STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. BUILDING _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and eleven (11) Complaint Investigations (CI MS #26373, CI MS #26431, CI MS #26742 CI MS #26914, CI MS #27173, CI MS #27365, CI MS #27377, CI MS #27340, CI MS #27429, CI MS #27468, and CI MS #27564) at the facility from 1/06/25 through 1/09/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F561, F584, F623, F625, F641, F655, F656, F677, F727, F851, and F880. The SA identified non-compliance and cited F655, F656 and F677 for failure to implement a care plan and provide Activities of Daily Living for CI MS #26914, CI MS #27365 and CI MS #27564. The SA cited F584 regarding environment issues for CI MS #26373 and CI MS #27564. The SA identified non-compliance and cited F600 regarding abuse for CI MS #26431. The SA investigated CI MS #26742, CI MS #27173, CI MS #27340, CI MS #27377, CI MS #27429 and CI MS #27468 with no deficiencies cited. The census at the time of the survey was 97 and the facility was licensed for 107 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		1/31/25

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

Electronically Signed | 01/27/2025

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F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to honor a resident 's preferences for (1) one of 23 sampled residents. Resident #195 Findings include: A review of the facility policy titled, "Resident Rights," revised 04/2017, revealed, "Residents shall: C.) Be assured of choice and share responsibility for decisions... E.) Receive care and services that are adequate and appropriate..." An observation on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and	F 561	1. On 1/6/2025, Certified Nursing Assistant (CNA#1) completed a shower and activities of daily living (ADL) care to including shaving, nail care, and shower for Resident #195. On 01/10/2025 RN (Registered Nurse) #1 interviewed Resident # 195 to ensure all resident preferences with ADL care were accurate and being followed. On 1/7/2024 the Administrator educated CNA#1 and CNA#2 on completion of ADL care according to residents' preferences. 2. The facility determined that all residents have the potential to be affected. 3. On 1/10/2025 an audit was completed by RN (Registered Nurse) #1 with all	

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F 561	Continued From page 2 matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. In a continued interview with Resident #195, he stated he had been in the facility a little over two weeks, and he had not received a shower, a shave, or had his hair brushed at all. He went on to state he had told someone when he was admitted that he preferred a shower and had asked the staff for one several times, they would say ok but never come back. He then stated, "I am unable to get up by myself, or I would try to shower myself." In an interview and observation of Resident #195 on 1/6/24 at 12:10 PM with Certified Nurse Assistant (CNA) #1, she confirmed she had not attempted to give the resident a shower, and stated the facility does not have a set shower schedule for the residents. She then admitted that the resident's hair, beard and nails did not appear clean or that he had had a bath lately. In an interview and record review with the shower CNA #2 on 1/06/24 at 1:00 PM, she confirmed that the facility does not have a set shower schedule for the residents letting us know when they need one. She then revealed that if a resident receives a shower by the shower staff, then it would be documented on the shower schedule forms. After record review she confirmed that Resident #195 had no documented shower since admission. In an interview with the Director of Nursing (DON) on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule in place at this time. She stated, "we had one in place for a while, but no one was following up on it and so it	F 561	residents to verify the accuracy of ADL care to include showers, nail care, and shaving. The audit results were care planned by the MDS (Minimum Data Set) team to ensure staff were following the residents' preferences. This included modification of 12 (twelve) residents ADL (Activities of Daily Living) completed. On 1/10/2025 MDS (Minimum Data Set) team-initiated education with the Direct care staff on following the plan of care for resident preferences and how to utilize the Kardex, which contains the resident preferences. 4. Beginning 1/10/2025 RN (Registered Nurse) Supervisor will observe five (5) residents' weekly observations for 4 weeks and then monthly for three (3) months to ensure staff provide care according to the care planned resident preferences. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 561	Continued From page 3 was stopped." She confirmed she was aware there was a problem and should have put something in place to ensure residents received their showers. She stated that failing to provide Resident #195 showers per his preference is a failure to honor the residents' right of choice. Record review of the January Shower Record revealed there was no documented shower for Resident #195. Review of the "Admission Record" revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure. Record review of Resident #195's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section F0400 : Interview for Daily Preferences revealed, C. "How important is it to you to choose a bath, shower, bed bath, or sponge bath?" Coded: "Very Important."	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		1/31/25

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F 584	Continued From page 4 (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: Based on observations, resident and staff interviews, and facility policy reviews, the facility failed to provide a clean, comfortable, and homelike environment as evidenced by broken blinds or window coverings on three (3) of six (6) hallways observed during survey. Rooms 203, 505, 601, and 607. Findings included:	F 584	1. On 1/8/2025 the Maintenance Director replaced broken blinds on Room #203, 505, 601, and 607. On 1/8/2025 the Administrator conducted an Inservice with the Maintenance Director on repairs of facility to include documentation of TELS (The Equipment Lifecycle System) for a safe, clean, and comfortable home like environment. On 1/8/2025 the	

