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F 000	INITIAL COMMENTS	F 000		
Ok ✓ Lg	Correction date: 7/9/2025 The following deficiencies resulted from the facility's special focus recertification survey and investigation of complaints # 128433-C, and #128732-C, conducted June 6, 2025 to June 9, 2025. Complaint #128433-C resulted in a deficiency. Complaint #128732-C did not result in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 628 SS=D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 628	✓	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Gwaltney	Administrator	6/28/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

§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 (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

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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;
(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

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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(l).

§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

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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.

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and policy review the facility failed to document a resident's transfer to the hospital, physician and family notification, and a bed hold for 1 of 3 residents reviewed. (Resident #7) The facility

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reported a census of 75 residents.

Findings include:

The Minimum Data Set (MDS) for Resident #7 dated 4/10/25, included diagnoses of Non-Alzheimer's Dementia, stroke, and heart failure and a Brief Interview for Mental Status score of 99 indicating the resident was not able to complete the assessment due to severe cognitive impairment.

Resident #7's Clinical Census documented the resident on hospital leave 1/27/25 - 2/12/25.

The Progress Notes for Resident #7's revealed the following:
1/28 - 2/11/25 - hospitalized.
2/3/25 at 5:43 PM - resident was admitted to the hospital.
2/12/25 at 1:20 PM - resident returned.

Review of Resident #7's Progress Notes 1/27/25 - 2/12/25 lacked documentation of the resident's transfer to the hospital, physician and family notification of transfer to the hospital, and bed hold completed.

Resident #7's hospital discharge and transfer form dated 2/12/25 documented primary discharge diagnosis of altered mental status.

Facility policy "Transfer and Discharge" reviewed/revised 2/2025 revealed:
1. The facility will obtain a physician's order for emergency transfer
2. For transfer to another provider, ensure necessary information is provided along with the facility's transfer form.

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F 628	Continued From page 6 3. Document assessment findings and other relevant information regarding the transfer in the medical record. 4. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative. On 6/9/25 at 1:20 PM, the Corporate Nurse confirmed she was unable to find any documentation in the resident's electronic health record (EHR) on the resident assessment prior to transfer to the hospital, the bed hold provided to the family, transferring information provided to the receiving facility, and physician and family notification. Additionally, the Corporate Nurse stated her expectation for all the information to be documented in the resident's EHR.	F 628		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 641		

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(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and policy review the facility failed to accurately complete a Minimum Data Set (MDS) Assessment by not identifying a resident had a serious mental illness as considered by the state level II Preadmission Screening and Resident Review (PASRR) for 1 of 16 residents (Resident #34) reviewed. The facility reported a census of 75 residents.

Findings include:

The MDS for Resident #34, dated 3/22/25, included diagnoses of Psychotic Disorder, Anxiety Disorder, and depression and documented the resident was not currently considered by the state level II PASRR process to have serious mental illness.

Resident #34's Notice of PASRR Level II Outcome dated 1/20/24, revealed an approved PASRR Level II outcome with the determination explanation of the resident meets PASRR criteria for serious mental illness for the diagnosis of Major Depressive Disorder.

Facility policy, "Conducting an Accurate Resident

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F 641	Continued From page 8 Assessment" reviewed/revised 1/2025 revealed that all residents receive an accurate assessment and correctly document the resident's medical, functional, and psychosocial problems. On 6/09/25 at 2:21 PM, the Corporate Nurse stated her expectation was the resident's MDS to be completed accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to submit an updated Preadmission Screening and Resident Review (PASRR) evaluation for 1 of 4 residents reviewed with mental health diagnosis and medications (Resident #31). The facility reported	F 644		

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a census of 75 residents.

Findings include:

Review of the Minimum Data Set (MDS) dated 5/10/25, revealed Resident #31 was admitted to the facility on 5/12/2023, a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact and diagnoses of cancer, heart failure, peripheral vascular disease, renal insufficiency, alcoholic cirrhosis of liver, cannabis abuse, Werrnicke's encephalopathy (serious brain disorder caused by a deficiency of thiamine. Often associated with chronic alcohol abuse) delusional disorders, Non-Alzheimer's Dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated Resident #31 is taking the following pharmacological classed medications; antipsychotics, antianxiety, antidepressant, anticoagulant, diuretic, and hypoglycemic.

Review of Resident #31's Care Plan indicated the following:
1. Created on 12/26/2023, Resident #31 is at risk for alterations in mood and behaviors, as evidenced by time of being non-compliant with cares, treatments, and medications. Resident #31 has a history of trouble adjusting to the nursing facility and blaming family for placement. This is related to dementia, delusional disorder, depression and anxiety. Resident #31 also has a history of cannabis and alcohol use.
2. Created on 12/18/2024, Resident #31 is at risk for verbal behavioral symptoms related to depression, ineffective coping skills, and poor impulse control.
3. Created on 5/4/2023, Resident #31 has impaired cognitive function/dementia or impaired

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thought processes related to Werrnicke's Encephalopathy.
4. Created on 5/24/2023, Resident #31 uses antianxiety medications, hydroxyzine and buspirone related to anxiety.
5. Created on 5/24/2023, Resident #31 uses antidepressant medications, duloxetine and mirtazapine related to depression.
6. Created on 5/24/2023, Resident #31 uses psychotropic medications related to behavior management.
7. Created 1/28/2025, Resident #31 has a diagnosis of anxiety, depression, with loss of impulse and takes antianxiety medication, antidepressants and antipsychotics.

Review of Resident #31's Order Summary Report, revealed Resident #31 receives the following medications:
1. Buspirone 10mg by mouth three times daily for anxiety.
2. Duloxetine 60mg by mouth twice daily for depression.
3. Hydroxyzine 25mg by mouth three times daily for anxiety
4. Mirtazapine 15mg by mouth at bedtime for depression.
5. Risperidone 1mg by mouth at bedtime for delusional disorders.

Review of Resident #31's PASRR, submitted on admission, dated 6/5/2023 indicated Resident #31 had no mental health diagnoses, substance related diagnoses, or dementia/neurocognitive disorders. No interpersonal behaviors or mental health symptoms. And Resident #31 was not receiving mental health medications including, antidepressants, mood stabilizers, antipsychotics, or other mental health medications. The PASRR

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outcome rationale stated the following: The level I screen indicates that a PASRR disability is not present because of the following reason: there is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted.

During an interview on 6/4/25 at 10:51 AM, Staff D, Social Services, stated audits had been completed on all Resident's PASRRs that are in Point Click Care (PCC)(Electronic Health Record Program) and stated the PASRRs in PCC are the most current for each resident. Staff D, reviewed Resident #31's PASRR located in PCC and stated she will check the online site to see if there were more current PASRR documents for Resident #31.

On 6/04/25 at 4:40 PM, Staff D, Social Services, stated the provided PASRR is all the facility had and had been informed by Administration this document had been reviewed during the last certification in December of 2024, and found there was no concerns with it so no changes had been made.

During an interview on 6/5/25 at 11:27 AM, Staff G, Administration, stated Resident #31's PASRR had been asked about during the Recertification in December 2024, this discussion was not related to Resident #31's current diagnoses and medications. Staff G stated the PASRR should have been resubmitted with Resident #31's current diagnoses and medications at the time Resident #31's Care Plan was updated indicating the diagnoses, behaviors, and medications.

