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F 000	INITIAL COMMENTS Correction date: 5/9/25 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #126563-C, #127121-C, #127196-C, #127475-C, #127628-C, and facility reported incident #127679-I/M conducted March 31, 2025 through April 9, 2025. Complaints #126563-C, #127121-C, #127196-C, #127475-C, #127628-C were substantiated. Facility reported incident #127679-I/M information will be sent to the facility under a separate cover. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Bogdan
TITLE: Administrator
(X6) DATE: 5/2/25

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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severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interviews, staff interviews, and policy review the facility failed to treat 3 of 7 residents reviewed with dignity and respect while providing care and services (Residents #30, #49, and #51). The facility reported a census of 74 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the

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resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The resident was marked as touch assistance for toileting transfers with the MDS further documenting tub/shower transfers and bathing were not attempted in the look back period due to medical condition or safety concerns.

The Care Plan for Resident #30 included interventions dated 7/10/24 to transfer the resident to her wheelchair at night for toileting, as well as to encourage participation in activities that promote exercise and physical activity for strengthening and improved mobility. An intervention dated 10/12/24 indicated the resident used XXL disposable briefs and directed staff to change or offer toileting every 2 hours and PRN (as needed).

On 3/31/25 at 11:16 AM the resident was noted to be asleep in her recliner wearing a red plaid nightgown. From the door of her room, her hair appeared oily and there was an odor outside of her room.

On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly the same position as the day before. She was wearing the same plaid nightgown as the day before. Her hair remained oily and tight to the side of her head.

During an interview on 04/01/25 at 07:54, when asked about staff treating her with dignity and respect, the resident reported certified nursing assistants (CNAs) had told her she had to go (urinate and defecate) in her brief due to 'spells' she had quite a while ago in the bathroom. She said she felt 'nasty' going in her brief, which

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caused trouble getting it out and constipation. They told her to finish going and call them when she was done. She stated it had happened more than once in the past week, mostly at night. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She reported she had been wearing the current clothing for 3 days.

A Progress Note dated 7/12/24 at 8:19 PM documented the resident became upset waiting to use the restroom. She told the nurse she would need to use the toilet versus 'going in the brief' that night. Documentation indicated that would be passed on to the night shift. It did not include that it was passed on to the Director of Nursing or the Administrator to discuss why she thought she had to go in her brief.

On 04/01/25 at 07:25 PM observed Staff E, CNA walk into Resident #30's room without knocking or announcing herself. Between 7:25 PM and 8:11 PM Staff E entered and exited resident rooms 7 times without knocking or announcing herself. 3 of the rooms were dark with residents sleeping and the noise Staff E made could be heard in the hallway.

During a follow up interview with Resident #30 on 04/01/25 at 08:16 PM she reported she'd had a shower after dinner. The resident stated the briefs they put her in afterwards were too tight. The surveyor observed the open package of briefs on the bed were XL. The resident stated she needed XXL and staff told her they didn't have any. She reported they were 'cutting' in to her front and back. She further stated the

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evening shift CNAs changed her brief but would not take her to the bathroom. She confirmed using the bathroom was her preference.

On 04/03/25 at 02:50 PM Staff I, Licensed Practical Nurse (LPN), stated she was aware of staff refusing to take the resident to the bathroom at night. She thought the CNA was disciplined and didn't think that person worked there anymore.

An interview with Staff G, LPN on 04/07/25 at 11:08 AM revealed the resident needed the wheelchair and 2 CNAs to take her to the bathroom and to change her brief. She stated the resident had told her about concerns with 2nd shift staff not taking her to the bathroom. She did not know if that had been reported to anyone.

While interviewing Staff H, CMA/CNA on 04/07/25 at 10:46 AM she stated Resident #30 required pretty much full care. She reported the resident had been upset some mornings when she arrived because the resident said staff at night made her go to the bathroom in her brief. She stated the resident did have 'little episodes' but if staff stayed with her in the bathroom it was fine.

2. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia. It documented a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene.

The resident's Care Plan with an admission date of 8/21/23 indicated the resident used an

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electronic tablet to assist with communication due to hearing deficit. Interventions included anticipating and meeting needs and monitoring for non-verbal signs of distress and frustration. Focus areas included risk for developing pressure ulcers, bowel and bladder incontinence, risk for falls, and fragile skin.

On 03/31/25 at 01:19 PM observed the resident's roommate and a guest who opened and closed the curtain dividing the room. Resident #49 asked to speak with the surveyor somewhere private because she felt her roommate listened to everything. At 01:40 PM the resident was transferred to her wheelchair to move to a private area. She reported she was only getting one bath a week, she had to ask repeatedly to get up in the morning, her medications were often late and her pain cream was missed some days. She stated that on 3/4/25 at 11:50 AM a CNA came in and turned off her call light without helping her leading to a 2.5 hour wait to get changed. When asked if she felt staff were respectful she stated she didn't think having to ask the CNAs to make sure she was clean after going to the bathroom, missing showers, or making residents wait so long for care was respectful at all. Resident #49 also reported staff did not provide appropriate daily care for false teeth and it was sometimes hard to get her clothes changed in the morning unless her significant other helped and shut the door.

On 04/03/25 at 2:50 PM Staff I, Licensed Practical Nurse (LPN) stated the resident probably had missed showers due to staffing issues. She was not aware of missing denture cleaning.

Staff H, Certified Nursing Aide (CNA), during an

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interview 04/07/25 at 10:46 AM, indicated residents often complained about missing baths, mostly second shift. Staff H stated oral cares should be provided at least every morning. She stated this resident had spoken to her about her care before.

On 04/07/25 at 11:08 AM Staff G, LPN reported Resident #49 had expressed concerns about showers, medications, and staff who have told her to wait and then not returned. She addressed it the times she was there but that was only part time. She thought the facility was short staffed for the care residents needed in the building.

3. The MDS for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS indicating intact cognition. He was dependent on staff for oral hygiene, toileting hygiene, and chair/bed transfers. He required substantial/maximal assistance for toilet transfers and dressing.

The Care Plan for Resident #51 with an admission date of 12/9/24 included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring.

On 03/31/25 at 11:30 AM the resident reported he was generally happy with his care. During a follow up interview with the resident on 04/08/25 at 9:05 AM he revealed that sometimes he was confused and embarrassed about some of the things he heard. When asked to explain that, he reported he had heard staff in the building talking about about him and a former employee. He stated he did feel safe but also felt 'under duress.'

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On 4/7/25 at 11:08 AM Staff G, LPN reported staff had talked about the resident and former employee when they still worked at the facility.

On 4/9/25 at 9:47 AM Staff H, CNA confirmed that she had talked about the resident, employee, and possible medication issues with other staff.

On 4/9/25 at 9:18 AM Staff F, CNA confirmed that she had talked about possible incidents with other staff and heard rumors among staff about a potential relationship.

On 4/7/25 at 9:22 AM the Director of Nursing was asked about resident dignity concerns and stated she expected nurses to check in with residents daily to make sure dressing, toileting, bathing, overall care was being completed and that every resident contact was an opportunity to ensure good care. She stated residents had complained to her about issues related to dignity such as bathing, timeliness, and staffing. She expected staff to knock before entering a room and that CNA's would help with oral care twice a day.

On 4/7/25 at 5:06 PM the Administrator reported the facility was continuing their investigation into Resident #51 concerns. She expected staff to remember this was a resident's home and didn't know staff had been talking about this incident.

A policy titled Resident Rights revised 3/4/25 revealed the resident had the right to a dignified existence. The resident had the right to be treated with respect and dignity. The resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The resident

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F 550	Continued From page 8 had a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care. The resident had a right to personal privacy and confidentiality of his or her personal and medical records.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		

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information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interviews, the facility failed to ensure resident records included advance directive wishes for 2 of 24 residents reviewed for code status (Residents #2 and #10). The facility reported a census of 74 residents.

Findings:

1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS listed her Brief Interview for Mental Status (BIMS) status score as 15 out of 15, indicating intact cognition.

A Care Plan entry, dated 2/13/25, stated the resident wished to be a Full Code.

On 4/1/25 at 8:45 a.m., the resident's face sheet on her electronic health record (EHR) did not include any information under the heading "Code Status". The binder at the nurse's station also did not include her Iowa Physician Orders for Scope of Treatment (IPOST).

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On 4/1/25 at 8:46 a.m., the Director of Nursing (DON) confirmed that Resident #2's IPOST was not in the binder nor the EHR. She stated she would correct this today.

A 4/1/25 9:32 a.m. Order Details report listed the resident as a Full Code.

2. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition.

A 5/12/22 Care Plan entry stated the resident requested to be a Do Not Resuscitate (DNR) code status.

On 4/1/25 at 8:19 a.m., Staff B Licensed Practical Nurse (LPN) stated aside from the EHR, resident code status information was located in a binder. She provided the binder which had a tab entitled "IPOST".

On 4/1/25 at 8:19 a.m., the binder under the tab entitled "IPOST" did not include an IPOST for Resident #10.