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F 584	Continued From page 5 A review of the facility policy titled "Homelike Environment" with a revision date of 02/2023 revealed under the "Policy Statement...Residents are provided with a safe, clean, comfortable environment ..." During an initial facility tour on 1/6/25, beginning at 7:45 AM, observations revealed broken or missing slats on window blinds in Rooms 203, 505, 601, and 607. This observation revealed there were residents residing in these rooms and the broken blinds allowed the room to be visible from outside the building. An observation of Room 601 on 1/6/25 at 8:00 AM, revealed four (4) broken slats on the left side of the blinds. An observation of Room 607 on 1/6/25 at 9:05 AM, revealed four (4) missing slats at the bottom of the blinds. An observation of Room 505 on 1/6/25 at 3:19 PM revealed ten (10) missing slats on the blinds. In an observation and interview with Certified Nursing Assistant (CNA) #4 on 1/7/25 at 1:00 PM, she confirmed that the window blinds were broken with multiple missing pieces. CNA #4 stated that maintenance needs are typically reported verbally to the Maintenance Director or Administrator, as there is no formal documentation process. She admitted she had noticed the broken blinds but forgot to report the issue due to other responsibilities. During an interview with the Administrator on 1/7/25 at 1:15 PM confirmed that she was aware	F 584	Maintenance Director conducted a facility wide audit to check on any broken blinds or repairs that were needed. The results of the audit include the replacement of blinds in 13 additional rooms. 2. All residents have the potential to be affected. 3. On 1/8/2025 an in-service was initiated with all staff on how to complete a TELS (The Equipment Lifecycle System) order when repairs are needed within the facility. 4. Beginning the week of 1/10/2025 the Maintenance Director will audit resident rooms to check on any repairs needed to include blinds on (5) five rooms weekly times (4) four weeks and monthly for (4) four months and quarterly thereafter. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted to QAPI (Quality Assurance Performance Improvement) committee by Maintenance Director on 1/31/2025 for review and recommendations then monthly for three (3) months. The Maintenance Director and Administrator are responsible for monitoring and compliance.	

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F 584	Continued From page 6 of the broken blinds because she conducts daily rounds. She stated that she reports maintenance needs to the maintenance director and that replacement blinds had been received but admits they had not been put up yet. She admitted there was no documentation of her rounds or maintenance notifications regarding the blinds. In an interview with the Maintenance Director on 1/7/25 at 1:24 PM, he confirmed that he was aware of the broken blinds in multiple rooms and stated that some replacement blinds had arrived the previous week, but none had been installed yet. He then verified that there was no documentation available to show when the blinds were ordered.	F 584		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		1/31/25

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F 623	Continued From page 7	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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F 623	Continued From page 8 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review, and facility policy review the facility failed to send a written transfer/discharge notice to a	F 623	1. On 1/14/2025 a transfer letter was mailed to resident #8□s resident representative by social services	

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F 623	Continued From page 9 resident or resident representative for a hospital transfer for three (3) of 3 residents reviewed. Residents #8, # 27, and #45 Findings include: Record review of the facility policy, titled "Transfer or Discharge Documentation and Notice "with a review date of 5/17/24 revealed under "Policy Interpretation and Implementation...5. The residents and representatives are notified in writing the following information: a. the specific reason for the transfer..." Resident #8 Record review of the Discharge Minimum Data Set (MDS) for Resident #8 with an Assessment Reference Date (ARD) of 8/22/24 revealed, Section A-2000: Discharge Date: 8/22/24 ... Section A-2105: Discharge Status: coded Short-Term General Hospital. During an interview on 1/7/25 at 12:45 PM, the Social Services Director revealed that she had not sent a written discharge/transfer notification form to any resident or resident representative and was unaware that she needed to provide the notifications when they went to the hospital. Record review of the Admission Record revealed that Resident #8 was admitted to the facility on 04/18/2023, and her most recent hospital stay was from 08/22/2024 to 08/30/2024. Resident #8 was admitted with medical diagnoses that included End Stage Renal Disease, and Diastolic (Congestive) Heart Failure. Resident #27	F 623	regarding transfer on 8/22/2024. On 1/14/2025 a letter was provided to resident #27 due to him being his own Resident Representative by social services regarding his transfer on 5/9/2024, 5/26/24,7/3/2024, and 7/13/2024. On 1/14/2025 a transfer letter was mailed to resident #45 resident representative by social services regarding his transfer on 12/6/2024 and 12/27/2024.On 1/28/2025 a transfer letter was mailed to resident #45 resident representative by social services regarding his transfer to include bed hold on 11/28/2024. On 1/7/2025 the Corporate Clinical Specialist conducted an in-service with The Social Services on the bed hold, transfer letter, and ombudsman notification on all transfers in a language that is easily understood. 2. All Residents who are transferred from the facility are potentially affected. 3. On 1/7/2025 an audit was conducted by the Social Services of transfers back to 9/1/2024, letters were mailed to twenty (20) resident representatives informing them of their respective resident's transfer, reason for transfer, where resident was transferred and Ombudsman□s contact information. Beginning on 1/10/2025 the Administrator provided in-service to BOM (Business Office Manager) and Social Services Director regarding requirement for written notification to be presented/mailed to resident or resident representative following a resident□s transfer from the facility, in a language that is easily understood, regarding reason for transfer,	

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F 623	Continued From page 10 Record review of Resident #27's electronic "Census" status revealed that the resident was transferred to the hospital on 5/9/24, 5/26/24, 7/3/24 and 7/13/24. Record review of Resident #27's electronic "Contacts" list revealed that Resident #27 was his own Responsible Party (RP). An interview with Resident #27 on 1/6/24 at 11:30 AM, he stated he had not received a written transfer notification for any of his hospitalizations. An interview with the Administrator on 1/7/24 at 2:45 PM stated that it was important to provide the resident or responsible party with a written transfer notification so that they could understand why they were transferred. The Administrator stated that it was her expectation that the Social Services Director would have provided the Resident/Resident Representative with a written transfer notification. Record review of the "Admission Record" revealed the facility admitted Resident # 27 on 3/15/21 with diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of the Quarterly MDS with an ARD of 12/5/24 revealed Resident # 27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates he is cognitively intact. Resident #45 Record review of the Discharge MDS for Resident #45 with an ARD of 11/28/24 revealed,	F 623	where the resident was transferred to, and information on contacting the ombudsman. 4. Beginning on 1/10/2025, the Business Office Manager will conduct an audit weekly for four (4) weeks, then monthly for three (3) months to determine for each transfer that a letter was mailed and logged on transfer letter tracking log. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the Business Office Manager to the QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Administrator is responsible for monitoring and compliance.	

