STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN REHABILITATION & NURSING CENTER	59 WEST FRONT ST , SKOWHEGAN, Maine, 04976

(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 On 7/28/25 through 7/31/25, on-site visits were conducted at Woodlawn Rehabilitation & Nursing Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, complaints 215519, 215514, 215510, 215509, 215508, 215505 and facility reported incident's 215518, and 215491. It was determined that Woodlawn Rehabilitation & Nursing Center was not in compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F0000	This Plan of Correction constitutes my written allegations of compliance for deficiencies during the recent survey on July 31st 2025. However, submission of this Plan of Correction is not the admission that a deficiency exists ot that it was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.	
F0551 SS = D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance	F0551	One resident was affected by this practice. All residents have the potential to be affected by this practice. Side-rail consent form was obtained from the POA and added to chart for R7. Audits were completed on side-rail consent forms for all residents and found to be accurate on 8/1/2025 Monthly audits of side-rail consents will be completed by Director of Nursing x's 3 months for all residents who have side-rails Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	8/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronica Hopkins	Administrator	8/22/2025

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F0551 SS = D	Continued from page 1 with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to provide education and/or obtain informed consent from a resident's representative regarding the use of bed rails for 1 of 6 residents reviewed for accidents (Resident #7 [R7]). On 7/30/25, R7's clinical record was reviewed and indicated the following: On 4/30/24, R7 completed an advanced directive identifying a representative to make medical decisions on his/her behalf. On 6/20/25, R7 had a Brief Interview for Mental Status score of 5, which indicated severe cognitive impairment. On 6/30/25, "Informed Consent Regarding Side Rail	F0551		

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F0551 SS = D	Continued from page 2 Usage" was provided to R7 to sign, indicating "having considered all of the above (Risks in the use of side rails), I hereby consent to rails." The clinical record lacked evidence that education was provided for the resident representative to give informed consent. On 7/30/25 at 8:37 a.m., during an interview with a surveyor and the Director of Nursing (DON), R7's clinical record was reviewed. The DON stated R7's son/daughter is responsible for R7, and the bed rail consent should have been completed with the resident representative. At this time the surveyor confirmed the clinical record lacked evidence that education was provided on the risks of side rail use and/or that informed consent was obtained from R7's representative.	F0551		
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative.	F0553	One resident was affected by this practice. All residents have the potential to be affected by this practice. Social Services will schedule and complete care plan meetings in a timely manner and document meeting has taken place and signed by all attendees. Audits will be completed weekly by Social Services to ensure care plan meetings are being held timely. Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	8/27/25

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F0553 SS = D	Continued from page 3 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) which included the participation of the resident and resident's representative after a Minimum Data Set (MDS) Quarterly Assessment, for 1 of 17 residents whose care plans were reviewed (Resident #2 [R2]). A clinical record review indicated R2 was admitted in 2021. The latest MDS Quarterly assessment was completed on 5/16/25. A review of R2 clinical record lacked evidence that a care plan meeting was held at any point as of 7/31/25 by the IDT that included, to the extent possible participation of R2 and/or his/her representative to review the Care Plan. On 7/31/25 at 9:15 a.m., in an interview with a surveyor, the Social Services Director confirmed that R2 clinical record lacked evidence that a care plan meeting was held after the last Quarterly assessment was completed on 5/16/25.	F0553		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents	F0578	One resident was affected by this practice. All residents have the potential to be affected by this practice. The advanced directive regarding code status for R24 was updated to reflect the accurate code status on 7/28/25. All current residents advanced directives were audited to ensure all code statuses were accurate on 7/30/25 Social Services will review advanced directives regarding code status with nursing to ensure accurate code status is updated as needed in resident chart. Social Services will provide quarterly progress notes confirming accuracy of code status for all residents to QAPI x's 3 months to ensure accuracy.	8/27/25

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F0578 SS = D	Continued from page 4 concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (indicates the type of medical interventions to receive, such as cardiopulmonary resuscitation [CPR] in the event of a medical emergency) was accurate in the resident electronic clinical record for 1 of 7 residents reviewed for advanced directives (Resident #24 [R24]). On 7/28/2025, Resident #24 medical record was reviewed. The electronic record indicated a code status of DNR/DNI (Do Not Resuscitate / Do Not Intubate). The electronic record and the paper chart also contained a "Physician Orders for Life-Sustaining Treatment (POLST)" dated "7/2/25", indicates a code status of "Attempt Resuscitation/CPR". On 7/30/2025 at 8:50 a.m., during an interview with a surveyor and the Director of Nursing, the medical record was reviewed for R24's advanced directive regarding code status. At this time the surveyor confirmed R24's advance directive regarding code status had conflicting information.	F0578	One resident was affected by this practice. All resident have the potential to be affected by this practice.	8/27/25
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment	F0584		

