| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/24/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Polaris Rehabilitation and Care Center** | **2700 E 12th Street , Cheyenne, Wyoming, 82001** |

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| F0000 | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare Licensing and Surveys from 10/21/25 to 10/24/25. The survey was prompted by complaint intakes #2598930, #2611934, #2639318, #2647189, #2646274, #2646289, and #2646316.<br><br>The following common abbreviations are used throughout this document:<br><br>ADL: Activities of Daily Living<br><br>BIMS: Brief Interview for Mental Status<br><br>CNA: Certified Nursing Assistant<br><br>DON: Director of Nursing<br><br>EVS: Environmental Services<br><br>LPN: Licensed Practical Nurse<br><br>MDS: Minimum Data Set<br><br>mg: milligram<br><br>NHA: Nursing Home Administration<br><br>RA: Resident Assistant<br><br>RN: Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F0000 | | |
| F0557<br>SS = D | Respect, Dignity/Right to have Prsnl Property<br><br>CFR(s): 483.10(e)(2)<br><br>§483.10(e) Respect and Dignity.<br><br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal | F0557 | 1. Corrective Action for Residents Found Affected:<br><br>Resident #1 – The resident's care plan was reviewed and updated to ensure the resident's right to dignity and respect was maintained during dining and daily care. The resident's care plan was reviewed and updated to reflect this expectation. The resident was assessed with no negative outcomes identified.<br><br>Resident #5 – The Social Services Director or designee met with the resident to discuss the resident's right | 11/21/2025 |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0557 SS = D | Continued from page 1<br>possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, medical record review, and resident and staff interview, the facility failed to ensure residents were treated with dignity and respect during 4 random observations which affected residents #1 and #5. The census was 71. The findings were:<br><br>1. Review of the 8/7/25 significant change MDS assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. The following concerns were identified:<br><br>a. Observation on 10/21/25 at 4:58 PM showed resident #1 was brought to the dining room and placed at the dining table with nothing in front of him/her. The resident was observed picking at the tablecloth. Meal service began at 5:07 PM and resident #1 was served his/her meal at 5:35 PM with assistance provided by CNA #2. CNA #2 was observed assisting resident #9 at 5:07 PM before moving to assist resident #1 at 5:35 PM.<br><br>b. Observation on 10/22/25 at 8:36 AM showed the resident was brought to the dining room for the morning meal at 8:36 AM. At 8:53 AM the resident was offered a beverage; however, was not served his/her meal until 8:58 AM.<br><br>c. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. The resident's back was turned to the dining room so s/he was looking at the wall. At 8:38 AM the resident was observed to independently drink an entire glass of water, move the tablecloth around, and pick-up and examine a tissue box. At 8:48 AM the resident was served breakfast by a nursing student. The nursing student sat with the resident and attempted to assist him/her with the meal. The nursing student asked the resident if s/he would like something to drink; however, the nursing student did not provide a beverage. At 8:56 AM the resident began to eat with the assistance of the nursing student. At 9:15 AM the resident attempted to drink from the empty water glass; more water was provided. At this time the resident was observed to use a spoon with his/her left hand and was able to bring the food to | F0557 | Continued from page 1<br>to retain personal possessions as outlined in their care plan. The Social Services Director or designee provided counseling support to Resident #5 regarding the room organization process and ensured the resident's consent and participation in any future room management activities.<br><br>2. Identification of Other Residents at Risk:<br><br>The DON or designee reviewed the care plans and dining assistance needs of residents requiring meal assistance to identify those with similar needs as Resident #1. The Social Services Director or designee reviewed care plans of residents with hoarding behaviors or extensive personal belongings to ensure their rights to retain personal possessions are being respected. Care plans were updated as needed.<br><br>3. Systemic Changes/Measures to Prevent Recurrence:<br><br>The Staff Development Coordinator or designee will educate all staff on or before 11/21/2025 on respect and dignity, including examples of maintaining dignity during the dining process and obtaining resident permission before entering or removing items from resident rooms.<br><br>4. Monitoring:<br><br>The DON or designee will complete at least 5 observations weekly for 4 weeks, then monthly for 2 months, to ensure residents requiring assistance receive timely meal service and appropriate supervision. The Social Services Director or designee will interview 5 residents weekly for 4 weeks, then monthly for 2 months, to ensure that residents have no concerns about unapproved room entry or removal of possessions. Results of the audits will be brought to QAPI for 3 months and until substantial compliance is achieved.<br><br>5. Date of Compliance: November 21, 2025 | |

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| F0557 SS = D | Continued from page 2<br>his/her mouth. The nursing student removed the utensil from the resident's hand and began to feed the resident herself. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. From 9 AM until 9:28 AM the only facility staff member in the dining room was RA #2; no staff members trained to assist residents with eating were present to supervise the nursing student.<br><br>d. Interview with restorative aide #1 on 10/22/25 at 1:30 PM revealed the resident required assistance with eating and was fed last so his/her food was "hot".<br><br>e. Interview with CNA #3 on 10/22/25 at 2:30 PM revealed only one person was assigned to the dining room during meal service and they were expected to do everything.<br><br>f. Interview with CNA #2 on 10/22/25 at 4 PM revealed the dining room was only staffed with 1 person when ideally 3 people were needed. In addition, the CNA stated 2 residents required assistance with eating; one resident would be assisted while the other one had to wait.<br><br>g. Interview with the DON and NHA on 10/24/25 at 12:43 PM revealed the residents, which required assistance with eating, should sit at the same table and be served at the same time.<br><br>2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Review of the resident's care plan, initiated on 6/25/24, showed "HOARDING: [resident] has a large collection of items, posing risk for falls" Interventions included to "Encourage [resident] to frequently declutter, Respect [resident's] right to collect items that do not pose risk, Speak respectfully and kindly when discussing [resident's] room, and Staff to help [resident] feel safe and secure." The following concerns were identified:<br><br>a. Observation and interview with resident #5 on 10/21/25 at 2:02 PM revealed s/he was "upset because the [NHA] had someone come into [his/her] room and go through [his/her] things" while s/he was in the hospital. The resident stated the NHA had directed the social worker to inform him/her that his/her room was a | F0557 | | |