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THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

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F 623	Continued From page 11 Section A-2000: Discharge Date: 11/28/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. ... Record review of the Discharge MDS for Resident #45 with an ARD of 12/06/24 revealed, Section A-2000: Discharge Date: 12/06/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. ... Record review Discharge MDS for Resident #45 with an ARD of 12/27/24 revealed, Section A-2000: Discharge Date: 12/27/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. ... Review of the "Admission Record" revealed Resident #45 was admitted by the facility on 11/12/24 with a diagnosis of Malignant Neoplasm of Glottis.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		1/31/25

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F 625	Continued From page 12 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review, and facility policy review the facility failed to send a bed hold notice to a resident or resident representative following a transfer for three (3) of 3 resident hospitalizations reviewed. Residents #8, # 27, and #45 Findings Include Record review of the facility policy, titled "Transfer or Discharge Documentation and Notice" with a review date of 5/17/24 revealed under "Policy Interpretation and Implementation...5. The resident and representative are notified in writing the following information...e. the facility bed hold policy..." Resident #8 Record review Discharge Minimum Data Set (MDS) for Resident #8 with an Assessment Reference Date of 8/22/24 revealed, Section A-2000: Discharge Date: 8/22/24 ... Section A-2105: Discharge Status: coded Short-Term	F 625	1. On 1/14/2025 a transfer letter was mailed to resident #8□s resident representative by social services regarding transfer to include bed hold on 8/22/2024. On 1/14/2025 a letter was provided to resident #27 due to him being his own Resident Representative by social services regarding his transfer to include bed hold on 5/9/2024, 5/26/24,7/3/2024, and 7/13/2024. On 1/14/2025 a transfer letter was mailed to resident #45 resident representative by social services regarding his transfer to include bed hold on 12/6/2024,and 12/27/2024. On 1/28/2025 a transfer letter was mailed to resident #45 resident representative by social services regarding his transfer to include bed hold on 11/28/2024. On 1/7/2025 the Corporate Clinical Specialist conducted an in-service with The Social Services regarding policy of resident representative notification regarding the bed hold policy during transfers. 2. All Residents who are transferred	

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F 625	Continued From page 13 General Hospital. Record review of the Admission Record revealed that Resident #8 was admitted to the facility on 04/18/2023, and her most recent hospital stay was from 08/22/2024 to 08/30/2024. Resident #8 was admitted with medical diagnoses that included End Stage Renal Disease, and Diastolic (Congestive) heart failure. Resident #27 Record review of Resident #27's electronic "Census" status revealed that the resident was transferred to the hospital on 5/9/24, 5/26/24, 7/3/24 and 7/13/24. Record review of Resident #27's electronic "Contacts" list revealed that Resident #27 was his own Responsible Party (RP). An interview with Resident #27 on 1/6/24 at 11:30 AM, he stated that he had not received a written notification of the facility bed-hold policy for any of his hospitalizations. Record review of the "Admission Record" revealed the facility admitted Resident # 27 on 3/15/21 with diagnosis that included Chronic Obstructive Pulmonary Disease. Record review of the Quarterly MDS with an ARD of 12/5/24 revealed Resident # 27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates he is cognitively intact. Resident #45 Record review Discharge MDS for Resident #45	F 625	from the facility are potentially affected. 3. On 1/7/2025 an audit was conducted of transfers back to 9/1/2024, to ensure resident representatives bed hold policy were mailed informing them of their respective resident's transfer to include bed hold policy reservation agreement. Results of audit included Twenty (20) letters were mailed to resident representatives informing them of their respective resident's transfer to the bed hold policy reservation agreement to ensure resident representatives bed hold policy were mailed informing them of their respective resident's transfer to include bed hold policy reservation agreement., reason for transfer, where resident was transferred and Ombudsman□s contact information. Beginning on 1/10/2025 the Administrator provided in-service to BOM (Business Office Manager) and Social Services Director regarding requirement for written notification to be presented/mailed to resident or resident representative following a resident□s transfer from the facility, to include the Bed hold Policy reservation agreement. 4. Beginning on 1/10/2025, the Business Office Manager will conduct an audit weekly for four (4) weeks, then monthly for three (3) months to determine for each transfer that a letter was mailed to include the Bed hold Policy Reservation agreement and logged on transfer letter tracking log. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings	

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F 625	Continued From page 14 with an ARD of 11/28/24 revealed, Section A-2000: Discharge Date: 11/28/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review Discharge MDS for Resident #45 with an ARD of 12/06/24 revealed, Section A-2000: Discharge Date: 12/06/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review Discharge MDS for Resident #45 with an ARD of 12/27/24 revealed, Section A-2000: Discharge Date: 12/27/24 ... Section A-2105: Discharge Status : coded Short-Term General Hospital. Review of the "Admission Record" revealed Resident #45 was admitted by the facility on 11/12/24 with a diagnosis of Malignant Neoplasm of Glottis. An interview with Social Services on 1/7/25 at 12:50 PM, she stated that she did not provide a written notification of the bed-hold policy to Resident #8, #27,or #45 for any of their hospital transfers. She stated that she did not realize that she needed to provide the residents or resident representative this notification. An interview with the Administrator on 1/7/24 at 2: 45 PM she stated that the importance of providing the resident or resident representative with a bed-hold notification was to give them an opportunity to decide if they want to hold their bed at the facility. The Administrator stated that her expectations were that Social Services would have provided the Resident/Resident Representative with a written bed-hold policy	F 625	will be submitted by the Business Office Manager to the QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Administrator is responsible for monitoring and compliance.	