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F0584 SS = E	Continued from page 5 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by:	F0584	On 8/15/2025 an additional outlet was added to room 112 to ensure R24 has sufficient outlets to accommodate her needs and eliminate tripping hazard All rooms were audited to ensure all rooms have sufficient number of outlets to accommodate resident needs to avoid tripping hazards. The shower room/bathroom floor was cleaned around base of toilet. Audits of all bathrooms were conducted to ensure area around toilets were clean on 8/19 /25. The cracked/stained ceiling around the shower exhaust fan was repaired and cleaned on 8/19/25 All ceilings and exhaust fans were audited to ensure they were clean and in good repair 8/19/25. The wooden windowsill in room 104 was replaced on 8/18/25 Audits of all windowsills were completed on 8/ 19 /25 to ensure there were no chipped/gouged or missing sealant. The lower part of the corner wall in the main lobby on west side was repaired and treated. The sit to stand lift was cleaned of all dirt and food debris. Audits of all lifts were conducted to ensure no lifts contained dirt or food debris on 8/19/25 The ceiling vent with the screw hanging down was repaired. The inside of the entrance door was repaired to allow for a cleanable surface. Audits will be reviewed by QAPI x's 3 months QAPI will then review quarterly ensure compliance.	

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F0584 SS = E	Continued from page 6 Based on observations and interview, the facility failed to provide a safe and comfortable environment for 1 of 6 residents reviewed for accidents (Resident #24 [R24]). In addition, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a safe, sanitary, orderly, and comfortable environment on 2 of 2 units (East and West) and the main lobby for 1 of 1 facility tour (7/31/25). 1. On 7/28/25 at 2:30 p.m., during an interview with two surveyors and the Maintenance Director, R24's bed chord was observed crossing the floor from the foot of the bed to the opposite wall and confirmed to be a trip hazard. On 7/29/25 at 3:30 p.m., during an observation with two surveyors, the Licensed Practical Nurse (LPN1) and the Maintenance Director, the following was observed and confirmed in Room 112: The television cable was running along the floor at the foot end of R24's bed creating a trip hazard. The cable for the bed remote was on the floor at the foot end of the bed creating a trip hazard. The power cord for R24's bed was observed unplugged and resting on the floor creating a trip hazard. On 7/29/25 at 3:32 p.m., LPN1 stated the bed is unplugged because R24 walked around the bed and unplugged the bed to plug in his/her fan. LPN1 stated there are not enough outlets to accommodate R24's appliances (including the bed, nebulizer machine, cell phone charger, oxygen concentrator, and fan) without running them across the floor. On 7/29/25 at 3:35 p.m., during an interview with the two surveyors, the Maintenance Director stated he addressed these concerns with management, but they declined the installation of additional electrical outlets. At this time two surveyors confirmed the environment was unsafe when cords and cables were crossing the floor in an area where the resident ambulates, and R24 wants his/her fan to stay running to maintain a comfortable environment temperature. 2. On 7/31/25 from 9:45 a.m. to 10:10 a.m., an Environment Tour was completed with the Maintenance Director and a surveyor in which the following findings	F0584		

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F0584 SS = E	Continued from page 7 were observed: East Wing Shower Room/Bathroom - The floor was dirty around the base of the toilet. The ceiling was cracked and stained around the shower exhaust vent. Resident Room 104 - The wooden windowsills were chipped/gouged and missing sealant exposing untreated wood. Main lobby- The lower part of the corner wall, in the main lobby headed toward the West Wing, was chipped/gouged and missing sealant exposing untreated wood. West Wing Shower room The patient sit-to-stand lift had dirt and food debris on the foot base area. The ceiling vent was hanging down, missing a screw and in disrepair. The inside of the entrance door had laminate that was ripped/torn creating an uncleanable surface. On 7/31/25 at 10:10 a.m., in an interview with a surveyor, the Maintenance Director confirmed the findings.	F0584		
F0656 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,	F0656	3 residents were affected by this practice. All residents have the potential to be affected by this practice. Re-education was provided to all nursing staff regarding timely and accurate documentation for meal intake. R17 care plan was updated on 8/1/25 to reflect use and compliance of hearing aids on her preference to use or not use hearing aids. Nursing staff will offer R17 assistance with hearing aids and document acceptance/refusal of hearing aids Weekly audits of C.N.A documentation will be completed by Director of Nursing to ensure completion of documentation	8/27/25