On 4/1/25 at 8:46 a.m., the DON stated if the IPOST was not in the binder and there was no access to the computer, she would need to check with social work or get a copy from the doctor if it was an immediate situation. She stated if they could not locate a code status, they would work under the assumption the resident was a Full Code. The State Agency (SA) informed the DON that Resident #10's IPOST was not in the binder. Staff B was present and located the IPOST in the

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binder under a different tab after approximately 2 minutes, at 8:48 a.m.

The resident's IPOST, dated 1/22/24, stated the resident resident's code status was a DNR.

The facility policy "Cardiopulmonary Resuscitation(CPR)", dated 7/31/23, stated the facility would carry out CPR in accordance with the resident's advance directives or in the absence of advance directives.

On 4/8/25 at 2:38 p.m., the DON stated code statuses should be up to date and in the binder.

F 602 SS=D Free from Misappropriation/Exploitation F 602
CFR(s): 483.12

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, pharmacy record review, resident interview, police narrative, staff interviews, and policy review the facility failed to protect 1 of 3 residents reviewed for abuse from misappropriation of property and exploitation (Resident #51). The facility reported a census of 74 residents.

Findings include:

The MDS (Minimum Data Set) for Resident #51,

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dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition.

The Care Plan for Resident #51 with an admission date of 12/9/24 included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring.

Three documents titled Shipment Details indicated the following medication deliveries for the resident from the resident's pharmacy:
Sildenafil Citrate 50 mg tablet, quantity 15, filled 8/30/24 (treat erectile dysfunction)
Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/8/24
Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/21/24

On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him.

Resident #51's Medication Administration Record (MAR) for August 2025 documented the resident received Sildenafil Citrate 50 mg from Staff M 8/31/24 at 6:14 PM. The record did not include documentation that 1 or 2 pills were distributed. The medication was discontinued on 9/7/24.

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SILVER OAK NURSING AND REHABILITATION CENTER LLC	**455 31ST STREET MARION, IA 52302**

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Progress Notes did not include documentation of what happened to the remaining 13 or 14 tablets at that time. No additional documentation was provided by the facility regarding this medication card.

The resident's MAR for September 2025 documented an order for Sildenafil Citrate 50 mg tablet. Give 100 mg by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. The resident received this medication from Staff M on the following dates:
9/8 - 9:40 AM
9/11 - 8:56 AM
9/13 - 6:04 PM
9/17 - 5:55 PM
9/21 - 4:57 PM
The resident's electronic health record did not document if the resident received 1 or 2 tablets for each administration.

Progress Notes did not include documentation of what happened to the other 5-10 tablets. The facility did not have additional information regarding this card.

The resident's MAR for October 2025 documented an order for Sildenafil citrate 50 mg tablet. Give 2 tablets by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. The resident received this medication from Staff M on the following dates:
10/4 - 6:17 PM
10/5 - 6:08 PM
10/6 - 6:27 PM
10/15 - 5:16 PM

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10/19 - 6:01 PM
10/20 - 5:21 PM
The resident's electronic health record did not document if the resident received 1 or 2 tablets for each administration. The facility did not have additional information regarding this card.

Progress Notes did not include documentation of what happened to the other 3-9 tablets at that time. No additional administration of this medication was documented in the resident's MAR. In total between 21 and 33 tablets of Sildenafil Citrate were unaccounted for.

On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M and Resident #51. The Administrator stated Staff M was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm they occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why they did not report it to the state.

On 4/2/25 at 2:40 PM the surveyor observed Staff N, Licensed Practical Nurse look through the contents of the medication cart. The cart did not contain any of the 3 missing medication cards. Staff N accompanied the surveyor to the medication storage room. The cards were not in the storage room or the pharmacy bin.

On 4/6/25 at 1:43 PM a county deputy emailed the surveyor a narrative of an investigation he

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was conducting. It noted that a backpack owned by Staff M contained a label from an unknown container, identified as a prescription for Sildenafil Citrate 50 mg to Resident #51 by his provider. The deputy provided a picture of the card top that included Resident #51's name. The narrative further documented Resident #51 resided at a care facility where Staff M was previously employed. Staff M refused to answer the deputy's questions regarding having a sexual and/or inappropriate relationship with Resident #51.

On 4/7/25 at 5:06 PM the Administrator stated she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give Resident #51 this medication.

On 4/9/25 at 9:18 AM Staff F, CNA (Certified Nurses Aide) stated that while she didn't see physical contact personally, Staff M and Resident #51 had a relationship she observed that was not professional and other staff did witness inappropriate things. She reported hearing Staff M took medications that belonged to residents and mentioned insulin because Staff M said she was 'allergic to cake', an anxiety medication when she had a panic attack at work, and the Sildenafil Citrate. Staff F indicated Resident #51 could be inappropriate with female staff, so staff provided cares in pairs. She reported Staff M and Resident #51 had private time together and she was in his room with the door closed when there was not a reason to be. She stated Resident #51 told other staff that Staff M gave him 'hand jobs,' made out with him, gave her money for her

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birthday, and gave her money for a phone he never got. She stated rumors increased after the two reports by her co-workers.

A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written.

Section III. Prevention of Abuse, Neglect, and Exploitation documented the following:
B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur;
H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.

Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included:
A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.
B. Written procedures for investigations include:
1. Identifying staff responsible for the investigation;
2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);
3. Investigating different types of alleged violations;

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F 602	Continued From page 17 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		

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incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, pharmacy record review, resident interview, staff interviews, and policy review the facility failed to report potential misappropriation and exploitation for 1 of 3 residents reviewed (Resident #51). Facility staff indicated they were aware of potential incidents as early as July 2024. The facility reported a census of 74 residents.

Findings include:

The MDS (Minimum Data Set) for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition.

The Care Plan for Resident #51 with an admission date of 12/9/24 included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring.

According to pharmacy records, the facility received the following medication cards for Resident #51:
Sildenafil Citrate 50 mg tablet, quantity 15, filled 8/30/24 (treat erectile dysfunction)
Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/8/24
Sildenafil Citrate 50 mg tablet, quantity 15, filled 9/21/24

Resident #51's Medication Administration

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F 609	Continued From page 19 Records (MAR) for August, September, and October 2025 documented an order for Sildenafil Citrate 50 mg tablet, 100 mg or two tablets by mouth as needed for vasculogenic dysfunction of corpus cavernosum, take 1-2 tablets as needed once daily. He received doses from Staff M (RN) 12 times. No other staff administered the medication. The electronic health record did not include documentation whether 1 or 2 pills were distributed at each administration. In total between 21 and 33 tablets were unaccounted for. The facility was unable to provide documentation regarding the location of the missing cards or audits of the medication carts or storage that would indicate when the medications went missing. On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him. He stated he kissed Staff M, and believed that was a romantic thing to do. He confirmed she was an employee of the facility at the time. He stated they had agreed to 'take it slow.' He told the surveyor Staff M talked about her ex with him and that he was really bothered by the fact that Staff M might have been married at that time because he didn't want to be responsible for her cheating. At the end of the interview the resident was tearful, unable to speak for a moment and covered his mouth with his hand. He said he just	F 609		

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missed her and this was hard. He thought he was in love with her, she never came back to see him, and he was confused about all of this.

On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M and Resident #51. The Administrator stated Staff M was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm the incidents occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why they did not report it. On 4/7/25 at 5:06 PM the Administrator added that she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give Resident #51 this medication.

On 4/2/25 at 2:40 PM the surveyor observed Staff N, Licensed Practical Nurse (LPN) look through the contents of the medication cart. The cart did not contain the 3 missing medication cards. Staff N accompanied the surveyor to the medication storage room. The cards were not in the storage room or the pharmacy bin.

On 4/7/25 at 10:46 AM Staff H, CMA (Certified Medication Aide) stated there was a lot going around when Staff M was still at the facility about an inappropriate relationship. There were comments that she stuck her tongue down his throat, and that he gave her money for a phone.

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She stated the relationship was different from nurse and patient, and that there was some weird stuff going on. On 4/9/25 at 9:47 AM Staff H added she also heard about Staff M taking medication. She believed it was reported to the Director of Nursing at the time or the Administrator.

On 4/7/25 at 11:08 AM Staff G, LPN stated she heard about 'tongue swapping' between Staff M and Resident #51, and money changing hands. She reported seeing Staff M in the building late, between 10 and 11, and Staff M would follow him. Staff G stated Staff M gave Resident #51 special treatment, and that the resident was madly in love with her. She stated he still wasn't over it. She indicated staff 'all' knew about it and Staff M pushed to get the Sildenafil Citrate on board.

On 4/9/25 at 9:18 AM Staff F, CNA stated that while she didn't see physical contact personally, Staff M and Resident #51 had a relationship she did observe that was not professional and other staff did witness inappropriate things. She reported hearing Staff M took medications that belonged to residents and mentioned insulin because Staff M said she was 'allergic to cake', an anxiety medication when she had a panic attack at work, and the Sildenafil Citrate. Staff F indicated Resident #51 could be inappropriate with female staff, so staff provided cares in pairs. She reported Staff M and Resident #51 had private time together and she was in his room with the door closed when there was not a reason to be. She stated Resident #51 told other staff that Staff M gave him 'hand jobs,' made out with him, gave her money for her birthday, and gave her money for a phone he never got. She stated rumors increased after the two reports by her

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F 609	Continued From page 22 co-workers. A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written. Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on a police narrative, clinical record review, resident interview, staff interviews, and facility policy review the facility failed to prevent further potential misappropriation of property and exploitation and failed to conduct thorough investigations into two incidents for 1 of 3 residents reviewed (Resident #51). The facility reported a census of 74 residents.