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Review of Facility provided, Resident Assessment- Coordination with PASARR Program Policy, revised 2/2025 stated the following:
This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.
1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.
a. PASARR Level I - initial pre-screening that is completed prior to admission
i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.
ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission.
b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.
2. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.
3. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual

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F 644	Continued From page 13 disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided 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	F 656		

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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, clinical record review, resident interview, staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 20 residents reviewed (Resident #25). The facility reported a census of 75 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 3/19/25, Resident #25 scored 14 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS included diagnoses for Resident #25 of debility, cardiorespiratory conditions, heart failure,

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diabetes mellitus, respiratory failure and need for assistance with personal care. The resident was dependent on staff for toileting hygiene and the resident did not perform the activity of toilet transfer. The resident was frequently incontinent of urine and always incontinent of bowel in the look back period. The resident was not on a urinary or bowel toileting program.

The Care Plan, with an initiation date of 6/24/22, included the resident had a self care deficit as evidenced by requiring assistance with Activities of Daily Living (ADL's), impaired balance during transitions requiring assistance and/or walking, incontinence. The Care Plan for Resident #25 lacked interventions/tasks and goals for toileting hygiene, assistance and cares.

During an interview 6/2/25 at 2:28 PM, Resident #25 stated she was not on a toileting program, she stated she was incontinent of both bowel and bladder. The resident stated staff are not consistent with when they check on her to determine if she had been incontinent and required assistance with toileting hygiene.

During an observation 6/2/25 at 2:30 PM, Resident #25's room had a strong odor of urine. Resident #25 shared a room with another resident.

During an observation 6/4/25 at 2:30 PM, Resident #25's room had a strong odor of urine.

During an observation 6/5/25 at 9:27 PM, Resident #25's room had a strong odor of urine.

During an interview 6/5/25 at 10:48 AM, Staff A, Certified Nursing Assistant (CNA), stated they

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look at the computer system, Point Click Care (PCC) to determine care needs for residents. Staff A stated Resident #25 should be checked every two hours to see if she had an incontinent episode and changed. Staff A stated the resident's room had an odor of urine sometimes, she believed it was partially due to the resident making her bed in the morning and the sheets are wet. Staff A stated the resident is a two person assist Hoyer lift for all transfers. Staff should check the resident's bed every morning to see if the sheets are wet.

During an interview 6/5/25 at 11:16 AM, the Director of Nursing (DON) acknowledged toileting is not identified in the Care Plan with interventions and steps for Resident #25. The DON stated an expectation of toileting being in the Care Plan, with interventions, goals and steps outlined.

During an observation 6/9/25 at 10:08 AM, Resident #25's room had a strong odor of urine.

During an interview 6/9/25 at 10:09 AM, the DON acknowledged Resident #25's room had an odor of urine when she went into the room on 6/5/25. Staff located soiled clothing and a soiled brief under the roommate's bed and removed this on 6/5/25. The room continues to have an odor of urine.

Review of the facility Comprehensive Care Plans policy, revised 3/2025, documented it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are

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F 656	Continued From page 17 identified in the resident's comprehensive assessment and meet professional standards of quality.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to revise the comprehensive care plan to accurately	F 657		

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reflect status of 1 of 20 (Resident #48) residents reviewed. The facility reported a census of 75.

Findings include:

Review of Resident #48's Minimum Data Set (MDS) dated 3/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 99, (indicating a resident is unable to complete the interview due to not being able to understand the questions, unable to respond, or other barriers to conducting the interview). The MDS indicated, Resident #48's preferred language is Bosnia and an interpreter is needed to communicate. Resident #48's diagnoses included hypertension, Non-Alzheimer's Dementia, anxiety disorder, and depression. The MDS also indicated Resident #48's mobility assistance for transfers required substantial/maximal assistance and supervision or touching assistance for walking with a walker.

Review of Resident #48's Electronic Health Record (EHR) revealed on 4/7/25 at 7:48 PM, Nursing Health Status note: Alerted by staff, resident was on the floor in her room. Resident self-transferred from her wheelchair. Upon entering the room, resident was found sitting upright on her butt leaning to the right side against a plastic bin with drawers. Vital signs assessed BP 125/67, P 56, R 16, 97% SpO2 on room air. Skin assessment with red abrasion to midback, range of motion to all four extremities, resident complains of pain to right shoulder, pain medications administered. Call placed to on-call provider with order for x-ray to right shoulder and to follow facility fall protocol. Intervention is to educate staff on interventions in place. Call placed to resident's representative and is aware of the plan. Monitoring continues at this time.

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Review of X-ray Report dated 4/9/25 revealed Resident #48 fractured right clavicle.

Further review of Resident #48's EHR revealed the following:
On 4/9/25 at 1:49 PM appointment made for Resident #48 at ortho clinic for tomorrow 4/10/25 at 10:30.
On 4/10/25 at 6:32 PM, Resident #48 returned from the ortho clinic with a new order for weight barring as tolerated (WBAT) to right arm. Physical Therapy/Occupational Therapy to evaluate and treat. Follow up with ortho clinic in four weeks.
On 4/10/25 at 8:11 PM, resident continues on fall follow up. Returned from ortho clinic with order for WBAT to right arm related to clavicle fracture.
On 5/15/25 at 2:30 PM, Resident #48 returned from ortho clinic with a new order for WBAT to Right Upper Extremity. (RUE)

Review of Physician's Orders document dated 5/15/25 indicated Resident #48 WBAT RUE.

Review of Resident #48's Care Plan revealed Resident #48 is at risk of falls related to poor balance and poor communication/comprehension. Resident #48 has a history of non-compliance with use of call light and Resident #48 abandons walker from time to time with cares. Interventions related to Resident #48's fall resulting in clavicle fracture on 4/7/25 included, Therapy to evaluate wheelchair for safety and positioning related to fall. Resident #48 is independent with transfers and utilizes a walker. At times of weakness she will use a wheelchair. Intervention dated 4/11/25, 20 inch wheelchair set at low height with anti-rollbacks. Resident #48's Care Plan failed to indicate the

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resident fracturing right clavicle and being WBAT RUE.

An interview on 6/9/25 at 1:55 PM, the DON stated she would expect Resident #48's Care Plan to indicate the clavicle fracture and WBAT RUE status.

Review of Facility Provided Care Plan Revision Upon Status Change Policy, revised 5/25 revealed the following:
Policy Explanation and Compliance Guidelines:
1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.
2. Procedure for reviewing and revising the care plan when a resident experiences a status change:
a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable.
b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.
c. The team meeting discussion will be documented in the nursing progress notes.
d. The care plan will be updated with the new or modified interventions.
e. Staff involved in the care of the resident will report resident response to new or modified interventions.
f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.
g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care.
h. The Unit Manager or other designated staff

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F 657	Continued From page 21 member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 3. The MDS Coordinator will determine whether a Significant Change in Status Assessment is warranted. If so, the assessment will be completed according to established procedures.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, staff interviews and policy review, the facility failed to ensure the resident's environment was free from hazards and each resident received adequate supervision to prevent accidents and ensure safety for 2 of 4 residents reviewed (Resident #75 and #5). The facility reported a census of 75 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 5/23/25, Resident #75 scored 15 on the Brief Interview for Mental Status (BIMS) indicting intact cognition. Diagnoses for the resident included medically complex conditions,	F 689		

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atrial fibrillation, hypertension, asthma, chronic obstructive pulmonary disease (COPD), and respiratory failure.

