses (DON) confirmed the resident's nails are long and need to be trimmed. The DON removed a piece of white material from the resident's hair and stated that it looks like fuzz. The DON confirmed this should not be in his hair. During an interview on 04/07/22 at 05:05 PM, the Director of Nurses (DON) confirmed Resident	F 656	hair, communication, and foley catheters. The Minimum Data Set (MDS) nurse or Director of Nursing will conduct three (3) care plan reviews per week for six (6) weeks beginning 5/2/22 to ensure comprehensive care plans are developed/implemented for residents. Observation Reports will be reviewed by the Quality Assurance Committee monthly x three (3) months beginning 5/12/22 to assure substantial compliance has been achieved as determined by the committee.	

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F 656	Continued From page 11	F 656		

#19's care plan was not followed for hair and nail care.

Resident #20

A record review of Resident #20's comprehensive care plan initiated 10/29/2020 and last care plan review completed 02/04/2022 revealed, "Focus The resident has a communication problem r/t (related to) being legally deaf and mute ...Interventions ... Ensure availability and functioning of adaptive communication equipment message board, telephone amplifier, computer, etc. ...Monitor effectiveness of communication strategies and assistive devices .... Provide translator as necessary to communicate with the resident ...Use communication techniques which enhance interaction: Allow adequate time to respond. Repeat as necessary, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues,, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs,, and pictures ...."

An observation on 04/04/22 at 10:15 AM, Resident # 20 could be heard loudly down the hall. Upon entering Resident #20's room the resident had a splint in her left hand and continued to make verbal sounds and shake the splint. Resident #20 tried to communicate via sign language in a frustrated manner. Certified Nurse Assistant (CNA) #1 entered the room and said that she doesn't like the splint, and gets upset when she has to wear it.

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(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
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An observation on 04/04/22 at 03:00 PM, revealed Resident #20 sitting in a Geri-chair in her room. She was attempting to communicate via sign language and hand gestures.

An interview on 04/06/22 at 02:55 PM, with Licensed Practical Nurse (LPN) #1 confirmed it's very difficult to understand what she wants, but I think the aides can understand her. The nurse confirmed there wasn't anything in the room to aide in communication with the resident.

An interview on 04/06/22 at 03:00 PM , with the Social Worker (SW), revealed Resident #20 is deaf and mute. The social worker stated, the resident has a communication board, a whiteboard, and a phone in her room that is used for communication.

An observation and interview on 04/06/22 at 03:10 PM, in Resident #20's room with the Social Worker (SW), and Director of Nurses (DON) confirmed there was no communication board or white board visible in the room. The DON began looking in the resident's chest of drawers for the communication board and found it in the second drawer under a brief. The SW found the whiteboard on the top shelf of the residents closet. The SW and DON confirmed that there was not a marker in the room to write on the communication board. The SW picked up a remote for the Sorenson device which was located on top of the chest of drawers. The SW revealed the resident a light on top of the machine will alert the resident when a call is coming through. The social worker (SW picked up the power cord to the Sorenson device and stated that it was disconnected. The SW revealed she had connected the device two (2)

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	255276	A. BUILDING _____ B. WING _____	C 04/07/2022

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weeks ago but it is disconnected now. The DON and SW confirmed that the staff would not be able to communicate with her with the whiteboard in the top of the closet and the communication board in the drawer and the device not plugged in. The SW revealed that she had done an inservice at the old facility, but had not done one since being in the new facility.

On 04/07/22 at 05:06 PM, in an interview with the Director of Nurses (DON) confirmed that Resident #20's communication careplan was not being followed.

Resident #42

An observation on 04/04/22 at 10:20 AM and at 3:10 PM, revealed Resident #42's fingernails long and approximately 1/2 inch past the tips of fingers on both hands.

An observation on 04/05/22 at 08:50 AM, revealed fingernails untrimmed.

An observation and interview on 04/05/22 at 03:50 PM, revealed Resident #42's fingernails untrimmed. The resident stated that he doesn't know the last time his fingernails were trimmed.

An observation on 04/06/22 at 09:15 AM and again at 12:50 PM, revealed resident's fingernails continued to be untrimmed and approximately 1/2 inch past the tips of fingers on both hands.

An observation and interview on 04/06/22 at 01:00 PM, with the Director of Nurses (DON) confirmed his nails were long and need to be trimmed. The DON stated, "I will make sure this gets done. "

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An interview on 04/07/22 at 01:16 PM, with the Minimum Data Set (MDS) nurse, revealed that she was responsible for completing the care plan. She stated that there was a box to check for nail care and that she failed to check it.

An interview on 04/07/22 at 05:21 PM, with the DON confirmed that Resident #42 did not have a nail care plan and that he should have had one.

A record review of Resident #42 comprehensive care plan initiated 02/17/2022 revealed, Focus The resident has indwelling Catheter ...Interventions/Tasks .... Position catheter bag and tubing below the level of the bladder and away from entrance room door.

Observations on 04/04/22 at 10:57 AM, 12:05 PM, and 03:05 PM, revealed Resident #42's urinary catheter bag was visible to the hallway. The catheter bag was on the right-hand side of the bed facing the entrance room door without a privacy bag. Urine was noted in the urinary catheter bag.