Findings include:

The MDS (Minimum Data Set) for Resident #51, dated 2/9/25, included diagnoses of multiple sclerosis, neurogenic bladder, anxiety, and depression. The resident scored 15/15 on the BIMS (Brief Interview for Mental Status assessment) which indicated intact cognition.

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F 610	Continued From page 24 The Care Plan for Resident #51 with an admission date of 12/9/24 included focus areas, goals, and interventions related to multiple sclerosis care, depression, anxiety, mood, and medication monitoring. On 4/1/25 at 8:01 PM the Administrator notified the surveyor they received a call from the local police department requesting information about Staff M (RN) and Resident #51. The Administrator stated Staff M, Registered Nurse (RN) was terminated in November (2024) for performance issues. She stated there were two incidents prior to that termination where staff in the facility reported Resident #51 and Staff M hugged and kissed. She stated they investigated and the facility was not able to confirm either incident occurred because the resident had a BIMS of 15 and denied them when questioned. She stated the denial was why the alleged abuse was not reported to the state. On 4/6/25 at 1:43 PM a county deputy emailed the surveyor a narrative of an investigation he was conducting. It noted that a backpack owned by Staff M contained a label from an unknown container, identified as a prescription for Sildenafil Citrate 50 mg to Resident #51 by his provider. The deputy provided a picture of the card top that included Resident #51's name. Staff M refused to answer questions regarding a sexual or inappropriate relationship with the resident. On 4/7/25 at 5:06 PM the Administrator stated she assumed Staff M took the medication because it wasn't in the medication cart or the storage room. She reported she contacted the pharmacy and none of the medication was returned. Staff M was the only person to give	F 610		

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Resident #51 this medication. The facility was unable to provide documentation that cart or storage room audits had been conducted prior to the report from the deputy that would have investigated for the missing Sildenafil Citrate cards.

On 04/08/25 at 9:05 AM the resident revealed he was very close to Staff M, RN (Registered Nurse). He stated he tipped her with 5 or 10 bucks for her birthday. When asked, the resident reported she kept the money and must have really needed it. When asked about a medication order from his urologist, Sildenafil Citrate, Resident #51 stated he knew on a personal level that Staff M had access to it. He thought she was the last one, maybe the only one, to give it to him. He stated he kissed Staff M, and believed that was a romantic thing to do. He confirmed she was an employee of the facility at the time. He stated they had agreed to 'take it slow.' He told the surveyor Staff M talked about her ex with him and that he was really bothered by the fact that Staff M might have been married at that time because he didn't want to be responsible for her cheating. At the end of the interview the resident was tearful, unable to speak for a moment and covered his mouth with his hand. He said he just missed her and this was hard. He thought he was in love with her, she never came back to see him, and he was confused about all of this.

The facility did not have documentation that Staff M reported a kiss by or with the resident. There was no indication the resident was separated from Resident #51 while either of the two reported staff reports were investigated. No information was provided that documented dates of the staff reports, written statements, interviews

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with the resident, the staff who reported the incidents, or other facility staff interviews to verify a thorough investigation was conducted.

A facility policy titled Abuse, Neglect and Exploitation reviewed/revised October 2022 documented it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, exploitation, and misappropriation of resident property. The facility would provide ongoing oversight and supervision of staff to ensure policies were implemented as written.

Section V. Investigations of Alleged Abuse, Neglect, and Exploitation included:
A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.
B. Written procedures for investigations include:
1. Identifying staff responsible for the investigation;
2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);
3. Investigating different types of alleged violations;
4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;
5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and
6. Providing complete and thorough documentation of the investigation.

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F 623	Continued From page 27	F 623		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		

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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 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, interview, and policy review the facility failed to notify the Office of the State Long-Term Care Ombudsman of resident transfers to the hospital for 3 of 3 residents reviewed for hospitalizations (Residents #31, #43, #70). The facility reported a census of 74 residents.

Findings include:

1. The Minimum Data Set (MDS) for Resident #31 dated 3/15/25 documented diagnoses including heart failure, renal failure, and non-rheumatic aortic (valve) stenosis with an admission date of 12/6/24.

Clinical record review revealed the resident was transferred to the hospital on the following date:
a. 2/19/25 at 8:25 PM

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2. The Minimum Data Set (MDS) for Resident #43 dated 3/14/25 documented diagnoses of cancer, Multidrug-Resistant Organism (MDRO) infection, seizure disorder, and respiratory failure with an admission date of 1/1/25.

Clinical record review revealed the resident was transferred to the hospital on the following dates:
a. 2/7/25
b. 2/27/25

3. The Minimum Data Set (MDS) for Resident #70 dated 3/11/25 documented diagnoses including orthostatic hypotension, diabetes mellitus, and stage 3 chronic kidney disease with an admission date of 11/6/24.

Clinical record review revealed the resident was transferred to the hospital on the following dates:
a. 3/3/25
b. 3/24/25

On 04/08/25 at 11:08 AM, when asked about documentation of Ombudsman notification for resident transfers and discharges, the Administrator stated she needed to see if the new facility social worker had started doing them. She reported she had called the ombudsman's office in February for the email address to send them to after the former social worker quit.

A follow up email from the Administrator on 04/08/25 at 12:25 PM determined the Ombudsman notifications had not been completed for these residents.

The facility's Bed Hold Policy, dated 2021, did not include notification of the Ombudsman's office.

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F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, Progress Notes, staff interview, and facility policy review the facility failed to notify a resident and their representative of the cost to hold their bed when the resident was transferred out of the facility for 3 of 3 residents reviewed for hospitalization (Residents #31, #43, #70). The facility failed to complete	F 625		

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written Bed Hold notices or provide potential costs to the resident or family representative. The facility reported a census of 74 residents.

Findings include:

1. The Minimum Data Set (MDS) for Resident #31 dated 3/15/25 documented diagnoses including heart failure, renal failure, and non-rheumatic aortic (valve) stenosis with an admission date of 12/6/24.

Clinical record review revealed the resident was transferred to the hospital on the following date:
a. 2/19/25 at 8:25 PM

A Progress Note dated 2/19/25 at 8:50 PM indicated the power of attorney was updated on the situation. The note did not include information that the Bed Hold policy or potential payment was discussed.

2. The Minimum Data Set (MDS) for Resident #43 dated 3/14/25 documented diagnoses of cancer, Multidrug-Resistant Organism (MDRO) infection, seizure disorder, and respiratory failure with an admission date of 1/1/25.

Clinical record review revealed the resident was transferred to the hospital on the following dates:
a. 2/7/25
b. 2/27/25

A Progress Note titled health status note dated 2/7/25 at 9:40 AM documented the resident was seen by the advanced registered nurse practitioner and it was determined the resident should be sent to the emergency room. The resident's wife agreed. The Progress Note did

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not include discussion of a Bed Hold, the policy for holding the bed, or potential cost to hold the room.

3. The Minimum Data Set (MDS) for Resident #70 dated 3/11/25 documented diagnoses including orthostatic hypotension, diabetes mellitus, and stage 3 chronic kidney disease with an admission date of 11/6/24.

Clinical record review revealed the resident was transferred to the hospital on the following dates:
a. 3/3/25
b. 3/24/25

A Progress Note dated 3/3/25 at 3:39 PM indicated the resident was transported to the hospital. It did not include discussion of Bed Hold policy or potential costs.

A Progress Note dated 3/24/25 at 7:24 AM revealed the resident had an order to be sent to the emergency room. It did not include discussion of Bed Hold policy or potential costs.

During an interview on 04/07/25 at 1:15 PM the Administrator stated the facility had a Bed Hold form a former Director of Nursing (DON) was going to be using. She needed to look for them.

An email from the Administrator dated 4/7/25 at 4:39 PM determined there was not a Bed Hold form for Resident #70. A follow up email 4/7/25 at 6:11 PM revealed there were not Bed Hold forms for Residents #31 or #43.

A policy titled Bed Hold Prior to Transfer, dated 2021, documented it was the policy of the facility to provide written information to the resident

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F 625	Continued From page 34 and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital. This would include duration of the hold, reserved bed payment policy if any, and conditions for the resident to return to the facility.	F 625		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview, and facility policy review the facility failed to provide services according to physician orders for 1 of 4 residents reviewed (Residents #49). The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #49 dated 3/16/25 included diagnoses of chronic pain syndrome, arthritis, osteoporosis, and fibromyalgia. It documented a Brief Interview for Mental Status (BIMS) of 15/15 indicating intact cognition. The resident's Care Plan with an admission date of 8/21/23 indicated staff should anticipate pain and respond immediately to complaints of pain, evaluate the effectiveness of pain interventions including review for compliance, dosing schedules, and resident satisfaction with results, and monitor/record/report signs and symptoms of non-verbal pain.	F 658		

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On 03/31/25 at 01:40 PM Resident #49 reported her medications were often late and her pain cream was missed some days. She stated she had discussed this with nurses, the Director of Nursing, and the Administrator.