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| F0557<br>SS = D | Continued from page 3<br>"fire hazard" and needed to be cleaned up. Observation of the resident's room showed the area was cluttered and unorganized and the dresser drawers appeared to be broken.<br><br>b. Review of a social services note, dated 10/6/25, showed "we discussed organizing [the resident's] room, [s/he] does not have family to assist in this as all family lives far away. [The resident] will need bins or bookshelves in order to complete this. [S/he] will look in to getting these so staff can help assist [him/her] to organize [his/her] room."<br><br>c. Interview with the social services director on 10/22/25 at 9:59 AM revealed the NHA had sent her an email asking her to approach 7 different residents to inform them their rooms needed to be cleaned up. The social worker revealed she had spoken with resident #5 and offered to assist her with cleaning up her room since she did not have any family to help her.<br><br>d. Review of nursing notes showed the resident was admitted to the hospital on 10/17/25 and was readmitted to the facility on 10/19/25.<br><br>e. Interview with the EVS manager on 10/24/25 at 9:38 AM revealed she was instructed by the NHA to enter resident #5's room while the resident was in the hospital to retrieve any property which belonged to the facility. The EVS manager confirmed she had entered the resident's room without the resident's consent and had found and removed items such as linens and clothing protectors which belonged to the facility.<br><br>f. Interview with the NHA on 10/24/25 at 12:43 PM confirmed she had authorized the EVS manager to enter the resident's room to remove any items which belonged to the facility. | F0557 | | |
| F0580<br>SS = D | Notify of Changes (Injury/Decline/Room, etc.)<br><br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; | F0580 | 1. Corrective Action for Residents Found Affected:<br><br>Resident #6 – The physician and responsible party were notified of the diet change, and the order was clarified. The resident's care plan was updated to reflect the correct diet order. The resident was assessed with no adverse outcomes noted.<br><br>2. Identification of Other Residents at Risk:<br><br>The DON and Dietary Manager audited all residents' diet orders to ensure that diet slips matched current physician orders. Discrepancies were reviewed with the medical provider for clarification. | 11/21/2025 |

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| F0580<br>SS = D | Continued from page 4<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident<br><br>representative(s).<br><br>§483.10(g)(15)<br><br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, resident representative interview, staff interview, and policy and procedure review, the facility failed to ensure a notification of change of condition was given for 1 of 8 sample | F0580 | Continued from page 4<br><br>3. Systemic Changes/Measures to Prevent Recurrence:<br><br>The Staff Development Coordinator or designee will educate all licensed nurses and dietary staff on or before 11/21/2025 on the facility's notification process when there is a change in condition, treatment, or diet order. Education will include timely notification of physicians and responsible parties and accurate documentation in the medical record.<br><br>4. Monitoring:<br><br>The Dietary Manager will audit 10 resident tray cards weekly for 4 weeks, then monthly for 2 months, to ensure that tray cards match current orders in PCC. Results of the audits will be brought to QAPI for 3 months and until substantial compliance is achieved.<br><br>5. Date of Compliance: November 21, 2025 | |

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| F0580 SS = D | Continued from page 5<br>residents (#6) reviewed. The findings were:<br><br>1. Review of the 10/9/25 admission MDS assessment for resident #6 showed the resident had a BIMS score of 12 out of 15 (moderately cognitively impaired), required partial to moderate assistance for toileting, showers, upper and lower body dressing, and putting on and taking off footwear. The resident had diagnoses which included diabetes mellitus type 2 (DM2), transient cerebral ischemic attack, Parkinson's disease, muscle weakness, and dysphagia. Review of the care plan showed "NUTRITIONAL STATUS: [resident name] is at risk for nutrition related problems r/t [related to] Parkinson's, DM2, PNA [pneumonia], dysphagia, anemia, HTN [hypertension], chronic respiratory failure, transient cerebral ischemic attack, AOC respiratory failure, falls. Resident/family decline recommended NPO diet and request regular chopped textures. They have been educated on risks associated with declining recommendations and understand risks involved with PO intake given MBSS indicating aspiration on all textures. Date Initiated: 10/04/2025 Revision on: 10/09/2025, Target Date: 01/13/2026. Explain and reinforce to the resident the importance of maintaining the diet ordered." Review of the physician orders showed diet, regular texture, regular consistency. The following concerns were identified:<br><br>a. Interview with resident #6 on 10/21/25 at 2:10 PM revealed s/he was getting enough food; however, was not sure what was being served as it was in the form of "blobs."<br><br>b. Interview with the residents' family on 10/23/25 at 4:25 PM revealed the resident was to be on a regular diet, not a mechanical soft diet. The resident's representative stated the facility did not notify them of the change in diet for the resident.<br><br>c. Review of the meal card for the resident on 10/23/25 showed a mechanical soft chopped diet was specified for all 3 meals.<br><br>d. Interview with the NHA on 10/24/25 at 12:50 PM revealed the resident's diet was recommended following a speech language pathology evaluation, and confirmed the family was not notified of the diet change.<br><br>2. Review of policy "Change in a Resident's Condition or Status" hand delivered on 10/23/25 at 5:15 PM by the NHA showed "...4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury | F0580 | | |

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| F0580 SS = D | Continued from page 6<br>including injuries of an unknown source. b. there is a significant change in the resident's physical, mental, or psychosocial status..." | F0580 | | |
| F0677 SS = D | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§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;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, resident representative interview, and staff interview, the facility failed to ensure routine bathing was provided for 2 of 8 sample residents (#1, #5) reviewed for activities of daily living. The findings were:<br><br>1. Review of the 8/7/25 significant change assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. Review of the resident's ADL care plan, last revised 9/15/25, showed the resident was a 1 to 2 person assist with bathing and preferred showers on Tuesdays and Fridays. The following concerns were identified:<br><br>a. Review of the October 2025 bathing documents, provided by the facility on 10/23/25 at 5:23 PM, showed the resident was given a bed bath on 10/8/25 at 11 PM and a shower on 10/16/25 (2 baths in 22 days). Interview with LPN #1 on 10/23/25 at 5:30 PM confirmed the bathing sheets were correct.<br><br>b. Interview with the resident's representative on 10/23/25 at 3:57 PM revealed the facility "said they were going to bathe [him/her] but do not do it."<br><br>2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Further review showed the resident was not coded as rejecting care during the look-back period. Review of the resident's care plan, last revised 8/20/25, showed the resident preferred a shower in the morning right after breakfast | F0677 | 1. Corrective Action for Residents Found Affected:<br><br>Resident #1 – The resident's bathing schedule was reviewed and updated to ensure preferred shower days are clearly listed in the care plan. The resident was provided a shower per preference.<br><br>Resident #5 – The resident's care plan and documentation were reviewed. The resident was provided a shower per preference.<br><br>2. Identification of Other Residents at Risk:<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>3. Systemic Changes/Measures to Prevent Recurrence:<br><br>The Staff Development Coordinator or designee will educate all CNAs, nurses, and scheduling staff on or before 11/21/2025 on the importance of providing and documenting scheduled ADL care, including bathing and hygiene routines, Chart-As-You-Go documentation, and proper documentation of refusals. Education will include how to document ADL care in Point of Care (POC) Charting and how to utilize Quick Entry Charting for bathing documentation to ensure tasks are completed and accurately recorded in real time.<br><br>4. Monitoring:<br><br>The DON or designee will conduct at least 5 bathing care and documentation observations weekly for 4 weeks, then monthly for 2 months to ensure residents are receiving showers or baths as scheduled and refusals are documented accurately. Results of the audits will be brought to QAPI for 3 months and until substantial compliance is achieved.<br><br>5. Date of Compliance: November 21, 2025 | 11/21/2025 |