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F 625	Continued From page 15 notification.	F 625		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review the facility failed to accurately complete "Section N" of the Minimum Data Set (MDS) assessment for a Resident, as evidenced by incorrectly coding anticoagulant medication usage during the 7-day observation look-back period for 1 (one) of three (3) residents reviewed for anticoagulant use. Resident # 17 Findings include: Review of the facility policy titled, "Certifying Accuracy of the Resident Assessment" with a revision date of November 2019 revealed "Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. ... 3 ...The information captured on the assessment reflects the status of the resident during the observation ("look-back") period for that assessment." Record review of the MDS with an Assessment Reference Date (ARD) of October 29, 2024, revealed under section N that Resident #17 received seven (7) days of anticoagulant medication for the observation look-back period of 10/23/24 through 10/29/24.	F 641	On 1/15/2025 The Annual Minimum Data Set (MDS) assessment for 10/29/2024 was modified and submitted by the MDS Registered Nurse (RN) #1 to reflect Resident #17 correction in coding anticoagulant not used in the look back period of 10/23/2024 to 10/29/2024. This correction was accepted effective 1/16/2025. On 1/14/25 an audit was conducted by the Registered Nurse MDS #1 to review for accurate coding of Section N1405E anticoagulant use. The audit reviewed 25 patients that had a Minimum Data Set assessment completed from 12/10/24 to 1/10/25. This audit had a 3 out of 25 error rates. On 1/13/2025 an in-service was conducted by the Regional Case Mix Registered Nurse with MDS Nurses on requirements to accurately coding of Section N1405E anticoagulant use per the Resident Assessment Instrument (RAI) Manual. Beginning on 1/13/2025, an audit will be conducted weekly for four (4) weeks by	1/31/25

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F 641	Continued From page 16 Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #17 did not receive anticoagulant medication between 10/23/24 and 10/29/24. An interview with the MDS Coordinator on 1/07/25 at 2:50 PM confirmed that Resident #17 was coded on the 7-day look-back period of 10/23/24 through 10/29/24 for receiving an anticoagulant medication. She revealed that the resident was not on an anticoagulant medication and that it was coded in error. Record review of the Admission Record for Resident #17 revealed the facility admitted the resident on 11/19/2019 with diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure.	F 641	Regional Case Mix Registered Nurse that will be submitted to the Administrator, DON and MDS RN Coordinator, then monthly for three (3) and quarterly thereafter to review accuracy of coding of Section N1405-E to involve anticoagulant use in the last 7 days. A report of audit findings will be submitted by MDS coordinator to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the MDS Registered Nurse #1 to the QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Administrator is responsible for monitoring and compliance.¿¿ The Director of Nursing is responsible for monitoring and compliance	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		1/31/25

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F 655	Continued From page 17 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to implement a baseline care plan related to preferences and personal hygiene	F 655	On 1/6/2025, Certified Nursing Assistant (CNA#1) completed a shower in accordance with resident preference with baseline care plan for Resident #195. On	

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F 655	Continued From page 18 care for (1) one of 29 resident care plans reviewed. (Resident #195) Findings include: Review of the facility policy titled, "Care Plans-Baseline," with a revision date of March 2022 revealed under "Policy Interpretation and Implementation...the baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality and must include the minimum healthcare information necessary to properly care for the resident..." Review of the Baseline care plan for Resident #195 dated 12/21/24, revealed, Daily preferences that a resident prefers: receiving showers checked. .... Functional Abilities and Goals-Self Care: Shower/bathe care: coded requires partial/moderate assistance. ... I.) Personal Hygiene: coded requires setup or clean-up assistance. An observation and interview with Resident #195 on 1/6/25 at 9:00 AM revealed his hair appeared mated and his fingernails were approximately one-half (1/2) inch past the tips of the fingers with a brown substance underneath. He stated that he had been in the facility a couple of weeks and had not had a shower, shave or brushed his hair. He stated that he told the staff during admission that he preferred showers and had asked for one several times. In an interview with the Minimum Data Set (MDS) Coordinator #2 on 1/07/25 at 10:50 AM, she revealed after reviewing the baseline care plan for Resident #195, that the care plan reflected	F 655	01/10/2025 RN (Registered Nurse) #1 interviewed Resident # 195 to ensure all resident preferences with ADL care were accurate and being followed. On 1/7/2025 the Administrator educated CNA#1 and CNA#2 on completion of ADL care according to residents' preferences. The facility determined that all residents have the potential to be affected. On 1/10/2025 an audit was completed by RN (Registered Nurse) #1 with Ninety-Six (96) residents to verify the accuracy of ADL care to include showers, nail care, and shaving. The audit results were care planned by the MDS (Minimum Data Set) team to ensure staff were following the residents' preferences on twelve (12) residents. On 1/10/2025 MDS (Minimum Data Set) team-initiated education with the Direct care staff on following the plan of care for resident preferences and how to utilize the Kardex, which contains the resident preferences. Beginning 1/10/2025 RN (Registered Nurse) Supervisor will observe five (5) residents' weekly observations for the next three (3) months to ensure staff provide care according to the care planned resident preferences. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance	

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F 655	Continued From page 19 that it was the resident's preference to receive showers and required assistance with bathing and personal hygiene. She then confirmed if staff did not shower the resident, they did not implement his care plan for his preferences. She also confirmed if staff did not assist the resident with bathing and personal hygiene needs, staff did not implement his care plan related to self-care performance. The MDS Coordinator also revealed the purpose of any type of care plan is to direct resident specific care required to meet their needs. Review of the "Admission Record" revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure. Record review of Resident #195's Admission MDS with an Assessment Reference Date (ARD) of 12/27/24, revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section GG0130: Self Care, revealed, E.) Shower/bathe: coded requires substantial/maximal assistance and I.) Personal Hygiene: coded requires supervision or touching assistance.	F 655	Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.¿¿	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		1/31/25

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F 656	Continued From page 20 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record reviews, and facility policy	F 656	On 01/07/2025, Resident #17 nails were cleaned and trimmed and facial hair	