The resident's Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed the resident's orders included Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to Bilateral knees topically three times a day for pain 4 grams. Treatments were missed during the evening medication pass (labeled 'supper') between 3/1/25 and 4/8/25:

3/2, 3/4, 3/5, 3/7, 3/8, 3/9, 3/10, 3/11, 3/13, 3/18, 3/22, 3/23, 3/24, 3/25, 3/27, 3/31, & 4/5.

During the same time frame, in addition to scheduled pain medication, Resident #49 required the following PRN (as needed) pain medications:
3/23/25 - Acetaminophen Oral Tablet 325 MG
3/27/25 - Acetaminophen Oral Tablet 325 MG
4/5/25 - Acetaminophen Oral Tablet 325

On 04/03/25 at 2:50 PM Staff I, Licensed Practical Nurse (LPN) acknowledged that medications had been missed or given outside of the scheduled time range.

On 04/07/25 at 11:08 AM Staff G, LPN reported Resident #49 had expressed concerns about showers, medications, and staff who had told her to wait and then not returned. She addressed it the times she was there and stated that she was only part time. When asked about staffing, Staff

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F 658	Continued From page 36 G stated she thought the facility was short staffed for the care residents needed in the building. A policy titled Medication Administration - General reviewed/revised 9/19/23 indicated medications were administered by licensed nurses, or other staff legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. Medications were to be administered within 60 minutes prior to or after scheduled times.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to provide bathing and/or grooming assistance for 8 of 13 residents reviewed for activities of daily living assistance (Residents #2, #10, #13, #30, #46, #49, #71, #231). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating	F 677		

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intact cognition.

The facility policy "Activities of Daily Living", dated 12/4/24, stated staff would assist residents with baths, dressing, and oral care.

A 2/19/25 Care Plan entry stated the resident usually required assistance to provide supervision, verbal cues, and touching/steadying or contact assistance with bathing. The entry stated the resident required assistance with washing her back and hair.

On 3/31/25 at 10:36 a.m., Resident #2 stated she only received one bath per week because the facility was short-staffed.

Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 2/11/25 and 4/2/25:

2/22/25 shower documented on paper Resident Bath/Shower Sheet
3/1/25 shower documented on paper Resident Bath/Shower Sheet
3/8/25 shower documented on March 2025 Documentation Survey Report V2
3/12/25 shower documented on March 2025 Documentation Survey Report V2
3/15/25 Resident Bath/Shower Sheet was blank
3/19/25 Resident Bath/Shower Sheet stated the resident did not want to shower and requested if she could shower "tomorrow"
3/22/25 shower documented on paper Resident Bath/Shower Sheet
3/29/25 shower documented on paper Resident Bath/Shower Sheet

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The facility lacked documentation of additional tub baths or showers received during the above time period including between 2/12/25 and 2/22/25, a span of 9 days, between 2/22/25 and 3/1/25, a span of 7 days, between 3/1/25 and 3/8/25, a span of 7 days, and between 3/22/25 and 3/29/25, a span of 7 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

2. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS stated the resident was dependent of staff for personal hygiene including combing hair. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition.

A 10/18/23 Care Plan entry stated the resident was depended on staff for combing hair.

On 3/31/25 at approximately 1:00 p.m., Resident #10 walked down the East hall and her hair was disheveled and sticking up in the back.

On 4/2/25 at 9:00 a.m., the resident ate breakfast in the dining room. The resident's hair was in a head band but her hair was sticking up on both sides and was matted at the crown of her head.

3. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition.

A 10/12/23 Care Plan entry stated the resident required partial to moderate assistance for

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bathing.

On 3/31/25 at 1:11 p.m., Resident #13 stated she was supposed to receive a bath twice per week but that did not happen.

Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25:
2/17/25 partial bed bath or wash up at sink documented on February Documentation Survey Report V2
2/20/25 shower documented on paper Resident Bath/Shower Sheet
2/22/25 shower documented on paper Resident Bath/Shower Sheet
3/3/25 shower documented on March 2025 Documentation Survey Report V2
3/13/25 The paper Resident Bath/Shower sheet was blank.
3/27/25 shower documented on March 2025 Documentation Survey Report V2
3/31/25 The resident refused according to the March Documentation Survey Report V2.

The facility lacked documentation of additional tub bath or showers received or offered during the above time period including between 2/1/25 and 2/17/25, a span of 15 days, between 2/22/25 and 3/3/25, a span of 8 days, between 3/3/25 and 3/10/25, a span of 6 days, and between 3/17/25 and 3/27/25, a span of 9 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

4. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #46 which included

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heart failure, non-Alzheimer's dementia, and depression and listed the resident's BIMS score as 11 out of 15, indicating moderately impaired cognition.

A 10/12/23 Care Plan entry stated the resident required assistance of staff for washing her back and hair and to provide assistance transferring into the tub or shower.

On 03/31/25 at 11:12 a.m., Resident #46 stated she went three weeks with no bath.

Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25:
2/7/25 shower documented on February Documentation Survey Report V2.
2/25/25 shower documented on February Documentation Survey Report V2.
2/28/25 shower documented on February Documentation Survey Report V2.
3/21/25 documentation of resident refusal of shower on March 2025 Documentation Survey Report V2
3/28/25 shower documented on February Documentation Survey Report V2.

The facility lacked documentation of additional tub baths or showers received or offered during the above time period including between 2/1/25 and 2/7/25, a span of 6 days, between 2/7/25 and 2/25/25, a span of 18 days, between 2/28/25 and 3/21/25, a span of 20 days, and between 3/21/25 and 3/28/25, a span of 6 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

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5. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (infection of the tissue) of the left lower limb, heart failure, and obesity and listed the resident's BIMS score as 15 out of 15, indicating intact cognition.

Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 3/7/25 and her discharge on 3/25/25:
3/12/25 shower documented on March 2025 Documentation Survey Report V2
3/13/25 shower documented on March 2025 Documentation Survey Report V2
3/15/25 bed bath documented on paper Resident/Bath/Shower Sheet and stated the resident did not want shower due to her leg dressings
3/24/25 shower documented on Resident Bath/Shower Sheet.

The facility lacked documentation of additional tub baths or showers received during the above time period including between 3/7/25 and 3/12/25, a span of 4 days and between 3/15/25 and 3/24/25, a span of 8 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

On 4/7/25 at 10:31 a.m., Staff C Certified Nursing Assistant(CNA) stated Resident #71 needed a shower and she felt like the facility needed to pay attention to how they sent residents out to appointments. She stated she remembered the resident going to dialysis and her hair was matted.

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On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should receive at minimum two baths per week and she had a plan to remedy the concern moving forward. She stated staff should comb a resident's hair before leaving the room.

6. The MDS assessment for Resident #231 dated 2/15/25 listed diagnoses of heart failure, renal failure, and non-Alzheimer's dementia and indicated the resident was unable to complete the BIMS assessment due to short and long term memory problems.

The resident's Care Plan with an admission date of 10/30/23 recorded actual skin impairment, risk of pressure ulcer development, nutritional problems, incontinence, and the need for the assistance of two helpers with bathing due to impaired cognition and weakness.

On 03/31/25 at 1:40 PM Resident #231's former roommate reported the resident went weeks without a bath, and she thought that was because Resident #231 couldn't speak up for herself like she could.

Facility documentation titled South Hall shower schedule listed Resident #231 was scheduled to receive a bath/shower on Mondays and Thursdays. No shower sheets with skin assessments were completed for the resident between 2/1/25 and 3/14/25.

Review of the resident's February and March 2025 Documentation Survey Report V2 revealed the resident received the following baths or showers from 2/1/25 through 3/14/25:

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2/10/25 #1 documented, which indicated the resident had a partial bed bath.
2/17/25 shower documented.
2/27/25 shower documented.
3/03/25 #1 documented.

The facility did not have documentation that staff communicated missed baths/showers or approached the resident on a different day.

7. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia and a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene.

The resident's Care Plan with an admission date of 8/21/23 included focus areas for risk of developing pressure ulcers, bowel and bladder incontinence, risk for falls, and fragile skin.

During an interview on 03/31/25 at 01:40 PM Resident #49 reported receiving 1 bath per week and she didn't want a bed bath to replace her showers. She wanted staff to take the time to dry her well after bathing so she didn't get sores under her breasts. She stated it was hard to get a CNA to find the Administrator or Director of Nursing (DON) when she wanted to talk about her concerns. She added regular bathing was important because 3 CNA's didn't get her completely clean, and sometimes she had to use wipes to clean herself.

A document titled Monthly Grievance log contained an entry dated 10/21/24 from Resident #49 that she was not receiving showers. It

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documented the issue was resolved the same day.

Review of the resident's Documentation Survey Report V2 and bathing/skin sheets for March 2025 documented:

3/3/25 #1 which meant washed up, sink bath, or partial bed bath. No shower/skin sheet.
3/5/25 #1. No shower/skin sheet.
3/7/25 shower documented. No shower/skin sheet.
3/10/25 blank. No shower/skin sheet.
3/12/25 #1. No shower/skin sheet.
3/14/25 blank, skin sheet documented a shower
3/17/25 #1. No shower/skin sheet.
3/19/25 blank. No shower/skin sheet.
3/21/25 shower documented, bathing sheet confirmed
3/24/25 not applicable documented. No shower/skin sheet.
3/26/25 #1. No shower/skin sheet.
3/28/25 shower documented. No shower/skin sheet.