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F0656 SS = E	Continued from page 8 mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for 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 record reviews, interviews, and facility policy review, the facility failed to update/implement interventions on the current comprehensive care plan for the areas of smoking for 1 of 2 residents reviewed for smoking (Resident [R]43), hearing aids and dental for 1 of 1 resident (R17) reviewed, nutrition for 1 of 2 (R1) residents reviewed, and mobility for 1 of 2 (R19) residents reviewed. 1.Review of R1's care plan updated 7/10/25 states "Monitor and document intake and output as per facility policy". Review of R1's "Nutrition: amount eaten" lacked	F0656	On 7/30/25 we updated care plan to identify interventions needed for R17. R17 is scheduled for dental appointment on 10/8/25. She is also on the cancellation list if it can happen sooner. R17 was assessed for any chewing/swallowing problems related to dental issue. At this time resident does not request any dietary changes. All staff will monitor R17 for any complaints related to dental pain and report to nursing if any assessment or intervention is needed. We have acquired the services of a traveling dental service to provide routine screening and preventative care to all eligible residents. Care plan updated on 7/29/25 to reflect interventions and goals regarding smoking for resident R43. Will update care plans for all residents who currently smoke to reflect accurate smoking status, goals and interventions during initial smoking assessment and as needed. On 7/31/25 R19 care plan was corrected to no longer reflect the use of a motorized wheelchair for mobility. Audits of residents smoking status will be reviewed quarterly and as needed.	8/27/25

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F0656 SS = E	Continued from page 9 documented intakes during: Breakfast on 7/1/25, 7/6/25, 7/19/25, 7/20/25, 7/22/25, 7/23/25, 7/24/25, 7/30/25 Lunch on 7/1/25, 7/3/25, 7/6/25, 7/9/25, 7/14/25, 7/17/25, 7/23/25 Dinner on 7/11/25, 7/13/25, 7/27/25, 7/30/25 During an interview on 7/30/25 at 4:15 p.m., the above was discussed with Director of Nursing (DON). 2.Review of R17's care plan updated 7/17/25 care plan states: "communication: ensure hearing aids are place appropriately." Observations of R17 on 7/28/25, 7/29/25 and 7/30/25 lacked evidence of hearing aid use. During an interview on 7/30/25 at 2:32 p.m., DON confirmed that R17 did have hearing aids that should be used. 3.Review of R17's clinical record revealed provider note dated 5/20/25 states: Patient lost filling in [his/her] right lower molar. [He/She] needs a referral to dentist. During an interview on 7/30/25 at 12:56 p.m., R17 stated that [his/her] tooth with the missing filling hurts whey eating and especially when [he/she] brushes, [his/her] teeth bleed. Review of R17 care plan lacks evidence it was updated to reflect any measures to take for missing filling. During an interview on 7/30/25 at 12:54 p.m. DON stated they did put a referral in for a dentist appointment, and they are waiting for an appointment, but they should have updated the care plan to put measures in place for the missing filling while they are waiting for the appointment. 4.R43 was admitted in July, 2025 and is an active cigarette smoker. Observations were made of R43's smoking outside on 7/26/25, 7/27/25, on 7/28/25, and 7/29/25. Review of R43's care plan lacked evidence that goals and interventions were placed in the area of smoking. During an interview on 7/29/25 at 4:35 p.m., R43 states	F0656		