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F 656	Continued From page 21 reviews, the facility failed to implement a comprehensive care plan for personal hygiene for three (3) of 23 resident care plans reviewed. Residents #17, #49, and #57 Findings include: Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" dated 10-2022 revealed under "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #17 Record review of Resident #17's "Care Plans", undated revealed "Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) decreased mobility and generalize weakness ...Interventions ...Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. The resident is totally dependent on one (1) staff with personal hygiene. On 1/06/25 at 9:30 AM, an observation and interview with Resident #17 revealed long and jagged fingernails with a brown substance under the nails on bilateral hands that measured approximately one (1) inch long. Facial hair measured approximately three-fourths (3/4) inch long to sporadic areas of her chin. Resident #17 stated, "I don't like these whiskers. They are very long, and they need to be cut." She revealed it's been a while since I've had my fingernails cut, and I would like them cleaned and trimmed.	F 656	shaved by CNA #2 in accordance with the resident's care plan. On 1/6/2025 Resident # 49 was shaved, and incontinence care was completed by CNA #2 in accordance with the resident's care plan. On 1/7/2025 Resident #57 nails were cleaned and trimmed along with facial shaving by CNA #2 in accordance with the resident's care plan. On 1/7/2025, the Administration educated CNA #1, CNA #2, CNA # 7 and CNA #8 on completion of ADL Care in accordance with resident's care plan. All residents had the potential to be affected. On 1/15/2025 Corporate Clinical Specialist initiated in-service with the Administrator and Director of Nursing on ADL Care to include resident preferences, care planning and best methods for completion. This in-service continued to all certified and licensed nursing staff by the Staff Development Coordinator to include how to read and understand the Point Click Care Kardex which shows the electronic care plan chart and provides a plan of care. On 1/10/2025 one hundred percent care plan audit completed. Beginning the week of 1/10/2025, Registered Nurse Supervisor will observe five (5) residents per week for three (3) months to ensure implementation of care plan preferences to include shaving, nail care, and incontinence care are being performed in accordance to orders, care plan, and Kardex in Point of Care on Point	

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F 656	Continued From page 22 On 1/07/25 at 1:00 PM, an observation and interview the Director of Nurses (DON) confirmed Resident #17's fingernails were long, jagged, and had a substance under them. The DON revealed that the nurses are responsible for trimming her fingernails since she is diabetic, and trimming her facial hair is part of her daily grooming when she gets a bed bath or shower. She revealed that with her fingernails, long and jagged, she could scratch herself and cause skin concerns. The DON confirmed that Resident #17 had long facial hair in her chin area and revealed that she had not been properly groomed. A review of the Admission Record revealed the facility admitted Resident #17 on 11/19/2019 with medical diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-29-2024 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates the resident is cognitively intact. Resident #49 Record review of Resident #49's "Care Plans," date initiated: 08/19/2024, revealed "Focus: The resident has an ADL self-care performance deficit r/t Activity Intolerance, Dementia, Limited Mobility ... Interventions: The resident is totally dependent on 1 staff with personal hygiene and oral care. The resident requires extensive assistance by two (2) staff for toileting.	F 656	Click Care. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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An observation on 1/06/25 at 08:15 AM, revealed a strong urine smell when standing by Resident #49's bed and with approximately ¾ inch of facial hair growth on his chin, above his lip, and on the sides of his cheeks. CNA #7 entered the room upon the State Agent's (SA) request and pulled back the blanket covering the resident. The resident was lying on a sheet that was saturated with urine extending from the right side of the resident's waist up to his torso and extending out approximately eight (8) inches towards the edge of the bed. The saturated urine area had a brown ring around the outer edges. CNA #7 confirmed that Resident #49 was lying in a large amount of urine and revealed that it looked like the night shift did not change him.

On 1/6/25 at 8:55 AM, during an interview the DON confirmed that Resident #49 had long facial hair and revealed she wasn't sure when he was last properly groomed. She revealed the plan of care regarding his hygiene was not being followed, and it should have been.

Record review of the Admission Record revealed Resident #49 was admitted to the facility on 08/07/2024 with diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis.

Resident #57

Record review of Resident #57's "Care Plans," date initiated: 10/20/2021, revealed "Focus: The resident has an ADL self-care performance deficit r/t Confusion, Impaired balance ... Interventions ... Personal Hygiene: The resident is totally dependent on two (2) staff members for personal hygiene.

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F 656	Continued From page 24 On 1/06/25 at 8:00 AM, an observation revealed Resident #57 lying in bed with approximately 1-inch long facial hair growth on his chin, above his lip, and on the sides of his cheeks. Resident #57's fingernails on bilateral hands were approximately one-half (1/2) inch long and jagged with a brown substance under his fingernails. On 1/06/25 at 8:30 AM, during an observation and interview the DON confirmed that Resident #57 was unshaven, and his fingernails were long, jagged, and dirty. The DON revealed that it is the CNAs' responsibility to ensure the resident is shaven and adequately groomed, and the nurses are responsible for his nail care since he is a diabetic. During an interview on 1/07/25 at 2:40 PM, the Minimum Data Set (MDS) Nurse #1 revealed both MDS Coordinators are responsible for developing the resident's care plans. She revealed that it is patient-centered and addresses all areas of care that the resident is to receive. She revealed that the comprehensive care plans for Residents #17, #47, and #59 were not followed if the residents were not adequately groomed. She revealed that personal hygiene and bathing also covered nail care, perineal care, and shaving. MDS Coordinator #1 revealed there is no excuse for a resident not to have the care specified in their care plan. Record review of the Admission Record for Resident #57 revealed he was admitted to the facility on 02/21/22 with diagnoses that included Need for Assistance with Personal Care and Type 2 Diabetes Mellitus.	F 656		