Facility documentation in Progress Notes and bathing sheets did not include documentation that the resident refused any baths/showers.

8. The MDS for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The MDS further documented tub/shower transfers and bathing

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were not attempted in the look back period.

The Care Plan for Resident #30 included interventions dated 7/10/24 to transfer the resident to her wheelchair at night for toileting. An intervention dated 10/12/24 directed staff to change or offer toileting every 2 hours and PRN (as needed).

On 3/31/25 at 11:16 AM observed the resident asleep in her recliner. From the door of her room, her hair appeared oily and there was a musty urine odor outside of her room.

On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly same position as the day before and wore the same plaid nightgown. Her hair remained oily and tight to the side of her head.

During an interview on 04/01/25 at 07:54 the resident reported certified nursing assistants (CNAs) told her she had to go (urinate and defecate) in her brief due to 'spells' she had in the bathroom. She said she felt 'nasty' going in her brief, which caused trouble getting it out and constipation. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She reported she had been wearing her current clothing for 3 days.

Review of the resident's March 2025 Documentation Survey Report V2 indicated the resident received 1 bath in March on 3/11/25 and refused a bath on 3/7/25. The facility was unable to provide bath/skin sheets to supplement missing days or document additional efforts to

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F 677	Continued From page 46 offer the resident a bath. Progress Notes for Resident #30 did not document additional baths given, alternate attempts after refusals, or offers of alternate interventions. Additional documentation in the V2 report for March 2025 indicated the resident was not assisted with oral hygiene, hair care, shaving, or washing hands and face the following mornings: 3/4, 3/10, 3/11, 3/13, 3/14, 3/15, 3/16, 3/18, 3/19, 3/22, 3/23, 3/30, and 3/31. During an interview with the DON on 4/7/25 at 9:22 AM she stated the nurses should be checking daily to ensure dressing and toileting were done, and that every contact with the resident was an opportunity to ensure cares were done, including oral care morning and night. She indicated residents had complained to her about bathing and linen changes. She did not think there was currently enough staff for all of the needs residents had. The DON confirmed staff had refused to take the resident to the bathroom at night. Staff had been re-educated 3 weeks before. She was not aware it was still happening. On 4/7/25 at 11:08 AM Staff G, LPN reported acuity impacted completion of tasks, and that call ins affected how much could get done in a day. She stated every resident could have better teeth care here. She expected staff to help with oral cares and other activities of daily living, and there was a domino effect when there was not enough staff.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interviews, the facility failed to carry out wound assessments and/or wound treatments for 3 of 6 residents reviewed for non-pressure wounds (Residents #63, #71, and #232). The facility reported a census of 74 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident #63 which included left foot drop, muscle weakness, and abnormal posture. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.

A 7/30/24 Care Plan entry stated the resident had actual impairment to skin integrity related to a left foot surgical wound.

An 8/1/24 surgical note stated the resident had a left fourth toe amputation and had a diagnosis of osteomyelitis(infection of the bone).

A 12/20/24 Order Note requested the

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discontinuation of a betadine (an iodine solution used to treat wounds) treatment to the left foot due to the area "long since healed".

A 12/28/24 Order Note stated the facility received a verbal order for betadine to the left second and third digits.

The facility lacked documentation of an assessment of the left foot and a reason for the betadine order.

A 1/3/25 Weekly Skin Observation lacked documentation of a current wound.

A 1/10/25 Weekly Skin Observation stated the resident had a "left foot mark" and "scar" but lacked any further assessment of the foot.

A 1/14/25 surgical note stated the resident had a wound on the left second and third toes which he stated began a couple of weeks prior.

The facility lacked further documentation of left foot assessments including a description of the wound and wound measurements from the date of the order on 12/28/24 until the 1/14/25 surgical appointment.

2. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (an infection of the tissues) of the left lower limb, heart failure, and obesity. The MDS stated the resident had two venous or arterial ulcers and listed the resident's BIMS score as 15 out of 15, indicating intact cognition.

A 3/3/25 hospital note stated the resident had non-healing bilateral lower extremity wounds and

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had lower left extremity black eschar (a thick, dry, leathery, and often dark-colored (black, brown, or tan) tissue that formed on a wound, typically after a burn or other severe injury) and erythema (redness) with purulent (referring to pus) drainage.

A 3/7/25 hospital Summary of Care report listed current medications including silver sulfadiazine 1% cream (used to treat and prevent infections) and zine oxide (used to protect skin) to bilateral lower legs and feet twice daily.

A 3/7/25 Health Status Note stated the resident arrived at the facility from the hospital.

A 3/7/25 Nursing Admission/Readmission Assessment, documented the resident had vascular wounds to the right and left lower legs.

A 3/7/25 Weekly Skin Observation documented the resident had left and right lower leg necrosis (referring to dead tissue), a right foot ulcer measuring 3 centimeters (cm) x 2 cm, and a left upper leg ulcer measuring 3 cm x 5 cm.

Care Plan entries, dated 3/8/25, stated the resident had potential/actual impairment to the skin integrity of the right and left legs and directed staff to carry out weekly documentation including measurements, tissue type, and other notable changes or observations.

The March 2025 Treatment Administration Record (TAR) included the following orders:
a. Silver Sulfadiazine Cream 1%, apply to bilateral lower extremities and feet topically every shift, cleanse
wound with soap and water, apply zinc oxide

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F 684	Continued From page 50 paste to peri-wound skin, apply thick layer like frosting of sulfadiazine on 4x4 gauze and apply to wound, cover with abdominal pads, wrap with kerlix (a type of gauze bandage) and secure with 2 inch paper tape. b. Silver Sulfadiazine Cream 1%, apply to left medial (referring to the middle portion) lower leg topically every shift, cleanse wound with saline and gauze, loosely fill wound with sulfadiazine moistened packing strip, cover with an abdominal pad, wrap with Kerlix, and secure with paper tape. c. Zinc Oxide External Paste 40%, apply to legs and feet per orders. The following entries were blank and lacked staff initials to indicated the completion of the above treatments: 3/8/25 6:00 a.m. dose, 3/11/25 night dose, 3/12/25 morning dose, 3/22/25 night dose. The 3/9/25 morning dose documented a "9" which directed to Progress Notes. 3/9/25 eMAR Administration Notes stated the facility waited for the resident's Silver Sulfadiazine Cream 1% and zinc oxide from the pharmacy. A 3/14/25 Nurse Practitioner note stated the resident had cellulitis of the lower extremities with non-healing ulcers and stated the dressings were intact and per nursing, the wounds were stable with no acute signs of infection. A 3/14/25 Weekly Skin Observation sheet stated the resident had vascular wounds to the bilateral lower legs. The document contained no other assessments or measurements of the wounds. A 3/21/25 Health Status Note stated the resident's	F 684		

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wounds to the left lower extremity were worsening and the redness extended to mid-thigh bilaterally.

A 3/21/25 Weekly Skin Observation stated the resident had pressure ulcers to the right and left heels. The sheet lacked documentation of an assessment to the legs.

A 3/21/25 Order Note stated the resident's bilateral lower legs weeped with a moderate amount of serosanguinous(bloody, watery) drainage. The wound beds vary with slough (a yellow, white, or tan, stringy, or thick substance, that overlayed a wound bed and hindered healing) and necrotic areas with surrounding redness noted.

The facility lacked further assessments of the residents legs during the time of her admission until her 3/25/25 discharge.

A 3/25/25 Progress Note stated the resident received orders to discharge.

The facility policy "Nurse Services and Sufficient Staff" revised 2/5/25, listed nursing duties to include: assessing, evaluating, planning, and implementing resident care plans and responding to resident needs.

The facility policy "Notification of Changes, revised 10/21/24, stated the facility would promptly consult the resident's physician when there was a change requiring notification.

On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should carry out treatments and should complete skin assessments weekly.

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On 4/8/25 at 2:38 p.m., the DON stated they did not locate anything additional for Resident #71 but were still working on it.

F 686 SS=D — Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) — F 686

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interview, the facility failed to complete regular assessments and treatments to treat a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #71). The facility reported a census of 74 residents.

Findings include:

The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may

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appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:
Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

The MDS assessment tool, dated 3/14/25, listed

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diagnoses for Resident #71 which included cellulitis (an infection of the tissues) of the left lower limb, heart failure, and obesity. The MDS stated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A 3/7/25 hospital note stated the resident had wounds to the left and right heel.

A 3/7/25 Health Status Note stated the resident arrived at the facility from the hospital.

A 3/7/25 Nursing Admission/Readmission Assessment, documented the resident had vascular wounds to the right and left lower legs.

A 3/7/25 Weekly Skin Observation documented the resident had left and right lower leg necrosis (referring to dead tissue), a right foot ulcer measuring 3 centimeters x 2 cm, and a left upper leg ulcer measuring 3 cm x 5 cm. The assessment lacked documentation the resident had heel wounds.