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| F0677 SS = D | Continued from page 7<br>twice a week on Tuesday and Friday. Further review of the resident's care plan, initiated on 8/25/25, showed the resident was resistive to bathing/showering, at times, with interventions which included "If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. Document all refusals." The following concerns were identified:<br><br>a. Review of the "Daily Shower Sheets", dated 10/3/25 through 10/24/25, for the resident showed the resident had received a bed bath on 10/10 after refusing on 10/8 and 10/9, and was in the hospital from 10/17 to 10/19. Review of the nurse progress notes showed the resident was educated on the importance of bathing on 10/9/25 and 10/15/25. There was no documentation the resident had refused to be bathed. No further documentation was available.<br><br>3. Interview with the DON and NHA on 10/24/25 at 12:40 PM revealed they had identified the need to provide a better quality of care. | F0677 | | |
| F0686 SS = D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br><br>§483.25(b)(1) Pressure ulcers.<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, medical record review, staff interview, and policy review the facility failed to ensure interventions to prevent ulcers development were implemented for 2 of 4 residents (#1, #2) reviewed for pressure ulcers. The findings were:<br><br>1 Review of the 2/17/25 admission MDS assessment, showed resident #1 was coded as being severely | F0686 | 1. Corrective Action for Residents Found Affected:<br><br>Resident #1 – The resident was assessed by the ADON, and all current wounds and pressure areas were evaluated. Preventive and treatment interventions were reviewed and updated in the resident's care plan to include heel offloading devices, repositioning frequency, and use of an appropriate pressure-relieving surface.<br><br>Resident #2 – The resident was evaluated by the ADON, and all skin areas were assessed for integrity. Interventions were initiated and documented in the care plan to prevent additional skin breakdown. The resident's treatment orders were reviewed with the attending physician to ensure appropriate wound management and prevention practices were in place.<br><br>2. Identification of Other Residents at Risk:<br><br>All residents have the potential to be affected by the alleged deficient practice.<br><br>3. Systemic Changes/Measures to Prevent Recurrence:<br><br>The Staff Development Coordinator or designee will educate all licensed nurses and CNAs on or before 11/21/2025 on Skin Integrity and Pressure Injury Prevention. Education will include: | 11/21/2025 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0686<br>SS = D | Continued from page 8<br>cognitively impaired and had diagnoses which included non-traumatic brain dysfunction, dementia, severe, with mood disturbance, deep vein thrombosis, diabetes mellitus, thyroid disorder, arthritis, non-Alzheimer's dementia, malnutrition, post traumatic stress disorder, anxiety, depression, disorder of bone density and structure, and other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain. The assessment showed the resident required assistance of supervision or setup for toileting, showers, upper body dressing, lower body dressing, putting on footwear, and personal hygiene. Further, review showed the resident was at risk for pressure ulcer development, did not have any pressure ulcers, and had a pressure reducing device in bed and chair. Review of the 5/7/25 quarterly MDS assessment showed the resident was coded as being severely cognitively impaired. The assessment showed the resident was independent with eating, oral hygiene, and required supervision/setup assistance for toileting, showers, upper body dressing, lower body dressing, putting on footwear, and personal hygiene. Further review the resident was at risk for pressure ulcer development, did not have any pressure ulcers, and had a pressure reducing chair. Review of the "Skin and Wound - Total Body Skin Assessments for 6/15/25 through 10/17/25 showed new wounds 0, except on 7/30/25 which showed 1 new wound. Review of the medical records showed the left heel wound was new on 7/29/25, the left dorsum wound was new on 7/29/25, and the right medial heel wound was new on 9/1/25. The following concerns were identified:<br><br>a. Review of the 8/7/25 significant change MDS assessment showed the resident was coded as being severely cognitive impaired. The assessment showed the resident was totally dependent for the ADLs of eating, oral hygiene, toilet, shower, upper body dress, lower body dress, putting on footwear, and personal hygiene. Further, review showed the resident was at risk for pressure ulcer development and had one unhealed stage 3 pressure ulcer. The resident had a pressure reducing chair and bed and was receiving pressure ulcer/injury care.<br><br>b. Review of the care plan showed "SKIN/CONNECTIVE TISSUE: [Residents name] is at risk for skin impairment related to. [Resident name] will maintain clean and intact skin throughout review, initiated on 2/12/25 with the target date of: 12/30/25. The intervention was weekly skin checks by licensed nurse dated 2/12/25. Further review showed other interventions were added on 10/21/25 e.g. barrier cream as needed, cushion around and under boney prominences, good nutrition and | F0686 | Continued from page 8<br>- Performing thorough weekly and shift-change skin assessments,<br><br>- Timely identification and reporting of skin changes to the charge nurse and ADON,<br><br>- Implementation of preventive interventions (turning/repositioning schedules, heel offloading, moisture management, and use of pressure-relieving devices),<br><br>- Documentation of skin observations in PCC,<br><br>- Coordination with the ADON for prompt physician notification and treatment updates.<br><br>4. Monitoring:<br><br>The ADON or designee will conduct at least 5 skin care and documentation observations weekly for 4 weeks, then monthly for 2 months to ensure preventive interventions and treatments are implemented and documented according to the resident's care plan. Results of the audits will be brought to QAPI for 3 months and until substantial compliance is achieved.<br><br>5. Date of Compliance: November 21, 2025 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535025 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/24/2025 |
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| F0686 SS = D | Continued from page 9<br>hydration, pressure reducing cushion to wheelchair, needs pressure relieving device to bed."<br><br>c. Review of the "Skin and Wound - Total Body Skin Assessment dated 7/30/25 showed the residents' skin turgor was poor elasticity, skin color pale, temperature was warm (normal, moisture was normal, condition was dry, new wounds was 1. Review of the nursing progress notes showed on 7/30/25 at 1:36 PM "Ensure resident to wear Gripper socks in bed and at all times.", and "Pt [patient] is in puff boots."<br><br>d. Review of "Compassionate Concierge Physicians (CCP) Mobile Wound Care" note dated 7/31/25 showed "...New patient Eval for Stage 3 Pressure Ulcer of Left Heel...Polaris staff reporting pressure wound to left heel that started about two weeks prior. Upon examination, there are offloading booties present. Left heel wound present with bruising..." Review of the 10/20/25 wound care team notes showed "...wound location: left heel, left medial foot, right heel...right hip the facility to manage. Frequency was CCP to change All dressing 2 times a week (Mon/Thurs). Polaris left heel: change 5 times a week and as needed if soiled or misplaced (Sun/Tues/Wed/Fri/Sat and as needed), All other wounds change 1 time a week and as needed if soiled or misplaced (Sat and as needed)."<br><br>e. Observation of the resident on 10/23/25 at 12:40 PM, while CCP was finishing wound care, showed the resident was lying on his/her back, heels down on the mattress, blue boots were on the bed, a heel lift cushion was beside the bed, a ribbed mattress, and a wedge was between the resident's legs. Interview at that time with the CCP provider revealed the resident had a new pressure ulcer to the buttock stage 1. The CCP provider stated they were going to recommend an air mattress. Further, interview revealed the facility calls the agency when they want a wound check.<br><br>f. Interview with the wound care nurse on 10/22/25 at 1 PM revealed she was hired on as the wound care nurse in August. She stated she was doing the best she could with the assessments; however, she continued to be assigned to the floor to work.<br><br>g. Interview with a CNA on 10/22/25 during the afternoon revealed when s/he did the bed bath for the resident the day before the pressure ulcer was identified the resident's socks were not removed during the bath The CNA confirmed s/he would not have been able to tell if there were wounds to the lower extremities. | F0686 | | |