The Care Plan, initiated 5/16/25, included Resident #75 may smoke with supervision per smoking assessment. Resident must have supervision by nursing with removing his oxygen and monitoring signs/symptoms of low oxygen saturation.

The facility Safe Smoking Assessment Form, dated 5/16/25 for Resident #75 documented the resident needed adaptive equipment, a smoking apron. The resident is unable to open the door to go outside, staff is needed to assist. The team decision was resident safe to smoke with supervision.

The facility Smoking: Accidents and Supervision form, signed by Resident #75 on 5/16/25, documented the resident required supervision while smoking, protective gear needed was a smoking apron and resident's lighter to be kept at the nurses station.

During an interview 6/3/25 at 9:07 AM, Resident #75 stated he smoked cigarettes and he kept his smoking supplies in his room, including his cigarettes and lighter. The resident stated he did not wear an apron when he smoked and did not require supervision to smoke. The resident stated his smoke time varied.

During an observation 6/3/25 at 9:10 AM, Resident #75 had his cigarettes and lighter in his room, located in the pouch of his wheelchair.

During an observation 6/4/25 at 10:32 AM,

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Resident #75 went to the outdoor courtyard to smoke independently, no staff member assisted the resident and no staff member supervised the resident while he smoked. The resident was not wearing a smoking apron. The resident had his supplies with him, in the pouch of his wheelchair and lit his own cigarette with the lighter kept with him. After the resident smoked one cigarette, the resident returned to his room, keeping his cigarettes and lighter.

During an interview 6/4/25 at 11:03 AM, Resident #75 stated he has never worn an apron while he smoked at the facility and has always kept his cigarette supplies with him in his room, including his lighter. The resident recalled signing forms when he admitted to the facility in May of this year, he did not recall signing another smoking assessment. The resident stated he had supervision by staff when he first admitted to the facility, but has not had staff supervise his smoking for awhile now.

During an interview 6/5/25 at 11:48 AM, Staff D, Social Services, stated she completed another smoking assessment yesterday with Resident #75, he is considered safe now to smoke independently. Staff D believed she completed the assessment on the resident in the morning yesterday, he signed the new assessment. Staff D stated if the resident was observed to smoke independently prior to the new assessment he was not cleared to smoke independently. Staff D stated an expectation the resident follow the current smoking assessment and an expectation Resident #75 have supervision, wear an apron and not have his lighter in his room prior to the new assessment. Staff D stated the new smoking assessment has now been uploaded

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into Point Click Care (PCC).

The Safe Smoking Assessment Form, dated 6/4/25, had a lock date of 6/4/25 at 11:42 AM. The team decision was the resident was safe to smoke without supervision, encourage resident to utilize smoking apron due to extra precaution for skin.

Review of the facility Resident Smoking policy, with a revision date of 1/2025, documented it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all.

2. According to the MDS assessment dated 5/16/25, Resident #5 scored a 10 on the BIMS indicating moderate cognitive impairment. The resident had diagnoses to include fractures and other multiple trauma, stroke, Multiple Sclerosis (MS), anxiety disorder and depression. The resident had lower extremity impairment on both sides. The resident required moderate assistance with toileting hygiene, shower/bathe self and lower body dressing and required substantial/maximal assistance for sit to stand, chair/bed to chair transfer and toilet transfer in the look back period. Car transfer and walking 10 feet was not attempted due to medical condition or safety concerns.

The Care Plan included Resident #5 was at risk for falls related to impaired balance and mobility

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and to assist with mobility. The resident had an ADL self care performance deficit related to left femur fracture repair and MS.

A Progress Note, titled Nursing and dated 5/3/25 at 11:44 AM, documented Resident #5 was located on cell phone. He had a friend pick him up and take him to the bank. Resident was educated on letting his nurse know he is leaving the facility and resident needs to sign out when he leaves. Progress Note written by Staff H, Registered Nurse (RN).

A Progress Note, titled Nursing and dated 5/3/25 at 12:19 PM, documented elopement assessment done with no risk of elopement. BIMS shows cognitively intact. Resident repeated education back to this nurse on notifying staff and signing out when leaving facility in the future. Progress Note written by Staff I, RN.

During an interview 6/4/25 at 1:43 PM, Staff H stated on the 3rd of May she was working as floor nurse for Resident #5's hall. One of the Certified Nursing Assistants (CNA's) saw the resident sitting by the front area and then saw his wheelchair out front by the circle drive without him in it. They looked all over the facility for him and the maintenance man started driving around looking for the resident. They went to the resident's room and hit redial on his room phone. His friend answered and said he took the resident to the bank. He said he forgot to sign the resident out. Staff H stated she talked to the resident when he got back to the facility and told him he needed to tell her or nursing staff when he was leaving the building. Staff H stated the resident does come up to her now and says he is going to the bank, he has gone to the bank again.

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Staff H felt the resident understood when she told him about the reasons he needed to let them know when he leaves. Staff H stated she told the resident he scared her and she was worried. Staff H stated she had concern too about how the resident transferred into his friend's car and if he tried to walk.

During an interview 6/5/25 at 9:04 AM, Resident #5 stated he cannot remember how long he has been at the facility. He said he came from the Assisted Living side, he had a fall there. He stated he is not sure how long he will be here, but he is getting Physical Therapy (PT) and is hoping to walk again on his own. When asked if he ever leaves the facility to go places, he said no, no he does not leave. When asked if he ever did leave the facility, he said one time, it was the 3rd of the month, he couldn't remember which month, he wanted to go get some cash from the bank, he said he liked having cash. Resident #5 stated he called his friend and his friend came and got him and drove him to the drive thru of the bank. They then drove to get some cigarettes and some chocolate. Resident #5 stated he did not get out of the car. He said the facility called everyone looking for him, he said they called his mom, his family and then called his friend on his car phone. His friend answered from the car and said Resident #5 was with him, the facility said to please come back. The resident said he felt like he was on America's most wanted with how everyone was looking for him. He said he did not know he had to sign out or tell anyone he was leaving, he said he did not have to do this at Assisted Living. He said he understands now that when he wants to leave he needs to tell the nurse and sign out. The resident stated he will not leave the facility again without telling someone.

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Resident #5 stated his friend helped him into his car.

During an interview 6/5/25 at 1:11 PM with a family member of Resident #5, the family member stated the facility called her last month and said they lost Resident #5, they said they could not find him. She told the facility she wondered if he found a way to get to the bank, but told them she did not know who would have taken him to the bank. They called her back later and said they located him, he did find someone to take him to the bank. He said he did not know that he couldn't just leave.

During an interview 6/5/25 at 1:40 PM, Staff I, RN, stated she was working on the 3rd of May, she works on the skilled hall (400-500 hall), not on Resident #5's hall. She recalled on the 3rd someone saying they couldn't find the resident, his wheelchair was found by the front door. They found out he left with a friend. Staff I was told to complete a BIMS assessment on the resident when he returned and an elopement assessment. Staff I stated she completed these assessments and thought the resident was alert and oriented, he answered all of her questions.

Review of the Incident Summary for Resident #5 leaving the facility on 5/3/25 documented the resident left the facility premises with a friend without signing out as per facility protocol.
Preventive Measures included:
1. Reinforced sign-out protocol with resident and family.
2. Staff were re-educated on the importance of monitoring and communication.
The Staff Communication section, sent to all staff members, with a subject line Reminder-Resident

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Sign-Out Protocol: Please be reminded of the importance of ensuring all residents sign out when leaving the facility, this ensures we can account for all residents at all times and respond appropriately in any emergency, thank you for staying diligent in maintaining resident safety and accountability.