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F0656 SS = E	Continued from page 10 he/she keeps cigarettes in the top drawer of the dresser and goes out to smoke approximately 2 times a day. R43 states he/she's been smoking since he/she was a small child. During an interview with a surveyor on 7/30/25 at 9:01 a.m. the above was discussed with DON. 5. Review of R19's "Care Plan Report" with a revision date of 3/26/25 states: "Focus: Risk for Injury to self or other residents secondary to use of power chair (motorized wheelchair for mobility)". On 7/31/25 at 1:35 p.m. in an interview with a surveyor, the DON stated that R19 no longer uses a power chair, hasn't used one for many months, due to safety, and confirmed that R19's care plan has not been updated to reflect that R19 does not use a power chair (motorized wheelchair for mobility).	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	One resident was affected by this practice. All residents have the potential to be affected by this practice. We will continue to audit and schedule IDT meetings weekly. To ensure all IDTs are held within the seven day window. Audits will be conducted weekly by Social Services to ensure all IDT meetings are held within the seven days of completion of MDS. Copies of the care plan will be offered to both the resident and their families at the time of the care plan meeting. Audits will be reviewed by QAPI x's 3 months.QAPI will review quarterly to ensure compliance.	8/27/25

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F0657 SS = D	Continued from page 11 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure an Interdisciplinary Care Plan Meeting (IDT) was held within 7 days after a Minimum Data Set (MDS) for 1 of 17 residents reviewed (Resident [R]17). Review of Resident [R]17 clinical record revealed Minimum Data Set (MDS) dated 7/11/25. Further review of R17 clinical record revealed an Interdisciplinary Meeting (IDT) meeting was held 7/28/25 (17 days late). During an interview on 7/29/25 at 3:00 p.m., the Social Services Director (SSD) stated she is supposed to schedule IDT meetings within 7 days of the MDS completion. At this time SSD confirmed R17's IDT meeting was held yesterday (7/28/25). SSD stated she originally scheduled the meeting for 7/24/25 (6 days late) but thinks the family couldn't make it on the 24'th so it was rescheduled to 7/29/25. At this time the SSD confirmed the original IDT meeting would not have been within the 7 days of the MDS completion. The surveyor then asked if SSD offered/provided a copy of the care plan after each IDT meeting. SSD confirmed she has not been offering residents/families copies of the care plan, but she will start. During an interview on 7/29/25 at 3:32 p.m. in the presence of 5 surveyors the above was discussed with Director of Nursing.	F0657		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the	F0685	One resident was affected by this practice. All residents have the potential to be affected by this practice. R17 care plan was updated on 8/1/25 to reflect use and compliance of hearing aids on her preference to use or not use hearing aids. Nursing staff will offer R17 assistance with hearing aids and document acceptance/refusal of hearing aids. Tasks to both C.N.As and Nurses to assist with both placement and removal of hearing aides. Resident may keep hearing aids at bedside if she prefers.	8/27/25

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F0685 SS = D	Continued from page 12 treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews the facility failed to ensure hearing aids were in use for 1 of 1 resident reviewed for communication (Resident #[R] 17). Observations of R17 on 7/28/25, 7/29/25 and 7/30/25 lacked evidence of hearing aid use. Review of R17 care plan updated 7/17/25 states "Communication: ensure hearing aids are place appropriately..." Review of R17 "New Admission Personal Item Inventory" dated 10/13/24 states [he/she] was admitted with both left and right hearing aids. Interview on 7/30/25 at 1:10 p.m., Licensed Practical Nurse #2 (LPN2) stated [he/she] was not aware that R17 had hearing aids. During an interview on 7/30/25 at 1:05 p.m., R17 stated [he/she] does have hearing aids, and they are in a box in [his/her] room, [his/her] sister mailed batteries, but [he/she] can't get them in and is waiting for someone to help [him/her]. R17 further stated she really needs them because [he/she] has a hard time hearing during activities and keeps having the Activity Director repeat what she's saying. Interview on 7/30/25 at 1:15 p.m. Certified Nursing Assistant #3 (CNA3) stated she was unaware that R17 had hearing aids. Interview on 7/30/25 at 1:23 p.m., CNA5 stated she was unaware that R17 had hearing aids. During an interview on 7/30/25 at 2:32 p.m. with a surveyor DON confirmed R17 wore hearing aids and they should be used.	F0685	Re-education was provided to nursing staff on Kardex location and how to locate information regarding resident ADL needs. Weekly audits of nursing documentation will be completed by Director of Nursing to ensure completion of documentation Audits will be reviewed by QAPI x's 3 months. QAPI will review quarterly to ensure compliance.	8/27/25
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(l) § 483.25(l) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and	F0695	One resident was affected by this practice. All residents have the potential to be affected by this practice. O2 concentrator filter for R24 was pulled and cleaned on 7/29/25	8/27/25