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| F0686 SS = D | Continued from page 10<br>2. Review of 8/22/25 admission MDS assessment for resident #2 showed s/he was coded as being moderately cognitive impaired, The assessment showed the resident required partial/moderate assistance with eating, toileting, showers, upper body dressing, lower body dressing, and putting on footwear. The diagnoses included repeated falls, displaced fracture of upper end of left humerus, weakness, other specified disorders of bone density and structure, and diabetes mellitus. Further, review showed the resident was at risk for pressure ulcer development, had no pressure ulcers, and had a pressure reducing chair and bed. Review of the 8/17/25 care plan showed skin/connective tissue goal to maintain clean and intact skin. The interventions included weekly skin checks by a licensed nurse. The following concerns were identified:<br><br>a. Review of a nursing progress notes dated 8/30/25 at 11:12 AM showed "This nurse assessed residents skin and observed a sacral would (sic). Odor is present with white appearance on wound. Wound nurse notified with pictures taken on wound care phone." Review of the nursing progress note dated 8/31/25 at 10:17 AM showed "...#002: Skin issue has not been evaluated. Location: Coccyx. Issue type: Pressure ulcer / injury. Wound acquired in-house." Further review of the nursing progress noted showed on 8/31/25 at 2:09 PM "SBAR Summary: Vitals Signs: BP 103/60 - 8/31/2025 13:12 Position: Other , P 60 - 8/31/2025 13:12 Pulse Type: Irregular - new onset , R 20.0 - 8/31/2025 10:36, T 98.0 - 8/31/2025 10:36 Route: Forehead (non-contact), ...RN Assessment/LPN Appearance of resident - What I think is going on with the resident is: Sepsis."<br><br>b. Review of the "Weekly Skin Assessment" dated 8/29/25 showed the skin turgor: good, elasticity, color: normal, temperature: warm (normal), moisture: normal, condition: normal, no new wounds noted.<br><br>c. Interview with the wound care nurse on 10/23/25 at 2:50 PM revealed the resident did not have a pressure ulcer upon admission.<br><br>3. Review of policy "Pressure Injury Prevention Guidelines" hand delivered on 10/23/25 at 4:10 PM showed "To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present." "...Preventive Skin Care: 1 . Inspect skin while providing care, paying close attention to bony prominences. .." | F0686 | | |
| F0690 SS = D | Bowel/Bladder Incontinence, Catheter, UTI | F0690 | 1) Corrective Action for Affected Residents: | 11/21/2025 |

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| F0690<br>SS = D | Continued from page 11<br><br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br><br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, resident and staff interview, and review of concern forms, the facility failed to provide timely incontinence care to 2 of 8 sample residents (#1, #5). The findings were:<br><br>1. Review of the 8/7/25 significant change assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. The following concerns were identified: | F0690 | Continued from page 11<br><br>Resident #1 and Resident #5 received incontinence care per need; care plans and documentation were updated accordingly.<br><br>2) Identification of Other Residents with Potential to be Affected:<br><br>DON or designee reviewed residents who are incontinent or who have indwelling catheters to ensure plans of care are appropriate and being followed; toileting assistance and incontinence care needs were verified.<br><br>3) Measures Put into Place / Systemic Changes:<br><br>Staff Development Coordinator or designee will educate CNAs and Licensed Nurses on or before 11/21/2025 on: (a) timely incontinence care per care plan; (b) monitoring for moisture/redness/irritation with prompt nurse notification; and (c) accurate documentation of care and observations.<br><br>4) Plan to Monitor Performance:<br><br>DON or designee will complete at least 5 observations weekly x4 weeks, then monthly x2, to ensure residents receive timely incontinence care and that any signs of moisture, skin redness, or irritation are reported to the nurse. Results of the audits will be brought to QAPI for 3 months and until substantial compliance is achieved.<br><br>5) Date of Compliance:<br><br>11/21/2025 | |