A 3/8/25 Care Plan entry stated the resident was at risk for developing a pressure ulcer.

The March 2025 Treatment Administration Record (TAR) listed an order for skin prep to the bilateral heels every shift and as needed and listed a discontinue date of 3/7/25. The TAR lacked documentation of a heel treatment from the resident's admission on 3/7/25 until her discharge on 3/25/25.

The resident's clinical record contained no

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F 686	Continued From page 55 documentation of wounds on the resident's heels from her admission date on 3/7/25 until 3/21/25. A 3/21/25 Weekly Skin Observation assessment stated the resident had a Stage 3 pressure ulcer to the right heel and a Stage 4 pressure ulcer to the left heel. The document contained no further description or measurements of the wound. A 3/21/25 Care Plan entry stated the resident had a Stage 3 pressure ulcer to the right heel and a Stage 4 pressure ulcer to the left heel. A 3/21/25 Health Status Note stated the resident had a Stage 4 (pressure ulcer) to the left heel and the facility notified the physician. A 3/21/25 Order Note stated the provider visited and observed the resident complete her dressing change. The note did not mention the resident's heel pressure ulcers. The facility lacked documentation of bilateral heel treatments completed from 3/21/25 to the resident's discharge on 3/25/25. A 3/25/25 Progress Note stated the resident received orders to discharge. On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should carry out treatments and should complete skin assessments weekly. The facility policy "Pressure Injury Prevention and Management", revised December 2024, stated the facility would review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and	F 686		

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document a summary of findings in the medical record.

F 689 SS=D — Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2) — F 689

§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, clinical record review, and staff interview, the facility failed to ensure safe wheelchair movement for 1 of 1 residents reviewed for wheelchair safety (Resident #41). The facility reported a census of 74 residents.

Findings include:

The Minimum Data Set (MDS) assessment tool, dated 1/21/25, listed diagnoses for Resident #41 which included heart failure, non-Alzheimer's dementia, and anxiety. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 3 out of 15, indicating severely impaired cognition.

A 10/28/23 Care Plan entry stated the resident was dependent on staff to move the wheelchair.

On 3/31/25 at 12:53 p.m., Staff A, Certified Nursing Assistant (CNA) pushed Resident #41 down the hall in her wheelchair and her left foot drug on the ground during the transfer. Staff A

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F 689	Continued From page 57 pushed the resident approximately 50 feet down the hall. On 4/7/25 at 9:22 a.m., the Director of Nursing (DON) stated staff should utilize foot pedals when pushing residents in a wheelchair. On 4/9/25 at approximately 2:00 p.m., the Administrator stated the facility did not have a policy pertaining to the use of wheelchair foot pedals.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		

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paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure sufficient staff in order to provide bathing and/or grooming assistance for 8 of 13 residents reviewed for activities of daily living assistance (Residents #2, #10, #13, #30, #46, #49, #71, & #231). The facility reported a census of 74 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The facility policy "Nursing Services and Sufficient Staff", revised 2/5/25, stated the facility would provide sufficient staff with appropriate competencies and skill sets 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.

The facility policy "Activities of Daily Living", dated 12/4/24, stated staff would assist residents with baths, dressing, and oral care.

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A 2/19/25 Care Plan entry stated Resident #2 usually required assistance to provide supervision, verbal cues, and touching/steadying or contact assistance with bathing. The entry stated the resident required assistance with washing her back and hair.

On 3/31/25 at 10:36 a.m., Resident #2 stated she only received one bath per week because the facility was short-staffed.

Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 2/11/25 and 4/2/25:

2/22/25 shower documented on paper Resident Bath/Shower Sheet
3/1/25 shower documented on paper Resident Bath/Shower Sheet
3/8/25 shower documented on March 2025 Documentation Survey Report V2
3/12/25 shower documented on March 2025 Documentation Survey Report V2
3/15/25 Resident Bath/Shower Sheet was blank
3/19/25 Resident Bath/Shower Sheet stated the resident did not want to shower and requested if she could shower "tomorrow"
3/22/25 shower documented on paper Resident Bath/Shower Sheet
3/29/25 shower documented on paper Resident Bath/Shower Sheet

The facility lacked documentation of additional tub baths or showers received during the above time period including between 2/12/25 and 2/22/25, a span of 9 days, between 2/22/25 and 3/1/25, a span of 7 days, between 3/1/25 and 3/8/25, a span of 7 days, and between 3/22/25

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F 725	Continued From page 60 and 3/29/25, a span of 7 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal. 2. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS stated the resident was dependent of staff for personal hygiene including combing hair. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition. A 10/18/23 Care Plan entry stated the resident was depended on staff for combing hair. On 3/31/25 at approximately 1:00 p.m., Resident #10 walked down the East hall and her hair was disheveled and sticking up in the back. On 4/2/25 at 9:00 a.m., the resident ate breakfast in the dining room. The resident's hair was in a head band but her hair was sticking up on both sides and was matted at the crown of her head. 3. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. A 10/12/23 Care Plan entry stated the resident required partial to moderate assistance for bathing. On 3/31/25 at 1:11 p.m., Resident #13 stated she was supposed to receive a bath twice per week but that did not happen.	F 725		

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Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25:
2/17/25 partial bed bath or wash up at sink documented on February Documentation Survey Report V2
2/20/25 shower documented on paper Resident Bath/Shower Sheet
2/22/25 shower documented on paper Resident Bath/Shower Sheet
3/3/25 shower documented on March 2025 Documentation Survey Report V2
3/13/25 The paper Resident Bath/Shower sheet was blank.
3/27/25 shower documented on March 2025 Documentation Survey Report V2
3/31/25 The resident refused according to the March Documentation Survey Report V2.

The facility lacked documentation of additional tub bath or showers received or offered during the above time period including between 2/1/25 and 2/17/25, a span of 15 days, between 2/22/25 and 3/3/25, a span of 8 days, between 3/3/25 and 3/10/25, a span of 6 days, and between 3/17/25 and 3/27/25, a span of 9 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

4. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #46 which included heart failure, non-Alzheimer's dementia, and depression and listed the resident's BIMS score as 11 out of 15, indicating moderately impaired cognition.

A 10/12/23 Care Plan entry stated the resident

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required assistance of staff for washing her back and hair and to provide assistance transferring into the tub or shower.

On 03/31/25 at 11:12 a.m., Resident #46 stated she went three weeks with no bath.

Review of the resident's February and March 2025 Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers during the period of 2/1/25 and 4/2/25:
2/7/25 shower documented on February Documentation Survey Report V2.
2/25/25 shower documented on February Documentation Survey Report V2.
2/28/25 shower documented on February Documentation Survey Report V2.
3/21/25 documentation of resident refusal of shower on March 2025 Documentation Survey Report V2
3/28/25 shower documented on February Documentation Survey Report V2.

The facility lacked documentation of additional tub baths or showers received or offered during the above time period including between 2/1/25 and 2/7/25, a span of 6 days, between 2/7/25 and 2/25/25, a span of 18 days, between 2/28/25 and 3/21/25, a span of 20 days, and between 3/21/25 and 3/28/25, a span of 6 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

5. The MDS assessment tool, dated 3/14/25, listed diagnoses for Resident #71 which included cellulitis (infection of the tissue) of the left lower limb, heart failure, and obesity and listed the resident's BIMS score as 15 out of 15, indicating

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intact cognition.

Review of the resident's Documentation Survey Report V2 and paper bath sheets revealed the resident received the following baths or showers between her admission on 3/7/25 and her discharge on 3/25/25:
3/12/25 shower documented on March 2025 Documentation Survey Report V2
3/13/25 shower documented on March 2025 Documentation Survey Report V2
3/15/25 bed bath documented on paper Resident/Bath/Shower Sheet and stated the resident did not want shower due to her leg dressings
3/24/25 shower documented on Resident Bath/Shower Sheet.

The facility lacked documentation of additional tub baths or showers received during the above time period including between 3/7/25 and 3/12/25, a span of 4 days and between 3/15/25 and 3/24/25, a span of 8 days. The facility lacked documentation staff re-approached the resident on a different day after a refusal.

On 4/7/25 at 10:31 a.m., Staff C Certified Nursing Assistant (CNA) stated Resident #71 needed a shower and she felt like the facility needed to pay attention to how they sent residents out to appointments. She stated she remembered the resident going to dialysis and her hair was matted.

On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should receive at minimum two baths per week and she had a plan to remedy the concern moving forward. She stated staff should comb a resident's hair before

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leaving the room.

6. The MDS for Resident #30 dated 3/21/25 documented diagnoses of heart failure, weakness, seizure disorder, and anxiety. The MDS included a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition. It reported the resident needed assistance with set up for oral care and was dependent for toileting hygiene, sit to stand, and chair/bed transfers. The MDS further documented tub/shower transfers and bathing were not attempted in the look back period.

On 3/31/25 at 11:16 AM observed the resident asleep in her recliner. From the door of her room, her hair appeared oily and there was a musty urine odor outside of her room.

On 04/01/25 at 07:49 AM the resident was observed in her room, asleep in nearly same position as the day before and wore the same plaid nightgown. Her hair remained oily and tight to the side of her head.