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F 677	Continued From page 25	F 677		
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, resident and staff interviews, record review, and facility policy review, the facility failed to provide personal hygiene for four (4) of 29 sampled residents. Residents #17, #49, #57, and #195 Findings include: Review of the facility policy titled "Activities of Daily Living (ADL), Supporting" with a revision date of March 2018 revealed, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. " Resident #17 An observation and interview with Resident #17 on 1/06/25 at 9:30 AM revealed long and jagged fingernails measuring approximately one (1) inch long past the tip of the fingers with a brown substance under the nails on bilateral hands, facial hair approximately three-fourths (3/4) inch long to sporadic areas of her chin. Resident #17 stated, "I don't like these whiskers. They are very long, and they need to be cut." She revealed it's been a while since she had her fingernails cut and wanted them cleaned and trimmed.	F 677	On 01/07/2025, Resident #17 nails were cleaned and trimmed and facial hair shaved by CNA #2 in accordance with the resident's care plan. On- 1/6/2025 Resident # 49 was shaved, and incontinence care was completed by CNA #2 in accordance with the resident's care plan. On 1/7/2025 Resident #57 nails were cleaned and trimmed along with facial shaving by CNA #2 in accordance with the resident's care plan. On 1/6/2025, Certified Nursing Assistant (CNA#1) completed a shower and ADL care to including shaving, nail care, and shower for Resident #195. On 1/7/2025 the Administrator educated CNA#1, CNA#2, CNA #7, and CNA #8 on completion of ADL care according to residents' preferences. All residents had the potential to be affected. On 1/15/2025 Corporate Clinical Specialist initiated in-service with in-service with Administrator and Director of Nursing on ADL Care to include resident preferences, care planning and best methods for completion. This in-service continued to all certified and	1/31/25

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F 677	Continued From page 26 An observation on 1/06/25 at 2:45 PM revealed Resident #17 sitting in the hallway with no change in appearance. An observation on 1/07/25 at 8:25 AM revealed Resident #17 with no change in appearance regarding long, jagged nails and long facial hair to the chin area. An observation and interview on 1/07/25 at 12:50 PM Certified Nurse Aide (CNA) #6 revealed she was assigned to Resident #17 today and confirmed the resident had a lot of facial hair to her chin area and the resident's fingernails were long and jagged with a brown substance under them. She revealed she couldn't cut the resident's fingernails but could have ensured they were cleaned up. Resident #13 told CNA #6 she wanted her nails trimmed and her facial hair removed. An observation and interview on 1/07/25 at 1:00 PM, the Director of Nurses (DON) confirmed Resident #17's fingernails were long, jagged, and had a substance under them. The DON revealed that the nurses are responsible for trimming her fingernails since she is diabetic, and trimming her facial hair is part of her daily grooming when she gets a bed bath or shower. She revealed that with her fingernails, long and jagged, she could scratch herself and cause skin concerns. The DON confirmed that Resident #17 had long facial hair in her chin area and revealed that she had not been properly groomed. During an interview on 1/07/25 at 1:47 PM, Licensed Practical Nurse (LPN) #1 revealed she cleaned and trimmed Resident #17's fingernails about a month ago. She revealed there is no set	F 677	licensed nursing staff by the Staff Development Coordinator to include how to read and understand the Point Click Care Kardex which shows the electronic care plan chart and provides a plan of care. On 1/10/2025 an audit of all residents was completed for activities of daily living (ADL). On 1/10/2025 Neighbor Rounds are being conducted weekly to observe for ADL completion. Beginning the week of 1/10/2025, Registered Nurse Supervisor will observe five (5) residents per week for three (3) months to ensure the completion of ADL care is being provided for dependent residents according to the plan of care to include shaving, nail care, and incontinence care. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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day to do nail care and there is not a reminder in the documenting system; she stated, "We just do nail care when we notice that it needs to be done. I take full responsibility for not doing her nail care."

Record review of the "Admission Record" revealed the facility admitted Resident #17 on 11/19/2019 with medical diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure.

Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-29-2024 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates the resident is cognitively intact.

Resident #49

On 1/06/25 at 08:15 AM, an observation revealed a strong urine smell when standing by Resident #49's bed. CNA #7 entered the room upon the State Agent's (SA) request and pulled back the blanket covering the resident. The resident was lying on a sheet that was saturated with urine extending from the right side of the resident's waist up to his torso and extending out approximately eight (8) inches towards the edge of the bed. The saturated urine area had a brown ring around the outer edges. CNA #7 confirmed that Resident #49 was lying in a large amount of urine and stated, "You can tell he has not been changed in a while because of that brown ring around the outer edge." This observation also revealed Resident #49 with approx. ¾ inch of facial hair growth on his chin, above his lip, and on the sides of his cheeks.

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During an observation and interview on 1/06/25 at 8:20 AM, LPN #1 confirmed she could smell a strong urine smell and that the urine-saturated sheet had a dried brown ring. She revealed that the urine looked like it had been there for a while and confirmed the resident was unshaven and unkempt.

During an observation and interview on 1/06/25 at 8:30 AM, the Administrator (ADM) confirmed that Resident #49 was lying on a urine-saturated sheet with a brown ring around the outer edges of the stain. She revealed that this is not acceptable and confirmed that he doesn't look like he has been groomed in quite some time and has been left wet for a while.

An observation and interview on 1/6/25 at 8:35 AM CNA #7 revealed she is assigned to the resident today and made quick rounds when she came on her shift at 7 AM, just glancing in at her residents, and Resident #49 was asleep; she revealed she hadn't changed his brief this morning because she got busy assisting with breakfast. She stated the resident had not been shaved in quite some time, and "with his sheets being wet, I can tell you that the night shift did not change him like they were supposed to."