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| F0690 SS = D | Continued from page 12<br>a. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. The resident remained in the therapy room and was a passive participant until 11:50 AM when s/he was taken back to the dining room and placed at the same table as before. The resident was offered a glass of water at 11:53 AM in which s/he drank half. At 12:11 PM the contractual wound care nurse approached the resident at the dining room table and then transferred him/her back his/her room to provide wound care. The resident was transferred using a Hoyer lift by LPN #1 and CNA #2 to his/her bed and then exited the room for the wound care team to provide care. At 12:59 PM the wound care team exited the resident's room. At 1:50 PM RA #1 was observed bringing the resident's noon meal into the room and then left stating she needed to find a nurse or CNA to assist the resident with the meal. At 1:53 PM LPN #1 and a nursing student entered the room where incontinence care was provided (approximately 6 hours). LPN #1 confirmed the resident's brief was wet.<br><br>2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Further review showed the resident had an indwelling catheter and was frequently incontinent of bowel. Review of the resident's ADL care plan, last revised 9/5/25, showed the resident required a bedpan for bowel movements with the extensive assist of 2 staff members for placement. The following concerns were identified.<br><br>a. Interview with the resident on 10/21/25 at 2:02 PM revealed s/he was not receiving care in a timely manner and had telephoned the facility to request help because his/her call light was not being answered. Review of a 10/20/25 concern form, provided by the resident showed the form was completed with the assistance of the business office manager (BOM). The description of the concern showed "Resident had to call the facility to get assistance on the bed pan. [BOM] in the business office came to address needs. [Resident] stated [s/he] has been waiting to be put on bed pan. [S/he] stated [CNA #5] came to his/her room stated she did not have time to put resident on bedpan due to needing to complete bed baths. Call light was going off the whole-time cares were being performed and nobody | F0690 | | |

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| F0690<br>SS = D | Continued from page 13<br>covered the light. This was on for about an hour and unsure how long it was on prior. This is the second time resident had to call the facility to have [his/her] needs addressed. The first time was 10/16/25. It was also evident that pericare was not being performed. The same staff member was working from (sic) 10/20/25 and 10/16/25 (sic) was working the floor on these occasions." In addition, the concern form stated this concern had been previously voiced.<br><br>b. Interview with the BOM on 10/22/25 at 1 PM confirmed the resident had phoned the facility asking for assistance. The BOM stated she was also a CNA and went to the resident's room to assist the resident with the bedpan. The BOM confirmed the resident's call light was on for approximately 1 hour while she provided care to the resident with no response from the unit staff.<br><br>2. Interview with the DON and NHA on 10/24/25 at 12:40 PM revealed they had identified the need to provide a better quality of care. | F0690 | | |
| F0725<br>SS = F | Sufficient Nursing Staff<br><br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35 Nursing Services.<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a) Sufficient Staff.<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (f) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides. | F0725 | 1) Corrective Action for Affected Residents:<br><br>Residents on all units received prioritized assistance and supervision while staffing was stabilized; resident care needs identified during rounds were addressed on or before 11/21/2025<br><br>2) Identification of Other Residents with Potential to be Affected:<br><br>All residents have the potential to be affected. DON and Administrator reviewed unit coverage and resident acuity to ensure staffing assignments meet care needs.<br><br>3) Measures Put into Place / Systemic Changes:<br><br>Implementation of a full time Shower Aide position on 11/11/2025. Southeast hall closed on 11/7/2025 to condense resident care areas and improve response times. Contract initiated with Clipboard staffing agency to assist in filling open shifts. Administrator will review staffing during daily stand up to ensure appropriate deployment.<br><br>4) Plan to Monitor Performance:<br><br>Administrator or DON/designee will complete at least 5 observations weekly x4 weeks, then monthly x2, to verify sufficient staff are present to meet resident needs and that residents receive timely assistance and supervision. Results of the audits will be brought to | 11/21/2025 |

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| F0725<br>SS = F | Continued from page 14<br><br>§483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, medical record review, resident representative and resident interview, review of resident council minutes, and concern forms, and staff interview, the facility failed to ensure sufficient nursing staff was available to provide the highest practicable physical, mental, and psychosocial well-being on 2 of 2 resident care units (North hall, South hall). The census was 71. The findings were:<br><br>1. Review of the 8/7/25 significant change MDS assessment for resident #1 showed s/he was determined to be severely cognitively impaired and exhibited inattention and disorganized thinking on a continuous basis, and suffered from delusions. The resident was totally dependent on staff for all areas of self-care and mobility. Review of the resident's ADL care plan, last revised 9/15/25, showed the resident was a 1 to 2 person assist with bathing and preferred showers on Tuesdays and Fridays. The following concerns were identified:<br><br>a. Observation on 10/21/25 at 4:58 PM showed resident #1 was brought to the dining room and placed at the dining table with nothing in front of him/her. The resident was observed picking at the tablecloth. Meal service began at 5:07 PM and resident #1 was served his/her meal at 5:35 PM with the assistance of CNA #2. CNA #2 was observed assisting resident #9 at 5:07 PM before moving to assist resident #1.<br><br>b. Observation on 10/22/25 at 8:36 AM showed the resident was brought to the dining room for the morning meal at 8:36 AM. At 8:53 AM the resident was offered a beverage; however, was not served his/her meal until 8:58 AM.<br><br>c. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. The resident's back was turned to the dining room so s/he was looking at the wall. At 8:38 AM the resident was observed to independently drink an entire glass of water, move the tablecloth around, and pick-up and examine a tissue box. At 8:48 AM the resident was served breakfast by a nursing student. The nursing student sat with the | F0725 | Continued from page 14<br>QAPI for 3 months and until substantial compliance is achieved.<br><br>5) Date of Compliance:<br><br>11/21/2025 | |

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| F0725 SS = F | Continued from page 15<br>resident and attempted to assist him/her with the meal. The nursing student asked the resident if s/he would like something to drink; however, the nursing student did not provide a beverage. At 8:56 AM the resident began to eat with the assistance of the nursing student. At 9:15 AM the resident attempted to drink from the empty water glass; more water was provided. At this time the resident was observed to use a spoon with his/her left hand and was able to bring the food to his/her mouth. The nursing student removed the utensil from the resident's hand and began to feed the resident herself. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and taken to the therapy room. From 9 AM until 9:28 AM the only facility staff member in the dining room was RA #2; no staff members trained to assist residents with eating were present to supervise the nursing student.<br><br>d. Interview with restorative aide #1 on 10/22/25 at 1:30 PM revealed the resident required assistance with eating was served last so his/her food was "hot".<br><br>e. Interview with CNA #3 on 10/22/25 at 2:30 PM revealed only one person was assigned to the dining room during meal service and they were expected to do everything.<br><br>f. Interview with CNA #2 on 10/22/25 at 4 PM revealed the dining room was only staffed with 1 person when ideally 3 people were needed. In addition, the CNA stated 2 residents required assistance with eating; one resident would be assisted while the other one had to wait.<br><br>g. Review of the bathing documents provided by the facility on 10/23/25 at 5:23 PM showed the resident was given a bed bath on 10/8/25 at 11 PM and a shower on 10/16/25 (2 baths in 22 days.) Interview with LPN #1 on 10/23/25 at 5:30 PM confirmed the bathing sheets were correct.<br><br>h. Interview with the resident's representative on 10/23/25 at 3:57 PM revealed the facility "said they were going to bathe [him/her] but do not do it."<br><br>i. Observation on 10/23/25 at 7:58 AM showed the resident was seated at a small table in the dining room, which faced the back wall, and had a glass of water in front of him/her. At 9:28 AM the resident was removed from the table and was moved to the hallway in front of the North nurses' station where s/he sat until 10:53 AM when s/he was approached by a therapist and | F0725 | | |