During an interview on 04/01/25 at 07:54 the resident reported certified nursing assistants (CNAs) told her she had to go (urinate and defecate) in her brief due to 'spells' she had in the bathroom. The resident reported an instance when she sat with poop half in and half out all night. She also reported staff did not regularly comb her hair, change her clothes, help her brush her teeth, or bathe her. She did not think the facility had enough staff to take care of the residents.

Review of the resident's March 2025 Documentation Survey Report V2 indicated the

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F 725	Continued From page 65	F 725		

resident received 1 bath in March on 3/11/25 and refused a bath on 3/7/25. The facility was unable to provide bath/skin sheets to supplement missing days or document additional efforts to offer the resident a bath.

Additional documentation in the V2 report for March 2025 indicated the resident was not assisted with oral hygiene, hair care, shaving, or washing hands and face the following mornings: 3/4, 3/10, 3/11, 3/13, 3/14, 3/15, 3/16, 3/18, 3/19, 3/22, 3/23, 3/30, and 3/31.

7. The MDS for Resident #49 dated 3/16/25 included diagnoses of atrial fibrillation, neurogenic bladder, and fibromyalgia and a BIMS of 15/15 indicating intact cognition. Section GG revealed the resident required substantial to maximal assistance with transfers, toileting, bathing, dressing, and personal hygiene.

During an interview on 03/31/25 at 01:40 PM the resident reported she received 1 bath per week and she didn't want a bed bath to replace her showers. She wanted staff to take the time to dry her well after bathing so she didn't get sores under her breasts. She stated it was hard to get a CNA to find the Administrator or Director of Nursing (DON) when she wanted to talk about her concerns.

A document titled Monthly Grievance log contained an entry dated 10/21/24 from Resident #49 that she was not receiving showers. It documented the issue was resolved the same day.

Review of the resident's Documentation Survey Report V2 and bathing/skin sheets for March

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F 725	Continued From page 66 2025 revealed the resident received a shower on 3/7/25, 3/21/25, and 3/28/25. Facility documentation in Progress Notes and bathing sheets did not include documentation that the resident refused any baths/showers. 8. The MDS assessment for Resident #231 dated 2/15/25 listed diagnoses of heart failure, renal failure, and non-Alzheimer's dementia and indicated the resident was unable to complete the BIMS assessment due to short and long term memory problems. The resident's Care Plan with an admission date of 10/30/23 recorded the need for the assistance of two helpers with bathing due to impaired cognition and weakness. On 03/31/25 at 1:40 PM Resident #231's former roommate reported the resident went weeks without a bath, and she thought that was because Resident #231 couldn't speak up for herself like she could. Facility documentation titled South Hall shower schedule listed Resident #231 was scheduled to receive a bath/shower on Mondays and Thursdays. No shower sheets with skin assessments were completed for the resident between 2/1/25 and 3/14/25. Review of the resident's February and March 2025 Documentation Survey Report V2 revealed the resident received 2 showers from 2/1/25 through 3/14/25, on 2/17 and 2/27. The facility did not have documentation that staff communicated missed baths/showers or approached the resident on a different day.	F 725		

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F 725	Continued From page 67 During an interview with the DON on 4/7/25 at 9:22 AM she stated the nurses should be checking daily to ensure dressing and toileting were done, and that every contact with the resident was an opportunity to ensure cares were done, including oral care morning and night. She indicated residents had complained to her about bathing and linen changes. She did not think there was currently enough staff for all of the needs residents had. On 4/7/25 at 11:08 AM Staff G, LPN reported acuity impacted completion of tasks, and that call ins affected how much they could get done in a day. She stated every resident could have better oral care. She expected staff to help with oral cares and other activities of daily living, and stated there was a domino effect when there were not enough staff.	F 725		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in	F 728		

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F 728	Continued From page 68 §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on personnel file review, the Health Facility Database (HFD), and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) was certified prior to employment. The facility reported a census of 74 residents. Findings include: A review of staff personnel files on 4/8/25 determined that Staff J did not have an active CNA certification. A note in the file dated 11/6/23 written by Staff K documented that the facility was waiting on his CNA application. A criminal background check documented that on 11/13/23 there was not a record found for a CNA	F 728		

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F 728	Continued From page 69 with Staff J's name and date of birth. An additional undated document in the file from the HFD confirmed there was not a certification date for Staff J. On 4/10/25 at 3:27 PM the HFD page titled DCW Details (Direct Care Worker) did not include a certification date for Staff J and documented that he was not currently employed. An interview with the Administrator on 4/8/25 at 3:37 PM confirmed Staff J was not certified. She stated he had told the facility he was certified in another state. She reported there was an Administrator in training responsible for the building the previous summer who must have realized the error and sent him to take the skills test. As soon as the current Administrator and the facility scheduler confirmed Staff J was not a CNA he was asked to clock out and leave the facility. At 3:38 PM on 4/8/25 Staff L, Scheduling, stated she called the DCW hotline and learned that Staff J failed the CNA test 7/25/24. She thought Staff J was aware he had been caught working without certification because of the 'vibe' she got when they called him in to the office to ask him about it.	F 728		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		

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F 730	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff training records, and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) received a performance evaluation, competency evaluation, or training based on performance reviews. The facility reported a census of 74 residents. Findings include: A review of staff personnel files on 4/8/25 determined that Staff J was not evaluated for performance between his hire date of 12/5/23 and 4/8/25. The personnel file did not include orientation training or competency evaluations. Training records documented a single training on 3/19/24 for 15 minutes of education regarding communicating effectively. During an interview with the Administrator on 4/8/25 at 3:37 PM she confirmed she was not able to locate evaluations or training based on CNA evaluations.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		

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F 755	Continued From page 71 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, and staff and resident interviews, the facility failed to ensure the availability of routine medications for 2 of 7 residents reviewed for medications (Resident #17 and #13) The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set(MDS) assessment tool, dated 1/17/25, listed diagnoses for Resident #17 which included heart failure, diabetes, and anxiety. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.	F 755		

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A 9/25/23 Care Plan entry directed staff to administer medications as ordered.

On 3/31/25 at approximately 1:00 p.m., the resident stated she missed some pills today.

The March 2025 Medication Administration Record (MAR) listed an order for Methocarbamol (a muscle relaxant) 750 milligrams(mgs) three times per day. The following entries lacked a check to indicate staff administered the medication: 3/30/25 supper dose, 3/31/25 lunch and supper doses.

eMAR Administration Notes on 3/30/25 at 4:35 p.m., 3/31/25 at 1:08 p.m., and 3/31/25 at 5:02 p.m. stated the resident's medication was not available.

2. The MDS assessment tool, dated 1/20/25, listed diagnoses for Resident #13 which included severe obesity, anxiety, and depression and listed the resident's BIMS score as 15 out of 15, indicating intact cognition.

On 3/31/25 at 1:11 p.m., Resident #13 stated she missed some medications today because the facility did not have them.

The March 2025 MAR listed the following orders:
a. Fesoterodine Fumarate 8 mg one time a day for overactive bladder.
b. Lexapro 20 mg one time a day for major depressive disorder.
c. Metolazone 2.5 mg once time a day for edema(swelling)
d. Spironolactone 100 mg one time a day for hypertension.
e. Naproxen 500 mg twice daily for pain.

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f. Hydroxyzine Pamoate 25 mg three times daily for anxiety.

The entries for the morning dose on 3/31/25 lacked a checkmark to indicate staff administered the above medications.

The facility policy "Medication Administration-General", revised 9/19/23, stated staff administered medications as ordered by the physician and in accordance with professional standards of practice.

On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated there were issues with medication availability and there was a problem with this last medication changeover (from March to April 2025). She stated routine medications should be available.

F 803 SS=D Menus Meet Resident Nds/Prep in Adv/Followed F 803
CFR(s): 483.60(c)(1)-(7)

§483.60(c) Menus and nutritional adequacy. Menus must-

§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

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§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility menus, facility policy review, and staff interview, the facility failed to follow the menu for 2 out of 2 residents on a pureed diet to ensure nutritional needs were met. The facility reported a census of 74 residents.

Findings include:

On 4/1/25 at 11:01 a.m., Staff D, Cook, pureed meatballs. Staff D did not puree any bread with the meatballs.

On 4/1/25 at 12:03 p.m., a resident on a pureed diet received the following lunch:
pureed meatballs, mashed potatoes, and pureed cake. The tray contained no bread.

The Week 2 Therapeutic Spread Report stated resident on a regular diet should receive 1 slice of bread and residents on a pureed diet should receive 1/2 cup of pureed orzo (a type of pasta).

On 4/2/25 at 3:56 p.m., the Administrator stated they would order pureed bread mix and add it to the meat during preparation.