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F0695 SS = D	Continued from page 13 tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection on 2 of 4 days of survey (7/28/25 and 7/29/25). On 7/28/25 at 11:45 a.m., a surveyor observed Resident #24 (R24)'s oxygen tubing labeled 7/28/25, connected to an oxygen concentrator. The filter on the concentrator was observed to be heavily soiled with dust/debris. On 7/29/25 at 3:30 p.m., during an interview with two surveyors and the Licensed Practical Nurse (LPN1), R24's oxygen concentrator was observed to have new tubing related to the addition of humidification dated 7/29/25. The nasal cannula tubing was observed to be dated 7/28/25. The concentrator filter was observed to be heavily soiled with dust/debris. LPN1 stated the filter should be washed with tubing changes. At this time the surveyor confirmed the filter was not cleaned with the tubing change and was heavily soiled with dust/debris.	F0695	Re- education was provided by the Director of Nursing or designee to staff to remove and clean filter while changing O2 tubing on scheduled dates. All newly hired nursing staff will be educated on how to properly maintain and clean O2 equipment. Weekly audits will be conducted by Director of Nursing or designee to ensure O2 equipment is maintained and clean. Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	No resident was affected by this practice. All residents have the potential to be affected by this practice. Education was provided by DON to nurses to label medication with date upon opening. Weekly audits will be done by DON or designee to ensure compliance with labeling and securing of all medications Weekly audits will be conducted by DON or designee to ensure medication is properly secured, labeled, and verify expiration date according to regulations. Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	8/27/2025

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F0761 SS = E	Continued from page 14 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored in a locked compartment for 1 of 3 medication areas (East Medication Storage Room), opened insulin was labeled with an open date, and expired medications were removed from the available for use supply in 2 of 3 medication storage rooms (West Medication Storage Room and East Medication Storage Room). On 7/29/25 at 9:30 a.m., during an observation and interview with two surveyors and the Licensed Practical Nurse #1 (LPN1), the following were observed and confirmed to be on the shelf and available for use in the West Medication Storage room:1 open box containing 650 milligrams (mg) Acetaminophen Suppositories with an expiration date of "12/2024"1 tube containing 1 ounce (oz) Vagicaine Anti-itch Cream, with an expiration date of 6/30/241 box containing Miconazole Vaginal Antifungal 7 day treatment with an expiration date of 5/24/251 pre-filled 3mL insulin pen labeled Lantus Solostar (Insulin Glargine) 100u/mL , the pen was labeled with conflicting open dates (cap labelled with an open date of "6/27/25", pen base labelled as opened "6/25/25"). LPN1 stated, "insulin should be discarded 28 days after opening".2 open vials, 10 milliliter (mL) of insulin aspart 100 units (u)/mL,one vial had an open date of 6/18/25one vial was open and undated. LPN1 was unable to determined when the vial was opened or when it would expire.3 open vials, 10 mL of insulin glargine 100 u/ mL,one vial had an open date of 5/12/25one vial had an open date of 6/30/25one vial observed to be open and undated. LPN1 was unable to determined when the vial was opened or when it would expire. On 7/29/25 at 10:07 a.m., two surveyors observed and confirmed with LPN1 that insulin medications including vials, quick pens, needles and lancets were stored in an unlocked cabinet in an unsecured area behind the East Wing nurse station. On 7/29/25 at 10:08 a.m., during an observation with two surveyors and LPN1, the following was observed and confirmed, on the shelf and available for use in the	F0761		