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| F0725 SS = F | Continued from page 16<br>taken to the therapy room. The resident remained in the therapy room and was a passive participant until 11:50 AM when s/he was taken back to the dining room and placed at the same table as before. The resident was offered a glass of water at 11:53 AM in which s/he drank half. At 12:11 PM the contractual wound care nurse approached the resident at the dining room table and then transferred him/her back his/her room to provide wound care. The resident was transferred using a Hoyer lift by LPN #1 and CNA #2 to his/her bed and then exited the room for the wound care team to provide care. At 12:59 PM the wound care team exited the resident's room. At 1:50 PM RA #1 was observed bringing the resident's noon meal into the room and then left stating she needed to find a nurse or CNA to assist the resident with the meal. At 1:53 PM LPN #1 and a nursing student entered the room where incontinence care was provided (approximately 6 hours). LPN #1 confirmed the resident's brief was wet.<br><br>2. Review of the 9/16/25 quarterly MDS assessment for resident #5 showed a BIMS score was not determined; however, the staff assessment for mental status showed the resident to be independent with consistent/reasonable decision making. Further review showed the resident was not coded as rejecting care during the look-back period. Review of the resident's care plan, last revised 8/20/25, showed the resident preferred a shower in the morning right after breakfast twice a week on Tuesday and Friday. Further review of the resident's care plan, initiated on 8/25/25, showed the resident was resistive to bathing/showering, at times, with interventions which included "If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. Document all refusals." Review of the resident's ADL care plan, last revised 9/5/25, showed the resident required a bedpan for bowel movements with the extensive assist of 2 staff members for placement. The following concerns were identified:<br><br>a. Review of the "Daily Shower Sheets", dated 10/3/25 through 10/24/25, for the resident showed the resident had received a bed bath on 10/10 after refusing on 10/8 and 10/9, and was in the hospital from 10/17 to 10/19. Review of the nurse progress notes showed the resident was educated on the importance of bathing on 10/9/25 and 10/15/25. There was no documentation the resident had refused to be bathed. No further documentation was available.<br><br>b. Interview with the resident on 10/21/25 at 2:02 PM revealed s/he was not receiving care in a timely manner | F0725 | | |

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| F0725 SS = F | Continued from page 17<br>and had telephoned the facility to request help because his/her call light was not being answered. Review of a 10/20/25 concern form, provided by the resident showed the form was completed with the assistance of the business office manager (BOM). The description of the concern showed “Resident had to call the facility to get assistance on the bed pan. [BOM] in the business office came to address needs. [Resident] stated [s/he] has been waiting to be put on bed pan. [S/he] stated [CNA #5] came to his/her room stated she did not have time to put resident on bedpan due to needing to complete bed baths. Call light was going off the whole-time cares were being performed and nobody covered the light. This was on for about an hour and unsure how long it was on prior. This is the second time resident had to call the facility to have [his/her] needs addressed. The first time was 10/16/25. It was also evident that pericare was not being performed. The same staff member was working from 10/20/25 and 10/16/25 (sic) was working the floor on these occasions.” In addition, the concern form stated this concern had been previously voiced.<br><br>b. Interview with the BOM on 10/22/25 at 1 PM confirmed the resident had phoned the facility asking for assistance. The BOM stated she was also a CNA and went to the resident’s room to assist the resident with the bedpan. The BOM confirmed the resident’s call light was on for approximately 1 hour while she provided care to the resident with no response from the unit staff.<br><br>3. Review of the 8/25/25 resident council minutes showed “Old Business: Residents had filled out a grievance form for the issues presented at the June council meeting that had not been completed…and being told short staffing is the reason for long call lights, late meals, and not getting things when needed. New Business: The grievance from the last meeting was discussed. Residents stated they are happy that the AC is back in the activities room, but they are still being told that we are short-staffed all the time. Residents discussed staffing, stating they are being told we are short-staffed, and they believe it, as they are not receiving timely bed changes and showers. Call lights take a long time to be answered, and staff are turning the lights off and stating they will be right back, which often takes a considerable amount of time for them to return. Additionally, staff sometimes forget and do not return.” The minutes showed the residents completed a grievance form related to staffing. Review of the 9/22/25 resident council meeting minutes showed no evidence the grievance submitted by the resident council was acted upon. Further review showed the “Open Forum” section noted | F0725 | | |

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| F0725 SS = F | Continued from page 18<br>concerns of “Lack of communication between staff and residents, call lights turned off, and staff not returning in an acceptable amount of time.” Review of the Complaint/Concern/Compliment/Tracking Log showed no grievances related to staffing had been submitted on behalf of the resident council in August or September of 2025.<br><br>5. Staff interviews were conducted throughout the survey timeframe. The following concerns were identified:<br><br>a. Interview with staff #1 revealed s/he was unable to perform his/her job due to having to do the CNAs tasks prior to providing rehabilitation services. Staff #1 stated residents were not receiving quality care and cited repositioning, assistance to the toilet, incontinence care, proper pericare, and call lights not within reach. In addition, staff #1 stated there was not enough staff; communication was poor; and there was no follow through.<br><br>b. Interview with staff #2 revealed it was difficult to find a second person to assist with the Hoyer lift and found it difficult to complete his/her charting due to the lack of staffing. In addition, staff #2 stated the facility did not have a staff member assigned as a shower aide to assist with resident bathing and was lacking supplies such as “wipes” and “briefs”.<br><br>c. Interview with staff #3 revealed s/he had “never seen the facility this bad” with staff being stressed.<br><br>d. Interview with staff #4 revealed s/he had multiple responsibilities throughout the facility and did not have enough time to complete the additional tasks due to management continuously requiring him/her to work “the floor” to provide resident care. In addition, staff #4 stated lifts were being used inappropriately; there was an increase in falls due to residents not being rounded on properly; and resident bathing was not being completed in a timely manner. Further, staff #4 stated 2 CNAs on the North hall was inadequate due to the high acuity of the residents and staff were “frustrated because they did not know how to fix it.”<br><br>e. Interview with staff #5 revealed the facility did not have adequate staff to meet the needs of the residents and stated the residents on the North hall required more assistance with activities of daily living than the residents on the South hall. Further, the facility often lacked adequate supplies and staff would have to search the building for “wipes” and other supplies such as denture cleaner, denture adhesive, | F0725 | | |