During an interview on 1/6/25 at 8:55 AM, the DON confirmed that Resident #49 had long facial hair and revealed she wasn't sure when he was last properly groomed. She revealed there was no excuse for the resident to be found lying in urine and stated, "We obviously have an issue with care not being done."

Record review of the Admission Record revealed

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Resident #49 was admitted to the facility on 08/07/2024 with diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis.

Resident #57

An observation on 1/06/25 at 8:00 AM revealed Resident #57 lying in bed with facial hair growth on his chin, above his lip, and on the sides of his cheeks that was approximately 1 inch long. Resident #57's fingernails were approximately one-half (1/2) inch long, jagged and had a brown substance underneath them on both hands.

During an observation and interview on 1/06/25 at 8:10 AM, LPN #1 confirmed Resident #57 was unshaven with fingernails that were long and jagged, with a brown substance under them. She revealed she wasn't sure when the resident was shaven, but it looks like it has been a while. She revealed it is the nurses' responsibility to do his nail care since he is diabetic and revealed we do it whenever we notice they are getting long. She confirmed it had been about a month since the resident's nails were trimmed.

During an observation and interview on 1/06/25 at 8:20 AM, CNA #8 revealed she was assigned to the resident today and wasn't sure what day the resident was supposed to get his showers. She revealed we take them when they need to be cleaned up or give them a bed bath. She revealed that it looked like the resident hadn't been shaven in a long time, and his nails were very long and dirty.

During an observation and interview on 1/06/25 at 8:30 AM, the DON confirmed that Resident #57

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was unshaven, and his fingernails were long, jagged, and dirty. She revealed that the resident could scratch himself and possibly cause an infection. The DON stated, "The CNA's are responsible for making sure residents are properly groomed, and it honestly looks like it's been a while since that has happened."

Record review of the Admission Record for Resident #57 revealed he was admitted to the facility on 02/21/22 with diagnoses that included Need for Assistance with Personal Care and Type 2 Diabetes Mellitus.
Resident #195

An observation and interview on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. Resident #195 stated he had been in the facility for a little over two weeks and had not received a shower, a shave, or even had his hair brushed. He then stated that his nails had also not been trimmed or cleaned since he was admitted. Resident #195 stated he had asked for a shower several times and the staff would say ok but would never come back to give him a shower, and stated, "I am unable to get up by myself, or I would try to do it myself."

In an observation of Resident #195 on 1/6/24 at 12:10 PM with CNA #1 assigned to the resident, she confirmed that the resident's hair and beard were unkept and did not appear clean. She then stated he did not appear that he had received a shower lately and confirmed the resident's nails were dirty, long, and jagged with some type of brown substance under his nail beds. She then

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confirmed she had not attempted to do nail care on the resident or give him a shower. CNA #1 then revealed the facility did not have a shower schedule in place letting the staff know when the residents are to be bathed and stated that nail care should be provided as needed.

In an interview with the shower CNA #2 and record review on 1/06/24 at 1:00 PM, she confirmed the facility did not have a set shower schedule for the residents. CNA #2 then revealed that when a resident receives a shower by the shower team that it would be documented on the shower schedule. She then confirmed she was unable to find any documentation of showers for Resident #195.

During an interview with the DON on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule at this time. She stated "The facility had one in place for a while, but no one was following up on it, so it was stopped." She confirmed she was aware there was a problem with residents not receiving showers and confirmed she should have put something in place before now. She then stated concerns from failing to provide a resident with their showers and personal hygiene, is it could cause skin irritation, infection control issues, and dignity concerns.

Review of the "Admission Record" revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure.

Record review of Resident #195's Admission MDS with an ARD of 12/27/24, revealed the BIMS score was 13, indicating the resident was cognitively intact. Section GG0130: Self Care,

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F 677	Continued From page 32 revealed, E.) Shower/bathe: coded requires substantial/maximal assistance ... I.) Personal Hygiene: coded requires supervision or touching assistance.	F 677		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to provide a Registered Nurse (RN) eight (8) hours a day for one (1) of 14 staffing days reviewed. Findings Include Record review of the facility policy titled, " Staffing, Sufficient and Competent Nursing" with a review date of 3-2023 revealed under "Policy Interpretation and Implementation: Sufficient Staffing...A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week..."	F 727	On 12/27/2024 the Administrator and Director of Nursing reviewed the resident electronic clinical records for any adverse events to include falls, hospitalization transfers, or Intravenous medications missed that may have occurred due to this deficient practice. No adverse events noted. On 12/27/2024, the Administrator conducted education with the Director of Nurses on the CMS (Center for Medicare and Medicaid Services) requirements on RN coverage in facility for eight (8) consecutive hours for seven (7) days a week.	1/31/25

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F 727	Continued From page 33 Record review of the Staffing Grid for the dates of 12/24/24 through 1/6/25 revealed there was no RN coverage on 12/25/24. An interview on 1/6/25 at 11:15 AM with the Director of Nurses (DON) confirmed there was no RN coverage on 12/25/24. She stated that the RN that was scheduled did not call in or show up and no one notified her. She stated that she figured it out around noon on Christmas Day when she looked through the computer at the time clock ins. She admitted that she did not come to cover it, everyone else was on vacation and they are not allowed to use agency RN for coverage. She confirmed that the purpose of having an RN on duty is for supervision to handle emergencies or intravenous medications (IV). She admitted there were no incidents or IV therapy on 12/25/24. An interview on 1/6/25 at 2:45 PM with the Administrator confirmed there was no RN coverage on 12/25/24. She stated that the DON put an RN on the schedule that had already requested off for that day and is not sure if the DON just forgot or was not aware. She confirmed that they need an RN for at least 8 hours a day to handle emergencies and IV's. She verifies that the DON was the person that should have covered it. A follow up interview on 1/6/25 at 3:00 PM with the DON confirmed that she does the schedule, and she put an RN on the schedule that had requested off, but she was not aware of her request. She stated that after she put the schedule out that the RN called and told her that she had already requested off for that day. When asked if she expected her to come to work after	F 727	All residents had the potential to be affected. On 1/10/2025 the Director of Nursing initiated Inservice with all nursing staff on the licensed requirements with eight (8) hour coverage of Registered Nurse for seven (7) days a week. Beginning the week of 1/10/2025, the Director of Nurses will audit daily staffing to ensure every day has a Registered Nurse for eight (8) hours. This audit will be turned in weekly to the Administrator to review for compliance for three (3) months then quarterly thereafter. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing and Administrator is responsible for monitoring and compliance.	