Observations on 04/05/22 at 8:50 AM, and again at 3:50 PM, revealed Resident #42's urinary catheter bag on the right side of the bed facing the entrance room door without a privacy bag and visible to the hallway.

During an observation on 04/06/22 at 09:33 AM , Resident #42's urinary catheter bag was on the right side of the bed without a privacy bag and facing the entrance to the room, visible from the hallway.

During an observation and interview on 04/06/22

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F 656	Continued From page 15 at 1:00 PM with the Director of Nurses (DON), She confirmed the care plan was not followed. Resident had a privacy bag on the back of his wheelchair, but he should have a privacy bag for his bed, and his catheter bag should not be visible to the hallway.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, facility policy review and record review, the facility failed to provide personal hygiene as evidenced by long and jagged nails and flecks of white material in resident's hair for 2 of 24 residents observed. Residents #42 and Resident #19. Findings include: A record review of the facility policy "Fingernails/Toenails, Care of", undated, revealed, "Policy The purposes of this policy is to clean the nail bed, to keep nails trimmed, and to prevent infections ...Procedure ...6. Nail care includes daily cleaning and regular trimming ... 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin... " A record review of the facility policy titled "Shampooing Hair Policy", undated, revealed, Policy ... The purpose of this policy is to clean	F 677	Resident #19 and resident #42 fingernails were cut on 4/6/22. Resident #19 hair was cleaned and combed on 4/6/22. Nailcare be performed daily as needed and hair will be combed daily. All residents have the potential to be affected by this deficient practice. The Director of Nursing inserviced all certified nursing assistants and nurses beginning on 4/6/22 and completed on 4/28/22 on Activities of Daily Living". The Director of Nursing or registered nurse supervisor, will conduct three (3) observations of resident activities of daily living per week x six (6) weeks beginning 5/2/22 to ensure activities of daily living care is provided to residents. Observation reports will be reviewed by the Quality Assurance Committee monthly	5/31/22

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F 677	Continued From page 16 and maintain the resident's with healthy hair and scalp. Procedure 1. Use a comb to remove any tangles before washing the hair." Two observations on 04/04/22 at 10:44 AM and at 12:11 PM, of Resident #19 lying in his bed. His hair was matted with white fuzz in it. Nails are long and jagged approximately one -half (1/2) inch past the tip of the fingers on each hand. During an observation on 04/05/22 at 09:14 AM, Resident #19 was lying in bed, hair matted with white fuzz in it. Nails continue to be long and jagged approximately 1/2 inch past the tip of the fingers on each hand. An observation on 04/06/22 at 11:12 AM, revealed Resident #19 lying in bed. His hair was matted with white fuzz. Fingernails were long and jagged approximately 1/2 inch long past the tips of fingers on both hands. An interview and observation on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the resident's nails are long and jagged and need to be trimmed and smoothed out. CNA #1 confirmed the jagged edges of the nails could cut us or the resident could cut himself. CNA #1 also confirmed that the resident has white fuzz in his hair. She stated she is not sure where it comes from but it is always like that. She stated, "the resident's hair could be picked out." An interview and observation on 04/06/22 at 01:05 PM, the Director of Nurses (DON) removed a piece of white material from the resident's hair and stated that it looks like fuzz. The DON confirmed this should not be in his hair. She also	F 677	x three (3) months beginning 5/12/22 to assure substantial compliance has been achieved as determined by the committee.	

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confirmed the resident's nails are long and need to be trimmed. She stated that he could scratch and hurt himself with the jagged nails and she would make sure they get trimmed.

A record review of the Admission Record for Resident #19 revealed he was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Anxiety, Convulsions, and a Personal History of Traumatic Brain Injury.

Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/25/2022 revealed Resident #19 with a Brief Interview for Mental Status (BIMS) score of 03, which indicated resident has a severe cognitive impairment, requires extensive assistance of one person with personal hygiene. and total assistance of one person with bathing.

Resident #42

An observation on 04/04/22 at 10:20 AM and at 3:10 PM, revealed Resident #42's fingernails long and approximately 1/2 inches past the tips of fingers on both hands.

An observation on 04/05/22 at 08:50 AM, revealed Resident #42's fingernails untrimmed.

An observation and interview on 04/05/22 at 03:50 PM, revealed Resident #42's fingernails untrimmed. The Resident stated that he doesn't know the last time his fingernails were trimmed.

Observations on 04/06/22 at 09:15 AM and again at 12:50 PM, revealed the resident's fingernails continued to be untrimmed and approximately 1/2 inch past the tips of fingers on both hands.

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An observation and interview on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the nails are long and needed to be trimmed and smoothed out. Resident #42 stated that he would like his fingernails cut.

An observation and interview, on 04/06/22 at 01:00 PM, with the Director of Nurses (DON) confirmed his nails were long and need to be trimmed. The DON stated, "I will make sure this gets done. "

A record review of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022, with diagnoses of Neuromuscular Dysfunction of the Bladder, Chronic Gout, and Fracture of Left Femur.

A record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/22/2022, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact and requires extensive assistance of one person with personal hygiene.