Review of the Facility Elopement Drill, dated 5/3/25, time drill started 11:07 AM, time drill ended 11:41 AM. Summary of drill: Found resident wheelchair sitting outside by loading zone so did head count and found resident missing. Results of drill: Head count determined it was Resident #5, a full sweep of facility was conducted and drove the neighborhood and went to resident's bank and could not find him. Called family and they did not know where he was. Searched his phone records and he had his friend pick him up, resident returned.

During an interview 6/09/25 at 2:40 PM, the Administrator recalled the incident that occurred on 5/3/25 with Resident #5. The Administrator stated the resident left the facility without informing staff and did not sign out. The Administrator acknowledged staff should be aware of resident's whereabouts for safety reasons and residents should inform staff when they plan on leaving the facility. The Administrator stated Resident #5 would have been informed of the procedure to leave the facility during admission, the resident would have been informed of the need to tell staff where he was going and sign out. The Administrator stated he completed an incident summary. The Administrator stated they completed a Facility Elopement Drill when staff realized the resident was not in the facility. The Administrator believed

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F 689	Continued From page 29 the resident was gone for approximately 15 minutes after he was made aware. The Administrator stated an expectation staff are aware of resident whereabouts at all times and provide appropriate supervision. The Administrator stated the facility did not treat this incident as an elopement as they completed an Elopement assessment and BIMS assessment on that date, the resident scored a low risk for elopement and his BIMS score indicated he was cognitively intact. The Administrator acknowledged the resident scored an 8 on his BIMS assessment on the 4/8/25 MDS and a 10 on his BIMS assessment on the 5/16/25 MDS, indicating moderate cognitive impairment. Review of the facility Admission Agreement, revised 11/1/2023, documented the resident may leave the facility at any time, however the resident is required to provide at least twenty-four hours advance notice. The Admission Agreement further documented the resident has a right to a safe environment, including but not limited to receiving treatment and supports for daily living safely.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services 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	F 726		

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(d) Proficiency of nurse aides.

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and policy review, the facility failed to ensure knowledge and techniques necessary to care for residents' medication management in a timely manner for 1 of 5 residents reviewed for unnecessary medications, chemical restraints/psychotropic medications and medication regimen review (Resident #31). The facility reported a census of 75.

Findings include:

Review of the Minimum Data Set (MDS) dated 5/10/25, revealed Resident #31 was admitted to the facility on 5/12/2023, a Brief Interview for

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Mental Status (BIMS) score of 15, indicating cognitively intact and diagnoses of cancer, heart failure, peripheral vascular disease, renal insufficiency, alcoholic cirrhosis of liver, cannabis abuse, Werrnicke's Encephalopathy (serious brain disorder caused by a deficiency of thiamine. Often associated with chronic alcohol abuse) delusional disorders, Non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. The MDS indicated Resident #31 is taking the following pharmacological classed medications; antipsychotics, antianxiety, antidepressant, anticoagulant, diuretic, and hypoglycemic.

Review of Resident #31's Order Summary Report, revealed Resident #31 receives Mirtazapine 15mg by mouth at bedtime for depression.

Review of Pharmacist's Recommendation to Prescriber dated 5/12/25 revealed the following:
Resident #31 has been taking the following psychotropic medications:
1. Mirtazapine tab 15mg, one tablet by mouth at bedtime for depression.
2. Buspirone tab 10mg, one tablet by mouth three times daily.
3. Risperidone tab 1mg, one tablet by mouth at bedtime.
4. Duloxetine cap 60mg, one capsule by mouth twice daily.
5. Hydroxyzine tab 25mg, one tablet by mouth three times daily.
According to documentation, Resident #31 is a candidate for gradual dose reduction (GDR).
Recommendation:
1. GDR to Mirtazapine tab 15mg, one tablet by mouth at bedtime for depression.

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2. Monitor for symptom recurrence.
Prescriber's response: agree to recommendation and noted "we can try this." Signed by facility's Nurse Practitioner on 6/3/2025
Pharmacist's recommendation to prescriber document, failed to indicate notation of the charge nurse who received and/or processed the order.

During an interview on 6/5/25 at 3:35 PM, the Pharmacist's recommendation GDR was reviewed with the Director of Nursing (DON), and identified, Resident #31's current dosage of 15mg Mirtazapine was the same as the recommended dosage for reduction. DON acknowledged the need to contact the Nurse Practitioner to receive a clarification for the recommended GDR.

Electronic Health Record (EHR) Review on 6/09/25 at 11:09 AM, Resident #31's medications orders and nursing progress notes failed to indicate documentation of GDR dated 5/12/25 or clarification from the Nurse Practitioner regarding the recommended Mirtazapine reduction dosage.

On 6/9/25 at 11:11AM, Review of Resident #31's June Medication Administration Record (MAR) revealed Mirtazapine 15mg, take one tablet by mouth at bedtime for depression. Start date 12/17/2024.

Review of Facility provided Medication Order Policy, revised 5/2024 revealed the following:
Documentation of Medication Orders:
A. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR).

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F 726	Continued From page 33 B. Clarify the order. C. Enter the order on the medication order and receipt record. D. If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions and facility policy. E. Call or fax the medication order to the provider pharmacy. F. Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR. G. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing "DC'd" and the date, or discontinue the order as per the electronic software instructions and retype the new order. H. Enter the new order on the MAR or ensure the new order is in the electronic MAR. I. Notify resident's sponsor/family of new medication order. Specific Procedures for Medication Orders: A. Handwritten Order Signed by the Physician - The charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format, if not written by the physician. If necessary, the order should be clarified before the physician leaves the nursing station, whenever possible.	F 726		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		

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applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and policy review, the facility failed to safely store and label resident's medications. The facility reported a census of 75 residents.

Findings include:

Observation of a medication cart on 6/3/25 at 10:31 AM, revealed a medicine cup with approximately 12 pills, labelled with Resident #31's name. Staff B, Certified Medication Aide (CMA) stated "He likes his meds later." Continued observation revealed unsealed/opened stock medications that were not dated with the date the bottle was opened.

On 6/3/25 at 10:40 AM, the Director of Nursing (DON) was notified of undated stock medications.

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F 761	Continued From page 35 The DON observed the bottles in the medication cart and acknowledged the failure to indicate the opening dates. The DON stated the facility follows the Pharmacy's recommendations for labeling medications. During an interview on 6/5/25 at 3:35 PM, the DON stated residents medications should not be set up and left in the medication cart. The DON's expectations are meds to be prepared at the time the medications are administered. If residents prefer their medications later or at a different time than what is scheduled, DON expects staff to notify her to determine if administration times need to be changed and consult with the resident's provider. Review of Facility provided Expiration Dating, Disposal of Medications, Medication Related Equipment Policy, revised August 2024 stated, When the manufacturer's original seal is broken by Long Term Care facility personnel, the date opened shall be indicated on the medications.	F 761		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this	F 865		

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section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and

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facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

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§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, review of CMS-2567 reports, and facility policy review, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification survey. The facility reported a census of 75 residents.

Findings include:

Review of facility's CMS 2567 from recertification and complaint surveys on 12/19/24, 10/31/24, 10/10/24, and 6/19/24 revealed the facility received non-harm level citations for Develop/Implement Comprehensive Care Plan, Care Plan Timing and Revision, Free of Accident Hazards/Supervision/Devices, Label/Storage Drugs & Biologicals, Sufficient/Competent and Infection Prevention & Control.