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| F0725 SS = F | Continued from page 19<br>tissues, lotion, and draw sheets.<br><br>f. Interview with staff #6 revealed the low staffing level put a strain on the remaining staff; however, they were doing the best they could. Staff #6 stated it was a struggle to find a second person to assist with resident care when required; was unable to complete showers in a timely manner; the facility was short on supplies, and there was no routine in the North hall which s/he found to be challenging.<br><br>g. Interview with staff #7 revealed s/he had multiple responsibilities throughout the facility and did not have enough time to complete the additional tasks due to management continuously requiring him/her to work “the floor” to provide resident care. In addition, staff #7 revealed the facility was often low on supplies such as “wipes” and glucose strips.<br><br>h. Interview with staff #8 revealed the current staff did not work as a team. S/he stated it was a struggle to find a second person to assist with resident care, when required, and a lot of time was wasted searching for help which frustrated both the staff members and the residents. Staff #8 further revealed the North hall had a few residents which were “needy” and certain CNAs would not address their needs which led to their call lights being left on for extended periods of time. Further, the facility was short of bariatric briefs and “wipes” and staff would have to “scramble” or someone from management would be sent out to “shop”.<br><br>i. Interview with staff # 9 revealed the therapy department was unable to work efficiently due to the residents’ basic cares not being addressed, the high acuity of residents, and the lack of staff impeded the ultimate goal of discharge. Staff #9 stated 35% of the residents on the North hall and 51% of the residents on the South hall required a lift for transfers.<br><br>j. Interview with staff #10 revealed s/he was unable to perform his/her responsibilities up to “[his/her] own standards”. Staff #10 stated s/he was overwhelmed and felt like s/he was rushing through cares; was unable to help residents with “the little stuff”; was not providing showers as per the schedule; was unable to round on his/her residents every two hours and oftentimes s/he would only be able to round 3 times per a 12-hour shift.<br><br>k. Interview with staff #11 revealed everyday was hectic with the weekends being even worse. Staff #11 stated s/he was overwhelmed and could not give his/her “best care” noting showers were not being completed | F0725 | | |

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| F0725 SS = F | Continued from page 20<br>timely; charting was not done; meals were delivered late; and s/he admitted to transferring a resident, who required 2 staff members, without assistance because s/he could not find help.<br><br>l. Interview with staff #12 revealed the day-shift staff struggled to complete resident care in a timely manner leaving residents in wet incontinence products for extended periods of time.<br><br>m. Interview with staff #13 revealed s/he had observed residents which did not receive adequate pericare and timely incontinence care which made it difficult for the therapy department to provide rehabilitation services because the therapy department would have to either wait for the CNAs to perform the task or step in and perform the task themselves. In addition, staff #13 revealed facility staff were stressed as the human resource director, maintenance director, and admissions director recently were terminated from their positions, and the director of nursing had “walked out”. Further, staff #13 stated it was his/her opinion staff did not work as a team to provide resident care.<br><br>n. Interview with staff #14 revealed the administrator had informed the staff the facility was not short-staffed and their numbers were “okay”. Staff #14 stated resident care was not “okay”.<br><br>o. Interview with staff #15 revealed it was difficult to complete his/her job due to having to either wait for a CNA to provide care prior to a rehabilitation session or having to provide the care him/herself. Staff #15 stated if s/he provided the care it would “cut into the minutes” s/he could work with the resident. In addition, s/he had seen a “decline in the last month” with staff being overwhelmed.<br><br>p. Interview with staff #16 revealed the facility had “a lot of shake-ups lately”.<br><br>q. Interview with staff #17 revealed treatment plans were not being followed due to resident needs not being addressed which caused the residents’ rehabilitation sessions to be “rushed”.<br><br>6. Interview with the NHA on 10/24/25 at 12:43 PM revealed the corporation had recently developed a census tool to determine the staffing needs of the facility. The NHA stated the facility was working within the provided budget and "on paper" the facility was adequately staffed.<br><br>7. Interview with the chief executive officer (CEO) of | F0725 | | |

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| F0725 SS = F | Continued from page 21<br>the corporation on 10/24/25 at 1:47 PM revealed the corporation was "doing what they could and finding CNAs was challenging". The CEO stated the facility was "always trying to meet the PPD established to help them to be a reliable business"; however, the facility's census was currently about 20 residents short of average. In addition, the CEO stated they were doing the best they could and did not want to "cut direct care." | F0725 | | |
| F0757 SS = G | Drug Regimen is Free from Unnecessary Drugs<br><br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on medical record review, staff interview, and review of medication interactions, the facility failed to ensure residents did not receive unnecessary medications for 1 of 8 (#1) sample residents reviewed. This failure caused harm to resident #8 whose functional capacity declined from independent to dependent. The findings were:<br><br>1. Review of the 2/7/25 admission MDS assessment for | F0757 | 1) Corrective Action for Affected Residents:<br><br>Resident #1: MAR and physician orders were reviewed; valproic acid taper/discontinuation and lacosamide order changes from external providers were verified as implemented; duplicate or interacting medications were reconciled; and the care plan and documentation were updated.<br><br>Any other residents with active medication changes had orders verified and implemented per provider direction; documentation was updated accordingly.<br><br>2) Identification of Other Residents with Potential to be Affected:<br><br>DON or designee identified residents currently prescribed valproic acid, olanzapine, melatonin, or combinations thereof by reviewing the current MARs and orders, and verified that any specialist or hospital discontinuation orders were implemented. Potential drug interactions or duplications were reviewed with the provider for clarification or adjustment as indicated.<br><br>3) Measures Put into Place / Systemic Changes:<br><br>Staff Development Coordinator or designee will educate Licensed Nurses on or before 11/21/2025 on: (a) verifying accuracy and indication for all medication orders; (b) implementing provider/specialist discontinuation or change orders as prescribed; and (c) promptly communicating potential duplications or interactions to the provider and documenting actions taken.<br><br>4) Plan to Monitor Performance:<br><br>DON or designee will complete at least 5 audits weekly x4 weeks, then monthly x2, with confirmation that: (1) medications are administered per order; (2) medication changes or discontinuation orders are implemented as prescribed; and (3) medication regimens remain appropriate based on clinical needs. Results of the audits will be brought to QAPI for 3 months and until | 11/21/2025 |