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F 727	Continued From page 34 that phone conversation she stated, "she never said she wasn't". When asked if she should have come in and covered, she stated, "Yes but I was not coming in to cover someone else's responsibility and miss my family."	F 727		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse,	F 851		1/31/25

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F 851	Continued From page 35 certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of the four quarters reviewed. Fourth quarter 2024 Findings include: Record review of the facility policy titled, "Reporting Direct-Care Staffing Information	F 851	On 1/09/2025, the Administrator and Director of Nursing completed an audit of all direct care hours worked 10/1/2024 through 12/31/2024. Any direct care hours worked by Department Managers/Salaried Staff, that were not submitted correctly for Payroll Based Journal purposes, were immediately corrected in the facility's payroll system.	

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F 851	Continued From page 36 (Payroll-Based Journal)" Dated October 2022, revealed, ... 10 ...Staffing data includes the number of hours worked each day by each staff member." Record review of "PBJ Staffing Data Report CASPER (Certification and Survey Provider Enhanced Reporting) Report 1705D FY (Fiscal Year) Quarter 4 2024 (July 1-September 30)" revealed "Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low." During an interview on 1/09/25 at 8:27 AM with the Administrator and the Director of Nurses (DON), they confirmed that the data entered for the fourth quarter PBJ was entered incorrectly and did not capture the full direct care on the PBJ. The DON revealed they had an issue with employees failing to clock out and in for weekend mealtimes, affecting their overall weekend hours.	F 851	The resident daily population was not affected by the practice of not correctly reporting and submitting Department Managers/Salaried Staff hours, worked in direct care, to Centers for Medicare and Medicaid. On 1/10/2025, the Payroll Based Coordinator educated the Administrator and Director of Nurses on mandatory submission of staffing information based on payroll data. On 1/10/2025, all Department Managers/Salaried Staff were in-service by the Director of Nurses on reporting all hours, worked in direct care, clocking out during meals and working required scheduled time. Beginning 1/10/2025 all Department Managers/Salaried Staff will be required to submit a Payroll Edit form to the Director of Nursing and Administrator, for any hours worked in direct care, on a daily basis. Beginning 1/10/2025, the Corporate Payroll Based Journal Coordinator will confirm receipt of direct care hours, worked by Department Managers/Salaried Staff, bi-weekly for 2 (two) months and then quarterly for 1 (one) year. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the Payroll Based Coordinator to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director	

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F 851	Continued From page 37	F 851	of Nursing and Administrator is responsible for monitoring and compliance.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		1/31/25

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F 880	Continued From page 38 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene for one (1) of five (5) resident direct care observations. Resident #37	F 880	On 1/8/2025 Resident #37 was reviewed and assessed by the Director of Nursing for any adverse reactions due to failure to prevent the possibility of infections by failing to utilize proper hand hygiene during a direct care observation on	

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F 880	Continued From page 39 Findings include: Review of the facility policy titled, "Handwashing-Hand Hygiene Policy and Procedures" with a revised date of 10-2020 revealed, "This facility considers hand hygiene the primary means to prevent the spread of infections." ... 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...g. Before handling clean or soiled dressings, gauze pads, etc...; k. After handling used dressings ..." An observation and interview on 1/8/25 at 9:50 AM with Registered Nurse (RN) #1 providing wound care for Resident #37 with the Director of Nurses (DON) present revealed RN #1 washed her hands, applied clean gloves after removing the residents wound bandage. RN#1 then cleaned Resident #37's sacral wound, patted the wound bed with a dry gauze and then applied Santyl ointment to the wound without changing her soiled gloves, washing her hands, and applying clean gloves. RN #1 confirmed she had not washed her hands and changed her gloves between the dirty and clean procedures and acknowledged that not practicing proper infection control measures could potentially cause an infection in the wound. An interview on 1/08/25 at 2:34 PM with the DON confirmed proper hand hygiene was not performed during the wound treatment for Resident #37 and confirmed their policy is to make sure to change gloves and wash hands between dirty and clean wound treatment. She revealed that not doing so is an infection control	F 880	1/8/2025 by state surveyor. No adverse reactions were found. On 1/8/2025 the Assistant Director of Nurses was educated by the Director of Nursing on proper hand hygiene and completed a wound care skilled check off to include the monitoring of infection control practices and hand hygiene. No issues were found. All residents have the potential to be affected. On 1/9/2025 the Director of Nurses in-serviced nursing staff on the infection control practices to include hand hygiene during all direct resident care. On 1/9/2025 skilled wound care check offs were initiated on all licensed nurses to ensure accurate infection control practices were followed during direct care to include wound care. On 1/10/2025 the Infection Preventionist will make observation rounds on three (3) resident wound care treatments to ensure that accurate infection control practices were followed during direct care. These observations will occur weekly times four (4) weeks and then monthly for three (3) months. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the Infection Preventionist to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director	

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F 880	Continued From page 40 issue and could delay healing. A record review of Resident #37's Admission Record revealed the resident was admitted to the facility on 09/17/2024 with diagnoses that included a Pressure Ulcer of the Sacral Region, Stage 4.	F 880	of Nursing is responsible for monitoring and compliance.	