The facility's plan of correction for an annual recertification survey dated 12/19/24, revealed correction date of 1/23/25 for Develop/Implement Comprehensive Care Plans, Care Plan Timing and Revision, Free of

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Accident/Hazards/Supervision/Devices, and Infection Prevention and Control, revealed documentation present at the end of the CMS-2567 form included the following:

We assert that all correctives described in this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions.
Develop/Implement Comprehensive Care Plans
Corrective Action
1. On or before 1/23/2025, the MDS coordinator updated the care plan for resident #29 to include insulin and antidepressants.
2. On or before 1/23/25, the MDS coordinator updated resident #57's care plan in concurrence with the resident's updated smoking assessment. Resident #57's most recent assessment determined that he is independent with smoking and, therefore, may maintain all smoking materials on his person. Identification of Others
1. On or before 1/23/25, the MDS Coordinator updated residents' care plans for those prescribed antidepressants or insulin to ensure a comprehensive care plan.
2. On or before 1/23/25, the MDS coordinator updated residents' care plans for smokers to reflect their most recent smoking assessment.
Systemic Changes to Prevent Future Occurrence
On or before 1/23/25, the IDT team, including the MDS Coordinator, Director of Nursing (DON), and Social Services Director, was educated regarding comprehensive care plans, including medications and smoking. On or before 1/23/25, nursing staff were educated regarding following the comprehensive care plan. Monitoring The MDS Coordinator, director of nursing (DON), or

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designee will review 2 residents' Care plans per week for 12 weeks to ensure that the care plan Is Comprehensive and is followed. Audits will consist of residents who take insulin's, antidepressants, and those that smoke. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be in the monthly meeting for 6 months or until sustained compliance is achieved. Compliance Date: 01/23/25

Care Plan Timing and Revision Corrective Action
1. On or before 1/23/25, the MDS Coordinator reviewed and revised the care plans for residents # 10, 21, 26, 34, 45, and 61 to ensure they were by their smoking status or elected Advanced Directive status.
2. On or Before 1/23/25 The DON or MDS ensured Resident # 10's IPOST was updated to reflect DNR status 3. On or before 1/23/25 the DON or SSD updated resident 34's care plan to indicate DNR status per Resident/Responsible party wishes.
4. On or before 1/23/25, the DON or SSD updated resident 45's Care plan to indicate their code status.
5. On or before 1/23/25, The DON or Designee updated the smoking assessment for resident 21 to ensure the care plan had appropriate interventions in place in the care plan.
6. On or before 1/23/25 the DON or designee updated the smoking assessment for resident 26 to ensure the resident had appropriate interventions in place in the care plan
7. On or before 1/23/25, the Don or designee evaluated the resident's smoking status and ensured an appropriate assessment was in place, and the care plan was updated appropriately.
Identification of Others The deficient practice

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could potentially affect residents. On or before 1/23/25, the Social Services Director completed a whole-house audit to review residents' codes and smoking status. The care plan was updated to reflect these changes, and discrepancies were corrected immediately.
Systemic Changes to Prevent Future Occurrence
The IDT Team, including the social services director and MDS coordinator, was educated on or before 01/23/25 regarding care plan timing and revision. Monitoring The MDS Coordinator, Social Services Director, or designee will audit 2 residents' care plans weekly for 12 weeks to ensure the Code status is accurate, the order is in place, IPOST is in place, and the care plan is updated. The MDS Coordinator, Social Services Director, or Designee will audit 2 residents smoking status to ensure the care plan is in place, updated, and followed. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved. Compliance Date: 01/23/25

Free of Accident/Hazards/Supervision/Devices
Corrective Action
1. On or before 1/23/25, the DON or designee provided education to all staff regarding using foot pedals appropriately while assisting resident #20 in the wheelchair
2. On or before 1/23/25, the DON evaluated residents #21, 26, and 61 for appropriate use of a smoking apron.
3. On or before 1/23/25, the DON, SSD, or Administrator educated residents #21, 26, and 57 about maintaining their smoking materials. An evaluation was completed, and the residents 21 and 57 were determined to be independent with

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smoking. Resident 26 was determined to be supervised and need assistance with smoking. The policy was revised. Identification of Other Residents who smoke have the potential to be affected. On or before 1/23/25, the facility completed a whole-house audit of smoking residents. The policy was revised, residents who smoke were reevaluated, and their care plans were updated. Systemic Changes to Prevent Future Occurrence On or before 1/23/25, staff were educated on the revised smoking policy, and residents were reevaluated and determined to be independent or require supervised smoking at designated times. Newly admitted residents will be evaluated if they smoke and provided with the policy and education. Current residents who smoke will be reviewed with a change in condition or quarterly for safety with smoking. The care plan will reflect the residents' status.
Monitoring the Administrator, Social Services Director, or DON will conduct a random audit three times weekly for 12 weeks to ensure that all residents appropriately abide by the smoking policy. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved. Compliance Date: 01/23/25

Infection Prevention and Control Corrective Action
On or about 12/05/24, the DON immediately educated staff B regarding gloving, emptying the catheter bag, and UTI prevention by keeping the catheter bag lower than the bladder for resident #28. Identification of others residents that have an indwelling catheter have the potential to be affected. Systemic changes to prevent future

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occurrence
1. On or before 1/23/25 the Director of Nursing (DON) or designee conducted education for all nursing staff regarding gloving, emptying the catheter bag, and UTI prevention by keeping the catheter bag lower level than the bladder.
2. On or before 1/23/25, the Director of Nursing (DON) or designee conducted a competency for catheter care for all Certified Nursing Assistants.
Monitoring the Director of Nursing (DON) or designee will randomly audit a 2-resident sample weekly for 12 weeks to ensure that catheter care is completed appropriately. Audit results and additional corrected actions will be reported and discussed in QAPI, and further corrections will be discussed in the monthly meeting for 6 months or until sustained compliance is achieved.
Compliance Date: 01/23/25

The facility's plan of correction for complaint survey dated 10/31/24, revealed correction date of 11/17/24 Free of Accident Hazards/Supervision/Devices revealed documentation present at the end of the CMS-2567 form included the following:

We assert that all correctives described on this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions.
Free from Accidents and Hazards
Immediate Corrective action:
1. The MDS coordinator reviewed section E of the MDS and associated CAA. Care plans were reviewed and updated to reflect the audit findings
2. Resident #1 is no longer a current resident of the facility.

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3. Appropriate revisions were made to Care Plans and wander guards were checked for appropriate functioning.
4. All doors were immediately checked for proper functioning, and no concerns were identified.
5. Appointment made to outside company to have alarms inspected on 10/23/24 no issues identified.
6. Immediate education with all staff provided on the elopement and wander guard policy on 10/23/24.
7. The IDT team ensured that all residents identified as "at risk" for falls had safety measures and resident-specific interventions added to their care plans.
8. The DON or designee will audit all new admissions for elopement risk and ensure interventions are in place.
9. On 10/24/24, the IDT reviewed the most recent fall risk assessments for all residents identified as potentially at risk for falls. Residents determined to be at risk have completed care plan updates, and the interventions currently in place are appropriate.
10. The IDT team ensured that the safety measures and resident-specific interventions added to the care plans were also reflected on Kardex so that the CNAs had access to this information in both POC and Kardex.
11. The DON and designee(s) instructed the CNAs to review the updated Kardex before their next shift. Identification of Residents Affected or Likely to be Affected: On or before 10/31/24 The IDT (Interdisciplinary team) reviewed all residents and re-evaluated those that were at risk for elopement. Residents determined to be at risk their Care plan updates are complete and interventions that are currently in place are appropriate.