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| F0757 SS = G | Continued from page 22<br>resident #1 showed the resident was coded as being severely cognitively impaired with inattention and disorganized thinking continuously present; wandered 4 to 6 days of the look-back period; was coded as requiring supervision or setup assistance for all self-care areas and was independent with mobility. The resident was not coded as receiving an anticonvulsant medication. Review of the 5/7/25 quarterly MDS assessment showed the resident continued to be independent with mobility and was not coded as receiving an anticonvulsant medication. Review of the 8/7/25 significant change MDS assessment showed the resident was coded as being totally dependent on staff for all self-care and mobility areas. The resident was coded as receiving an anticonvulsant. The following concerns were identified:<br><br>a. Interview with the resident's representative on 10/23/25 at 3:50 PM revealed he recalled the resident participated in the July 4th celebration at the facility and by July 19th was unable to function. The resident's representative stated the facility had failed to follow orders from a neurologist to discontinue the valproic acid (anticonvulsant) medication which he thought caused the resident to be overmedicated.<br><br>b. Review of the 7/10/25 and 7/26/25 hospital's "After Visit Summary" showed the reason for the resident's visit was "Altered Mental Status". Further review of the 7/26/25 "After Visit Summary" showed the resident had diagnoses of somnolence and a history of seizure. The discharge instructions showed "Please start taking the lacosamide (anticonvulsant), in 2 days, stop the valproic acid. If breakthrough seizures, please increase the lacosamide to 100 mg twice daily. If worsening symptoms return to the Ed." Further instructions stated a follow-up appointment with a neurologist should be scheduled as soon as possible.<br><br>c. Review of the July 2025 medication administration record (MAR) showed the resident was administered 5 mg of olanzapine twice daily for behaviors with a start date of 6/30/25 and a discontinue date of 7/25/25; 5 mg of olanzapine once daily for behaviors with a start date of 7/25/25; 100 mg of lacosamide two times a day for seizures with a start date of 6/15/25 and a discontinue date of 7/26/25; 50 mg of lacosamide two times a day for post traumatic seizures with a start date of 7/26/25; and 5 ml of 250 mg/5ml valproic acid oral solution 3 times a day for post traumatic seizures with an order date of 7/1/25 and a discontinue date of 8/28/25. The resident was also prescribed 1 ml of lorazepam-diphenhydramine-haloperidol-ondansetron cream | F0757 | Continued from page 22<br>substantial compliance is achieved.<br><br>5) Date of Compliance:<br><br>11/21/2025 | |

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| F0757 SS = G | Continued from page 23<br>to be applied topically every 4 hours as needed with a start date of 5/19/25. The resident received 1 dose on 7/1 and 7/2; 2 doses on 7/3 and 7/5; 3 doses on 7/6, 1 dose on 7/8, 3 doses on 7/9, 1 dose on 7/10, 7/12, 7/13, and 7/14. No further doses were applied and the medication was discontinued on 8/28/25.<br><br>d. Review of the August 2025 MAR showed 5 ml of a 250 mg/5 ml valproic acid oral solution was to be administered 3 times per day for post traumatic seizures with a start date of 7/1/25 and a discontinue date of 8/18/25. Further review showed an order dated 8/18/25 for the same dose of valproic acid to be administered two times per day every Tuesday, Wednesday, and Thursday and then decreased to 2.5 ml once a day for 3 days and then to discontinue. The medication was discontinued on 8/29/25.<br><br>e. Continued review of the resident's August 2025 MAR showed the resident was administered melatonin for insomnia starting on 5/29/25, paroxetine (antidepressant) for major depressive disorder starting on 6/6/25, and olanzapine (an atypical antipsychotic) for unspecified dementia, severe with mood disturbance, and major depressive disorder starting on 7/25/25.<br><br>f. Review of a 6/25/25 nurse's note showed the resident had behaviors of "wandering, intrusive pacing, clenching fists, sharp voacal (sic) tone, shrugging away staff who approach to greet [him/her] and turning [his/her] back and changing directions, 'stating, Leave me alone!"<br><br>g. Review of the nurses' progress notes for July 2025 failed to include when or what triggered the decline in the resident's functional status.<br><br>h. Review of a 8/4/25 nurse's note showed "Follow up scheduled today from previous hospital visit at neurology...Resident is unable at times to sit up in wheelchair for staff to attempt to take [him/her]..."<br><br>i. Review of a 8/17/25 nurse's note, showed "Residents son approached this nurse and stated that he wants resident off of Valproic Acid. This nurse educated son of mechanism of action of the medication and reason for being on this medication and the risk of seizure activity when taken off the drug. Residents son stated an understanding and is willing to take the risk of resident being tapered off medication. Residents son requested keppa (sic) as a alternate. This nurse notified NP and awaiting orders."<br><br>j. Interview with CNA #4 on 10/22/25 at 4:30 PM | F0757 | | |

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| F0757 SS = G | Continued from page 24<br>revealed the resident was ambulatory and had aggressive behaviors upon admission and had declined after the onset of seizures. The CNA stated the resident had improved and was now able to communicate in complete sentences.<br><br>k. Interview with RN #1 on 10/21/25 at 4:39 PM revealed the resident was mobile upon admission; however, did not know what had caused the resident's decline from independent to dependent. The RN stated the resident used to be bed-bound and required repositioning every hour. In addition, the RN stated the resident had improved since s/he was taken off valproic acid.<br><br>l. According to WebMD located at https://www.webmd.com/interaction-checker/default.htm and accessed on 11/4/25 showed significant interaction was possible and monitoring by a physician was required as valproic acid, olanzapine, and melatonin each cause an increase in sedation and drowsiness.<br><br>2. Interview with the DON and NHA on 10/24/25 at 12:40 PM revealed neither were in the facility in July. They stated they did not know what happened with the medications and the resident at that time. In addition, both the DON and NHA revealed they had identified the need to provide a better quality of care. | F0757 | | |