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F0761 SS = E	Continued from page 15 East Wing Medication Storage area:1 open vial, 10mL insulin lispro 100ui/mL, with an open date of 6/24/251 tube of Halobetasol Propionate cream 0.05% with an expiration date of 4/2025	F0761		
F0812 SS = E	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. §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, interviews, and review of the facility's "Food Storage" policy/procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the three-bay pot sink and the walk-in freezer. Additionally, the facility failed to ensure foods were dated and/or discarded after best used by date in the walk-in refrigerator and on a beverage cart on a unit for 2 of 2 tours (7/28/25, and 7/29/25). The facility's "Food Storage" policy/procedure, dated 3/4/25, noted under Procedure: ...All containers or storage bags must be legible and accurately labeled and dated. Refrigerated Food Storage: All foods must be covered, labeled, dated and routinely monitored to assure foods are used by their use by dates or discarded.	F0812	No residents were affected by this practice. All resident have the potential to be affected by this practice. The Dietary Supervisor or designee will ensure that all containers and/or storage bags are accurately labeled and legible. All food will be covered, dated and used or discarded by their expiration dates. Routine audits will be conducted by dietary supervisor on accurately labeled food x's 3months to ensure foods are used or discarded by their use by dates. All staff will wear hair nets or face protaction prior to entering kitchen. Dietary will conduct routine audits to insure compliance is met regarding hair nets and facial protection x's three months. The chemical hoses that were hanging down in the three bay pot sink were adjusted so they no longer hang down into sink. Dietary will conduct routine audits on all containers of thickened water to insure that it is used or dicarded by best used by date. Dietary will conduct routine audits on all thawed food to insure it is used by or discarded by best used by date. The dietary supervisor or designee will conduct routine audits of the walk-in freezer to ensure no boxes are stored on the floor or under the freezer compressor to ensure food integrity is maintained. Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	8/27/28

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F0812 SS = E	Continued from page 16 1.On 07/28/25 from 11:10 a.m. to 11:55 a.m., two surveyors completed an initial kitchen tour in which the following findings were observed: - The maintenance man was observed in the kitchen with no hair or face protection for his facial and head hair. - The three bay pot sink had 2 chemical hoses hanging down in the sinks. - The dry storage room had two 46-ounce containers of thickened water that had best use date of May 26, 2025, available for use. - The walk-in refrigerator has a 16-ounce package of whipped topping with no thaw date. The manufacturer's directions noted the product was only good for 2 weeks after thawing. - The walk-in freezer had a large open box of hamburger buns on the floor and a package of bread sticks on a shelf, stored under the freezer compressor, that had ice buildup on and/or in them. On 07/28/2025 at 11:55 a.m., in an interview with the surveyor, the Food Service Director confirmed the findings. 2. On 7/29/25 at 8:08 a.m., a surveyor and the Director of Nursing [DON], observed an open container of thickened water with a best used by date of "MAY 26,2025", on the beverage cart in the East Wing hallway, and available for use. At this time, the DON confirmed the finding.	F0812		
F0814 SS = D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for two trash receptacles for an area outside by a dumpster for 1 of 4 days of survey (7/28/25). On 07/28/2025 from 11:10 a.m. to 11:55 a.m., two surveyors completed an initial kitchen tour in which the following finding was observed:	F0814	No residents were affected by this practice. All resident have the potential to be affected by this practice. The two trash receptacles located outside by the dumpster were removed on 7/28/25. The dietary supervisor or designee will ensure all trash receptacles are emptied routinely to ensure there is no trash receptacle overflowing. The dietary supervisor or designee will conduct routine audits of all trash receptacle x's 3 months to ensure compliance with garbage disposal is maintained. Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance.	8/27/25

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F0814 SS = D	Continued from page 17 - There were two of three, approximately 30 to 40 gallon trash receptacles, that had the swing lids open and exposed trash hanging out. On 7/28/25 at 11:55 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.	F0814		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F0842	One resident was affected by this practice. All residents have the potential to be affected by this practice. Re-education was provided to all nursing staff regarding timely and accurate documentation for meal intake. Weekly audits of C.N.A documentation will be completed by Director of Nursing to ensure completion of documentation Audits will be reviewed by QAPI x's 3 months. QAPI will then review quarterly to ensure compliance	8/27/25

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F0842 SS = D	Continued from page 18 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 records reviewed (Resident #1 [R1]).	F0842		