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Actions taken/systems put into place to prevent future occurrence include:
1. The social services designee will educate all new hires on elopement, wandering and resident safety.
2. The main entrance was moved to 1499 door, and receptionists were placed in front of it.
3. IDT team do Guardian Angel rounds to help with resident's quality care and resident safety checks.
4. The DON or designee educated all staff on facility Fall Prevention Program, all facility fall-related policies, how to conduct an RCA, and how to ensure timely and complete incident investigations.
5. The DON or designee will audit new admissions daily to ensure the completion of the Fall Risk Assessment Tool and the risk factors, safety measures, and resident-specific interventions are reflected in the care plan and updated on Kardex.
6. The DON or designee will review all falls at the daily stand-up meeting with the IDT for three months to ensure appropriate fall interventions are implemented, the resident care plan has been reviewed and revised and the Kardex has been updated.
How the corrective action will be monitored:
1. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and the plan of care is updated. The Director of Nursing (DON), or designee, will complete 5 random weekly chart audits for six (6) consecutive weeks then 2 random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans

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have been updated to reflect these interventions.
2. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and the plan of care is updated. The Director of Nursing (DON), or designee, will complete 5 random weekly chart audits for six (6) consecutive weeks then 2 random weekly chart audits for six (6) consecutive weeks and review all residents "at risk" for elopements and update assessments as needed.
3. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.
4. All exit doors will be checked daily for 30 days to ensure proper use and function.

The facility's plan of correction for complaint survey dated 10/10/24, revealed correction date of 10/29/24 Free of Accident Hazards/Supervision/Devices revealed documentation present at the end of the CMS-2567 form included the following:

We assert that all correctives described on this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions.
Free from Accidents and Hazards Immediate Corrective action:
1. The Director of Nursing Services and the MDS coordinator met with the nursing and direct care staff on or before 10/10/24 to provide education in regard to appropriate interventions and measures to mitigate falls.
2. Resident #2 is no longer a current resident of

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the facility.
3. Appropriate revisions were made to the Care plan/Kardex to reflect all current safety interventions at the time of the fall.
Identification of other residents having the potential to be affected:
On or before 10/25/24 The IDT (Interdisciplinary team) reviewed the most recent fall risk assessments for all residents who have been identified as having a potential risk for falls. Residents determined to be at risk their Care plan updates are complete and interventions that are currently in place are appropriate.
Actions taken/systems put into place to prevent future occurrence include:
1. On or before 10/10/24 all Licensed Nursing staff have been in-service on the facility policy for Falls, fall risk, and appropriate interventions to mitigate falls.
2. All resident falls/accidents will be reviewed daily in clinical five times per week by the IDT (Interdisciplinary team) to ensure appropriate implementation of safety interventions including updating the Care plan/Kardex and ensuring interventions are physically in place.
How the corrective action will be monitored:
1. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and plan of care is updated. The Director of Nursing (DON), or designee, will complete 5 random weekly chart audits for six (6) consecutive weeks then 2 random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions.
2. Audit results and additional corrected action

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will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

The facility's plan of correction for complaint survey dated 6/19/24, revealed correction date of 7/19/24 Free of Accident Hazards/Supervision/Devices revealed documentation present at the end of the CMS-2567 form included the following:

We assert that all correctives described on this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions.
Accidents hazards/supervision/devices Corrective Action
1. Resident #3's care plan was reviewed for appropriateness. Resident #3 is independent with Ambulation per a Therapy screen completed on 6/20/2024 to ensure safe ambulatory status.
Identification of Others:
The facility determined that all residents at risk for falls can be affected.
Systemic Changes to Prevent Future Occurrence:
On or before 7/19/2024, the DON or designee conducted an in-service education program with all staff regarding fall prevention, including appropriate assessment, scene analysis, implementation of immediate interventions, and preventative measures for those at risk. The IDT team reviews all Falls at daily clinical x5/week to ensure the Root Cause Analysis is complete and appropriate interventions are in place.
Monitoring:
The Director of Nursing Services, or designee,

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will conduct a random audit of five (5) residents at risk for falls per week for four (4) consecutive weeks. Then a random audit of 10 per month for 2 months. These residents ' medical records will be reviewed to ensure the care plan is updated promptly and interventions are in place. in place. Audit results and additional corrected action will be reported and discussed in QAPI, and further corrections will be in the monthly meeting for 6 months or until sustained compliance is achieved.

The facility's current recertification survey, entrance date 6/2/25, resulted in multiple repeated non-harm level deficient practices for the following areas: Develop/Implement Comprehensive Care Plan, Care Plan Timing and Revision, Free of Accident Hazards/Supervision/Devices, Label/Storage Drugs & Biologicals, Sufficient/Competent and Infection Prevention & Control.

Review of Centers For Medicare and Medicaid Services (CMS) CASPER Report, updated 5/27/25 revealed the Facility's repeat deficiencies for Annual Recertification Surveys:
Develop/Implement Comprehensive Care Plan: December 2024, August 2023, and May 2022.
Care Plan Timing and Revision: December 2024, August 2023, and May 2022.
Free of Accident Hazards/Supervision/Devices: December 2024, August 2023
Sufficient/Competent and Infection Prevention & Control: December 2024, August 2023

Review of Facility provided Quality Assurance and Performance Improvement (QAPI) Policy, revised 6/2024 revealed the following:

The governing body and/or executive leadership

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is responsible and accountable for the QAPI program. Governing oversight responsibilities include, but are not limited to the following:
a. Approving the QAPI plan annually, and as needed.
b. Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities.
1. Ensuring the program is sustained during transitions in leadership and staffing.
2. Ensuring the program is adequately resourced, including ensuring staff time, equipment, and technical training as needed.
3. Ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.
4. Ensuring that corrective actions address gaps in systems, and are evaluated for effectiveness.
5. Setting clear expectations around safety, quality, rights, choice, and respect.
c. The QAA Committee shall communicate its activities and the progress of its subcommittee activities to the governing body (if leadership role is greater than the administrator) at least quarterly, with a formal meeting no less than annually.
d. The QAA Committee shall submit supporting documentation of ongoing QAPI activities to the Governing Body upon request.
e. QAPI training that outlines and informs staff of the elements of QAPI and goals of the facility will be mandatory for all staff.

Program Systematic Analysis and Systemic Action -
a. The facility takes actions aimed at performance

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F 865	Continued From page 51 improvement as documented in QAA Committee meeting minutes and action plans. Performance/success of the actions will be monitored and documented in subsequent QAA Committee or sub-committee meetings. b. To ensure improvements are sustained, the effectiveness of performance improvement activities will be monitored in QAA Committee meetings in accordance with the QAPI plan, but no less than annually.	F 865		
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,	F 880		

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	165350	A. BUILDING _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND CARE CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

(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 880	Continued From page 52	F 880		

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 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.

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F 880	Continued From page 53	F 880		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and policy review the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. The facility reported a census of 75 residents.

Findings include:

During a continuous observation 6/2/25 beginning at 11:50 AM, Staff E, dietary staff, served residents drinks going from table to table in the dining room during lunch service. Observed Staff E place her hand on the rim of a drinking glass and place the glass down on the table in front of a resident. Staff E placed this same hand in a trash bag attached to the serving cart more than once, then used this hand to prepare drinks for residents, placing her hand on the rim of the drinking cup for several residents without sanitizing her hands. Staff E put this same hand on the spoon portion of a spoon, not the handle, and placed the spoon into a coffee cup and handed this to a resident. Staff E placed her hand in the trash bag several times during the approximate 25 minutes of observation, and placed her hand on the rim of drinking glasses several times. At no point while serving residents did Staff E sanitize her hands.

During a continuous observation 6/2/25 beginning at 12:17 PM, Staff F, Certified Nursing Assistant (CNA), assisted residents in the assisted section of the dining room during lunch service. Staff F picked up a french fry with bare hands off of a resident's plate and placed the french fry in a resident's mouth. Without sanitizing hands, Staff

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F 880	Continued From page 54	F 880		

F picked up a french fry for another resident off the resident's plate with bare hands and placed it in the resident's mouth. Without sanitizing hands, Staff F picked up a french fry for a separate resident with bare hands and placed it in the resident's mouth. In between placing the french fries in the resident's mouths, Staff F had her hands on the sides on her chair and on the table. Staff F continued to go back and forth between two residents picking up a french fry off of resident's plate with bare hands and placing it in the resident's mouths, without sanitizing hands or wearing gloves. After several minutes of this, Staff F was then observed to sneeze into her shirt and then with the same hand used to place french fries in residents mouth, swiped her hand up and over her nose. At no point did Staff F sanitize or wash her hands. After wiping her nose with her hand, Staff F got up from the table and walked over to the main dining room to get a drink for a resident from the drink cart, touching the rim of the glass and the lid. Staff F returned to the assistive area to bring the drinks she prepared to a resident. Then, without sanitizing or washing hands, Staff F brought a plate of food to a resident.

During a continuous observation 6/3/25 beginning at 9:54 AM, Staff C, CNA, exited resident room 116 with EZ Stand (a transfer-assist unit which actively engages the resident in the standing process) and pushed the stand in the hallway to enter resident room 118 with the stand. Staff B, CNA entered room 118 to assist. Approximately 15 minutes later, Staff B exited room 118 with the EZ Stand and parked it in the hallway. Staff C then exited room 118 and removed the battery off the EZ Stand and walked down the hallway. At no point during the observation did staff clean or

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F 880	Continued From page 55	F 880		

sanitize the EZ Stand, the stand was not cleaned in between resident use.

During an interview 6/4/25 at 1:18 PM, the Director of Nursing (DON) stated an expectation for staff to use infection control practices while assisting residents during meals and while serving residents. The DON stated staff should sanitize their hands in between serving residents food or drink if they touched the rim of the glass or the part of a utensil that a resident would use to eat. The DON stated staff should not touch food with bare hands and staff should wash hands after sneezing.

During an interview 6/9/25 at 4:21 PM, the DON stated an expectation the EZ Stand is cleaned/sanitized in between resident use for infection control purposes. The DON stated she also observed staff not cleaning the EZ Stand in between resident use recently and provided education to staff about this last week.

Review of the facility Hand Hygiene and Maintaining a Sanitary Tray Line policies, revised 7/2024 and 2/2025 respectively, documented all staff will perform proper hand hygiene procedures to prevent the spread of infection. Hand hygiene is required after sneezing, coughing and/or blowing or wiping nose. Staff shall wear gloves when handling food items, particularly when direct contact between the hands and food occurs or when handling ready to eat foods.

Review of the facility policy Cleaning and Disinfection of Resident-Care Equipment, with a revision date of 1/2025, documented resident-care equipment can be a source of indirect transmission of pathogens. Reusable

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F 880	Continued From page 56 resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Multiple-resident use equipment shall be cleaned and disinfected after each use.	F 880		

This serves as the credible allegation of compliance for Pine Acres Rehabilitation and Care Center. We assert that all correctives described in this plan of correction have been implemented. Regarding the specific deficiencies F628, F641, F644, F656, F657, F689, F726, F761, F865, F880, we have outlined our corrective actions and continued interventions to ensure compliance with the above regulations along with our plan of action. The staff of Pine Acres Rehabilitation and care center are committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Pine Acres Rehabilitation and Care Center is in substantial compliance as set forth below. We are confident that we will be found to be substantially in compliance with our resurvey. The statements made on this plan of correction are not an acknowledgment to and do not constitute an agreement with the alleged deficiencies. Pine Acres Rehabilitation has completed the following interventions because of the findings from the survey exiting 6-9-2025.

F 628 Discharge process:

Step 1 – Correction for Affected Resident(s):
On or about 6-17-2025 The facility ensured that resident #7 has appropriate notification, bed hold, and documentation for all other hospital stays. The DON or Designee educated the staff nurse at the time of the transfer on the appropriate policy for transfers to the hospital including but not limited to bed hold, documentation, assessment and notification.
Step 2 – Identification of Other Residents Who May Have Been Impacted:
On or about 6-27-2025 The DON or Designee completed an Audit to ensure that all residents that have discharged from the facility in the last 30 days and/or transferred to ensure that the proper discharge instructions are included including Documentation of transfer to hospital, PCP notification, order to transfer, family notification and bed hold.
Step 3 – Systematic Change to Prevent Reoccurrence:
The DON or Designee conducted an All-staff education on 6-18-25. Education included discharge documentation, reporting and follow up expectations of all residents that are transferred from the facility to another entity.
Step 4 – Monitoring for Sustained Compliance:
DON/Designee/IDT will review 2 discharges/transfer to the hospital (If any) x1/week for 12 weeks to ensure that there is proper documentation to include, discharge instructions, PCP notification with proper orders in place pertaining to transfer, family notification and that a bed hold was offered and documented appropriately. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
✓ All corrective actions will be completed by **July 9, 2025**.

F 641 Accuracy of assessments:

Step 1 – Correction for Affected Resident(s):
On or about 6-16-2025 the SSD/MDS or Designee completed a Modification of resident #34 MDS to ensure the PASSAR level 2 was reflected accurately and resubmitted to CMS.

Step 2 – Identification of Other Residents Who May Have Been Impacted:
On or about the 6-9-2025 DON/MDS or Designee completed a facility wide audit of all residents to ensure MDS's accurately reflect the PASSAR assessment.
Step 3 – Systematic Change to Prevent Reoccurrence:
All staff education was provided 6-19-25. Education included the importance of properly documenting MDS assessment and how information is obtained.
Step 4 – Monitoring for Sustained Compliance:
DON/MDS will conduct an audit x1/week for 12 weeks and monthly thereafter to ensure that MDS reflects accuracy of the PASSAR. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F 644: Coordination of PASARR and assessments

Step 1 – Correction for Affected Resident(s):
On or about 6-5-2025, the Social Service Director or Designee submitted resident #31 PASSAR; the resident was determined to require a level 1 PASSAR.
Step 2 – Identification of Other Residents Who May Have Been Impacted:
On or about 6-8-25 the SSD/MDS or Designee completed a Facility wide review of all residents PASSAR to ensure that all assessments are correct, care plans are updated appropriately, and services are provided per the PASSAR.
Step 3 – Systematic Change to Prevent Reoccurrence:
On or about 7-2-2025, the Administrator provided corrective education to the social worker in regard to coordination of PASARR assessments.
Step 4 – Monitoring for Sustained Compliance:
DON/SW or Designee will audit 3 random residents PASSAR weekly x 12 weeks then monthly as needed thereafter. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F 656 Develop/implement Comprehensive Care Plan:

Step 1 – Correction for Affected Resident(s):
On or about 6/5/2025, resident #25's care plan was updated to include toileting hygiene, assistance, and care. Staff were educated to check frequently and remove soiled clothing. Resident #25 has a history of hiding soiled clothing in her room.
Step 2 – Identification of Other Residents Who May Have Been Impacted:
Residents had the potential to be affected by the deficient practice. On or about 6/10/2025 The DON/Designee completed a facility wide audit for all residents' toileting hygiene and assistance status; any inconsistencies were updated.
Step 3 – Systematic Change to Prevent Reoccurrence:

On or about the DON or Designee completed training with all nursing staff to include managing toileting hygiene, and comprehensive care plan creation and maintenance.