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F0842 SS = D	Continued from page 19 R1 is has diagnoses to include paraplegia, Chronic kidney Disease (CKD) and Diabetes Mellitus (DM). Review of R1's care plan updated 7/10/25 states "Monitor and document intake and output as per facility policy." Review of R1's "Nutrition: amount eaten" lacked evidence of documented intakes during: -Breakfast on 7/1/25, 7/6/25, 7/19/25,7/20/25, 7/22/25, 7/23/25, 7/24/25, 7/30/25 -Lunch 7/1/25, 7/3/25, 7/6/25, 7/9/25,7/14/25, 7/17/25, 7/23/25 -Dinner 7/11/25, 7/13/25, 7/27/25, 7/30/25. During an interview on 7/30/25 at 4:15 p.m., the above was discussed with Director of Nursing.	F0842		
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, facility documentation and manufacturer's instructions, the facility failed to ensure that the laundry room equipment was maintained according to manufacturer's instructions and in a correct and safe operating condition for 4 of 4 days of survey (7/28/25, 7/29/25, 7/30/25 and 7/31/25). This has the potential to affect all residents. The manufacturer's instructions, dated 2007, noted in the Safety and Maintenance Instructions: 10. Do not tamper with the controls. 18. Keep the washer in good condition..... 24. Never operate the washer with any guards and/or panels removed. 25. DO NOT operate the washer with missing or broken parts. 26. DO NOT bypass any safety devices. 27. Failure to install, maintain, and or operate this washer according	F0908	No residents were affected by this practice. All resident have the potential to be affected by this practice. The control panel on the right side washing machine was replaced by 9/3/2025 At the time when washing machine on the left side is replaced the leaking issue will be resolved.The left sided washing machine will be replaced with a new washing machine. The new washing machine was ordered on 8/22/25 and will be installed in 10-12 weeks Maintenance conducts monthly audits of washing machines through the TELS system. Monthly audits will continue to ensure machines are free from loose exposed wires.	8/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0908 SS = F	Continued from page 20 to the manufacturer's instructions may result in conditions which can produce bodily injury and or property damage. Maintenance Instructions: 1. Weekly-Check the machine for leaks. On 7/30/25 at 9:00 a.m., a surveyor observed the following in the laundry:The control panel keypad on the left washing machine was missing 4 buttons and the control panel keypad on the right washing machine was missing 1 button. There was a bucket under a leak from the left washing machine that also had a wire running from the washing machine and hanging down in the bucket and then running out a wall attached to other wires. On 7/30/25 at 9:05 a.m., in an interview, the Laundry/Housekeeping supervisor confirmed the findings. She went on to state that the control panels have been broken with holes in them for many months and that the left washer has leaked for many months. There is a bucket under the leak which overflows every night and floods the laundry room floor by morning. On 7/30/25 at 10:40 a.m., in an interview, the Maintenance Director stated that the two washers have been in their current broken state for four or five months. When asked by a surveyor, he stated that he has no documented preventive maintenance program for the washers, but he does get a reminder monthly on his computer to look at them. The Maintenance Director also stated that the company that services their washers has stated that they can't get the parts to repair the machines and that administration has known they are broken and not repairable. At this time, the Maintenance Director confirmed the finding that the two washing machines were not maintained in a safe operating condition. On 7/29/25 at 9:00 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine. On 7/30/25 at 9:17 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine. On 7/31/25 at 8:30 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine.	F0908		

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F0908 ~~F0909~~ SS = F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 37 of 37 beds. This has the potential to affect the safety of all residents. On 7/28/25 at 2:12 p.m., a surveyor observed in Room 112, Resident #24 (R24)'s exposed bedframe at the head of the bed had a 4.83-inch wide by 4-inch long opening which created a risk for the entrapment of body parts. The foot of the bed had a 4-inch gap between the mattress and the footboard creating a risk for entrapment of body parts. The resident was not in bed at the time of the observation. At 2:15 p.m., during an interview with a surveyor and the Licensed Practice Nurse #1 (LPN1), R24's mattress was observed and confirmed to be offset from the bedframe, and the exposed the bedframe created the potential for entrapment of body parts. LPN1 stated the bed should have a bumper for the foot of the bed to prevent injuries. On 7/29/25 at 3:48 p.m., in Room 105, two surveyors observed a resident sleeping in bed. A 5-inch space was observed between the mattress and footboard creating a potential space for entrapment of body parts. At 5:51 p.m., in Room 108, two surveyors observed a Certified Nursing Assistant #1 (CNA1) assisting a resident in bed. The bed was observed to have a 5.5-inch space between the mattress and the footboard, partially filled with a 2-inch mattress extender. On 7/30/25 at 10:51 a.m., during an interview with two surveyors, the Maintenance Director stated he has never done bed assessments. He stated the facility has a Bionix System but only uses it for the handrails. He stated he does not know how to assess the bed	F0908 F0909	All residents have the potential to be affected by this practice. Audits of all beds were conducted by Maintenance Director to identify any possible risk of entrapment. Routine inspections will be conducted by Maintenace Director on all beds to identify the risk of a possible entrapment. Routine inspections of beds was added to the TELS system to ensure compliance. Education on bed assessments was completed by Maintenance Director on 8/22/25 Audits will be reviewed by QAPI x's 3 months.QAPI will then review quarterly to ensure compliance.	8/27/25