Step 4 – Monitoring for Sustained Compliance:

The DON or Designee will audit care plans weekly for 12 weeks, then monthly to ensure toileting hygiene, assistance and cares are reflected appropriately, to include resident needs with incontinence cares are met, and appropriate toileting programs are initiated. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:

All corrective actions will be completed by **July 9, 2025**.

F F657 Care Plan timing and Revision:

Step 1 – Correction for Affected Resident(s):

On or about 6-9-2025 DON/designee reviewed resident # 48's care plan to ensure accuracy of weight bearing status was added.

Step 2 – Identification of Other Residents Who May Have Been Impacted:

Residents had the potential to be affected. Care plans were audited for functional level and ADL status. Any discrepancies to the care plans were updated.

Step 3 – Systematic Change to Prevent Reoccurrence:

All staff training was conducted to provide education on the expectation of the care planning on 6-18-25.

Step 4 – Monitoring for Sustained Compliance:

DON/Designee will audit care plans for residents with changes in functional status weekly for 6 weeks, biweekly for 6 weeks then monthly. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:

All corrective actions will be completed by **July 9, 2025**.

F F689 Accidents and Hazards:

Step 1 – Correction for Affected Resident(s):

On or about 6/4/25, resident #75 was reevaluated by the IDT team and determined to be safe to smoke without supervision. An assessment was complete, and the resident signed the smoking agreement and agreed to abide by the smoking policy. On or about 5/3/25 Resident #5 was educated on the procedure for signing out and notifying staff that he was leaving the facility.

Step 2 – Identification of Other Residents Who May Have Been Impacted:

On or about 7-3-2025 The facility completed an audit of residents that smoke, these residents' status was reevaluated for safety and to ensure the care plan reflected the smoking status accurately.

Step 3 – Systematic Change to Prevent Reoccurrence:

The IDT team will evaluate each resident for admission that desires to smoke, on admission, quarterly, and with change in condition. The SW or Designee will educate all new residents on the appropriate signing out procedures upon admission and as indicated.

Step 4 – Monitoring for Sustained Compliance:
DON Social Service Director, or Designee will audit 3 residents who smoke weekly, for 12 weeks then monthly thereafter. The Administrator or Designee will randomly interview 2 new admissions (if any) per week for 12 weeks to ensure the residents understand the appropriate signing out procedure. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F 726 Competent Nursing staff:

Step 1 – Correction for Affected Resident(s):
On or about 6-6-2025, the DON spoke with the practitioner to clarify the order for resident #31. An appropriate GDR order was obtained and entered into the MAR by the DON. On or about the Regional Consultant provided Corrective education, the DON to ensure that going forward orders received will be processed in a timely manner.
Step 2 – Identification of Other Residents Who May Have Been Impacted:
Medication reviews completed by pharmacy monthly were reviewed and completed to ensure that all GDR's are in place.
Step 3 – Systematic Change to Prevent Reoccurrence:
All staff education conducted on 6-18-25.
Step 4 – Monitoring for Sustained Compliance:
DON/Designee monthly audits to ensure timely processing of GDR's to ensure compliance with physician orders. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F 761 Label/Store Drugs and Biologicals:

Step 1 – Correction for Affected Resident(s):
On or about 6-5-2025 the DON or Designee removed Medications from medication carts that were not dated then disposed of the open undated medications. On or about 6-27-2025 Staff B CMA received education and corrective action regarding the 5 rights of medication pass and safe medication administration. Resident #31 meds were discarded and re-populated when the resident was ready to take the medication.
Step 2 – Identification of Other Residents Who May Have Been Impacted:
On or about the DON or Designee completed an audit of all medication storage areas to ensure that medications were appropriately stored, labeled, and dated. On or about 7-3-25 all Nurses and CMAS completed a skills evaluation by the DON or Designee to ensure technique is appropriate.
Step 3 – Systematic Change to Prevent Reoccurrence:
On or about 6-18-2025 the DON provided education to All Licensed staff on safe medication administration and to ensure to date the stock medications when opened in the medication carts.
Step 4 – Monitoring for Sustained Compliance:

DON/Designee will complete medication cart, storage and medication pass audits 3 times weekly for 4 weeks, 2 times weekly for 2 weeks, weekly for 2 weeks, and monthly for thereafter. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F 880 Infection Prevention and Control:

Step 1 – Correction for Affected Resident(s):
On or about 6-30-25 Staff E and Nursing Staff F were provided with education on dining and food service hygiene to include touching multiple surfaces and hand hygiene. On or about 6-18-25 staff C was educated on resident equipment and surface cleaning to prevent the spread of infectious diseases.

Step 2 – Identification of Other Residents Who May Have Been Impacted:
On or about the facility, it was determined that all residents were at risk for the deficient practice. Facility audit conducted to ensure that all staff are following infection control when in the dining room, and using equipment

Step 3 – Systematic Change to Prevent Reoccurrence:
The DON, ICP, or Designee educated All staff on 6-18-25, regarding infection control, hand hygiene, equipment cleaning in between uses, and cross contamination.

Step 4 – Monitoring for Sustained Compliance:
DON/Dietary Manager will audit meal service 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks then monthly thereafter. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.

F865 QAPI Program/Plan

Step 1 – Correction for Affected Resident(s):
The QAPI Committee immediately convened to review the cited repeat deficiencies and formally analyzed past corrective actions that failed to yield sustained improvement. Targeted interventions were implemented and tracked for residents cited in the prior CMS 2567s to ensure each care plan concern, fall risk, medication safety, and infection control issue was corrected and fully integrated into the QAPI process.

Step 2 – Identification of Other Residents Who May Have Been Impacted:
This alleged deficient practice has the potential to impact all residents. A facility-wide audit was conducted to assess the effectiveness of care plan implementation, fall prevention measures, infection control protocols, and medication storage for all current residents.

Step 3 – Systematic Change to Prevent Reoccurrence:
All department heads, the QAPI Committee, and relevant frontline staff were re-educated on executing the QAPI plan as written, including data-driven identification of repeated deficient practices, timely follow-up on action plans, and tracking of outcomes. Emphasis was placed on adherence to the current policy for QAPI governance oversight, including interdisciplinary communication, documentation of sustained actions, and follow-through during leadership transitions.

Step 4 – Monitoring for Sustained Compliance:
The QAPI Chair and Administrator will audit 10% of departmental quality improvement activities weekly for 12 weeks to confirm root causes are identified, interventions implemented, and results reviewed for effectiveness. Findings will be reported monthly to the QAPI Committee and quarterly to the Governing Body to verify sustained compliance with CMS expectations and internal protocols.

Step 5 – Completion Date:
All corrective actions will be completed by **July 9, 2025**.