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F0909 SS = F	Continued from page 22 mattresses and/or bed frames, or if there are specific measurements to know. At this time, two surveyors confirmed that there is not a maintenance program to identify areas of possible entrapment through regular inspection of all bed frames, mattresses, and bed rails.	F0909		
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility's laundry room and equipment presented safety hazards to the employees by having a frayed/ripped power supply wire for the washing machines for 3 of 4 days of survey (7/28/25, 7/29/25, and 7/30/25) by not having safe and properly functioning washing machines for 2 of 2 washing machines and for having broken floor tiles for 4 of 4 days of the survey (7/28/25, 7/29/25, 7/30/25, and 7/31/25). On 7/30/25 at 9:05 a.m., a surveyor observed the following in the laundry room: - The entire laundry room tiled floor was heavily soiled with dirt. - There were approximately 16 cracked/broken and loose floor tiles, creating a trip hazard for staff. - There was exposed/untreated cement flooring in front of, to the sides of, and behind the two washing machines. - The control panel on the left washing machine was missing 4 buttons. - The control panel on the right washing machine was missing 1 button. - There was a bucket under a leak from the left washing machine that also had a wire running from the washing machine and hanging down in the bucket and then running out a wall attached to other wires. - The power supply wire for the equipment is observed	F0921	No residents were affected by this practice. All residents have the potential to be affected by this practice. The laundry room floor and surrounding environment was cleaned and broken/loose tiles were replaced on 8/13/25 The exposed/untreated cement floor in the laundry room was painted on 8/13/25 The control panel on the right side washing machine will be replaced on 9/3/2025. The washing machine on the left side will be replaced with a new washing machine, and leaking issue will be resolved. New washing machine ordered 8/22/25 The loose wire hanging down from the washer was secured back into place. This wire poses no electrical threat according to electrician. The power supply wire for the left washing machine that was loose from the wall was put back into place and verified by electrician to be a viable repair on 8/15/25 Education was provided to Laundry personal on keeping the dryers free from lint and how to clean the surrounding area. Laundry personal will provide routine cleanings to keep laundry room clean. Education was given on 8/22/25 A new washing machine for the left side was ordered on 8/22/25 and will be installed in approximately 10-12 weeks.	8/27/25

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F0921 SS = E	Continued from page 23 compromised with protective sheath broken and internal wires exposed at the point of connection to the wall. - The surrounding environment is heavily soiled with dryer lint increasing the flammability of the environment. On 7/30/25 at 9:05 a.m., in an interview with a surveyor, the Laundry/Housekeeping supervisor confirmed the findings. She went on to state that the control panels have been broken, with holes in them, for many months and that the left washer has leaked for many months. She stated that staff use their fingers or a wooden dowel to stick them into the control panel holes to activate the washing machines. The Laundry/Housekeeping supervisor showed the surveyor how she puts her finger in the control panel holes to run the machine. There is a bucket under the leak which overflows every night and floods the laundry room floor by morning. They have to mop up water that is all over the floor in front of the washing machines. She stated that she did not know how long the power cord to the machines were ripped open, but the staff have to go by it when they clean behind the washing machines. On 7/30/25 at 10:40 a.m., in an interview with a surveyor, the Maintenance Director, stated that the washers have been in their current broken state for 4 or 5 months. He went on to state that the staff use their fingers or the wooden rod to access the computer board behind the broken control panel to operate the washing machines and he knows this is not safe. At this time, the Maintenance Director confirmed the finding that the two washing machine's missing control panel buttons, the constant leaking of water and the crack/broken floor tiles create potential safety hazard concerns for the staff working in the laundry room. On 7/29/25 at 9:00 a.m., the surveyor observed both washing machine control panels keypads missing buttons, a leak from under the left washing machine and the power supply wire for the equipment to be frayed and ripped. On 7/30/25 at 9:17 a.m., the surveyor observed both washing machine control panels keypads missing buttons, a leak from under the left washing machine and the power supply wire for the equipment to be frayed and ripped. On 7/31/25 at 8:30 a.m., the surveyor observed both washing machine control panels keypads missing buttons	F0921		

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F0921 SS = E	Continued from page 24 and a leak from under the left washing machine.	F0921		