The facility policy "Food Preparation Guidelines",

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F 803	Continued From page 75 dated 4/9/24, directed staff to follow written menus during food preparation in the form that met individual resident needs.	F 803		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and resident and staff interviews, the facility failed to ensure staff served food at palatable hot holding temperatures for 1 of 1 meal observed. The facility reported a census of 74 residents. Findings include: 1. The facility policy "Food Preparation Guidelines", dated 4/9/24, directed staff to serve food at a safe and appetizing temperature. On 3/31/25 at 1:11 p.m., Resident #13 stated that the food in the East dining room was cold so she preferred to eat in the main dining room. On 4/1/25, the Dietary Manager obtained the following temperatures: Carrots 163 degrees Fahrenheit at 11:32 a.m. Mashed Potatoes 163 degrees Fahrenheit at	F 804		

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11:33 a.m.
Meatballs 189 degrees Fahrenheit at 11:33 a.m.

On 4/1/25 at 11:35 a.m., Staff D, Cook, began to plate meals for the East hall cart. The State Agency (SA) requested a test tray with a thermometer to be placed on the cart. Staff D placed a test tray on the cart and began plating the rest of the resident meals for the East cart. The plates that Staff D utilized did not come from a plate warmer.

At 11:47 a.m., Staff D completed the East cart meals and the Dietary Manager (DM) paged staff to inform them the cart was ready. The DM rolled the cart to the East hall at 11:48 a.m. At 11:50 a.m., staff members including the Activity Director began to serve the trays to residents in their rooms. At 11:57 a.m., staff finished passing the last room tray and took the cart into the East dining room. Staff passed the last dining tray at 11:58 a.m. and the SA immediately obtained the following temperatures from the test tray:

Carrots 104 degrees Fahrenheit
Mashed Potatoes 113 degrees Fahrenheit
Meatballs 107 degrees Fahrenheit

The SA tasted the food and it was barely warm.

On 4/2/25 at 12:57 p.m. the DM stated she expected hot holding temperatures to be over 140-145 degrees Fahrenheit.

F 812 SS=E Food Procurement,Store/Prepare/Serve-Sanitary F 812
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

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§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility cleaning schedules, and staff interview, the facility failed to maintain adequate kitchen sanitation for 2 of 2 kitchen observations. The facility reported a census of 74 residents.

Findings include:

The initial kitchen tour, conducted on 3/31/25 at 9:33 a.m., revealed the following concerns:
a. a thick layer of dust buildup on the back of the ice machine
b. dust particles suspended from the 3 spigots of the fire suppression system located above the stove burners.

A follow-up kitchen tour, conducted on 4/1/25 at 10:23 a.m., revealed the following concerns:
a. dust particles remained suspended from the 3 spigots of the fire suppression system located

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAK NURSING AND REHABILITATION CENTER LLC	455 31ST STREET MARION, IA 52302

(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 812	Continued From page 78 above the stove burners. b. a shelf to the right of the three compartment sink covered with a film of dust and hairs, located directly over steam table lids. c. the ceiling above a prep area where staff wrapped silverware had strings of dust hanging down approximately 3 inches in length. d. a thick layer of dust hung from the sprinkler above the prep sink. e. dust particles suspended from the ceiling panels above the steam table and covering a vent above the right hand side of the steam table. The undated facility Weekly Cleaning List directed staff to clean ceiling vents biweekly and clean shelves weekly. On 4/2/25 at 12:57 p.m., the Dietary Manager stated she expected kitchen vents and the ceiling to be clean and stated some of the ceiling panels needed replaced.	F 812		
F 880 SS=F	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:	F 880		

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F 880	Continued From page 79	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be 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

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F 880	Continued From page 80	F 880		

identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on facility policy and staff interview, the facility failed to carry out a system of surveillance to track and address infections and potential infections in the facility. The facility reported a census of 74 residents.

Findings include:

On 4/8/25 at 11:41 a.m., the Regional Director of Nursing (DON) stated infection control had not been completed well at the facility but they had a new person starting soon. She stated it was her expectation they carry out such activities such as mapping out infections and completing skills fairs.

The facility lacked documentation of an infection control surveillance system designed to identify possible communicable diseases or infections before they could spread to other persons in the facility such as:
a. systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors.
b. an ongoing system of surveillance designed to identify possible communicable diseases

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c. a system for surveillance based upon national standards of practice and the facility assessment, including the resident population and the services and care provided.
d. routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections.

The facility policy "Infection Surveillance", revised 6/2024, stated a system of infection surveillance served as a core activity of the facility's infection prevention and control program. The purpose was to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Data to be collected, including how often and the type of data to be documented, included:
a. the infection site, pathogen (type of bacteria or virus) (if available), signs and symptoms, and resident location.
b. summary and analysis of the number of residents (and staff, if applicable) who developed infections.
c. observations of staff including the identification of ineffective practices, if any.
d. the identification of unusual or unexpected outcomes, infection trends and patterns.
e. how the data would be used and shared and with appropriate individuals to ensure that staff minimize the spread of the infection or disease.

F 883 SS=E Influenza and Pneumococcal Immunizations F 883
CFR(s): 483.80(d)(1)(2)

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-

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F 883	Continued From page 82 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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F 883	Continued From page 83	F 883		

documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interview, the facility failed to offer influenza vaccines to 4 of 5 residents reviewed for immunizations (Residents #2, #8, #10, and #63). The facility reported a census of 74 residents.

Findings include:

The facility policy "Influenza Vaccination", dated 6/14/23, stated the facility would offer residents annual immunizations against influenza.

1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS stated the resident required substantial/maximal assistance with bathing and listed her Brief Interview for Mental Status (BIMS) status as 15 out of 15, indicating intact cognition.

2. The MDS assessment tool, dated 4/1/25, listed diagnoses for Resident #8 which included diabetes, seizure disorder, and low back pain and listed her BIMS score as 9 out of 15, indicating moderately impaired cognition.

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3. The MDS assessment tool, dated 1/5/25, listed diagnoses for Resident #10 which included non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. The MDS listed the resident's BIMS score as 7 out of 15, indicating severely impaired cognition.

4. The MDS assessment tool, dated 11/5/24, listed diagnoses for Resident #63 which included left foot drop, muscle weakness, and abnormal posture. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

The facility lacked documentation they offered influenza vaccines to the above residents during the 2024-2025 influenza season.

On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should be up to date with their vaccinations.

On 4/9/25 at 8:10 a.m., the Regional DON stated she could locate no additional influenza vaccine documentation.

F 887 SS=E | F 887

COVID-19 Immunization
CFR(s): 483.80(d)(3)(i)-(vii)

§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:
(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff

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members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;

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(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interview, the facility failed to offer a Covid-19 vaccine for 1 of 5 residents reviewed for vaccinations (Resident #2). The facility reported a census of 74 residents.

Findings include:

The facility policy "Covid-19 Vaccination" reviewed 11/4/24, stated the facility would offer residents the Covid-19 vaccine.

1. The Minimum Data Set (MDS) assessment tool, dated 2/18/25, listed diagnoses for Resident #2 which included heart failure, bipolar disorder, and depression. The MDS listed her Brief Interview for Mental Status (BIMS) status as 15 out of 15, indicating intact cognition.

The resident's clinical record lacked documentation the facility offered the resident a Covid-19 vaccination.

On 4/8/25 at 2:38 p.m., the Director of Nursing (DON) stated residents should be up to date with their vaccinations.

On 4/9/25 at 8:10 a.m., the Regional DON stated she could locate no additional Covid-19 vaccine documentation.

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F 947 SS=D — Required In-Service Training for Nurse Aides
CFR(s): 483.95(g)(1)-(4) — F 947

§483.95(g) Required in-service training for nurse aides.
In-service training must-

§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

§483.95(g)(2) Include dementia management training and resident abuse prevention training.

§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on personnel file review, staff training records, and interviews the facility failed to ensure 1 of 4 Certified Nursing Aides (CNAs) completed 12 hours of in-services per year that included abuse and dementia training. The facility reported a census of 74 residents.

Findings include:

A review of staff personnel files on 4/8/25 determined that Staff J did not complete orientation training, competency evaluations, or annual CNA training between his hire date of 12/5/23 and 4/8/25. The orientation checklist in

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F 947	Continued From page 88 the file was blank. Training records for this CNA documented one training on 3/19/24 for 15 minutes of education regarding communicating effectively. Staff J's files did not include a record of Dependent Adult Abuse training, abuse prevention, or dementia training for residents with cognitive impairments. During an interview with the Administrator 4/7/25 at 5:06 PM she stated she had to own that the facility was not caught up on training. They had staff meetings but their online training platform was switched and they were not caught up. On 4/8/25 at 3:37 PM the Administrator further confirmed she was not able to locate orientation documentation or additional training information for Staff J. She reported the only reason Staff J completed the training on communication was because another staff person sat with him to make sure it was done. She was not able to provide verification of required Dependent Adult Abuse training or facility directed online training completed by Staff J.	F 947		

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 257	58.12(1) Admission, transfer, and discharge 481-58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. This Statute is not met as evidenced by: THE FOLLOWING DEFICIENCIES RELATE TO THE IOWA ADMINISTRATIVE CODE (IAC) CHAPTER 58. 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans' affairs within 30	L 257		

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L 257	Continued From page 1	L 257		

days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans' affairs within 90 days after May 5, 2004.
If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III)

Based on record review and staff interview, the facility failed to ensure timely submission of veterans affair status for 4 of 4 resident veterans reviewed (Residents #14, #22, #54, and #59). The facility reported a census of 74 residents.

Findings include:

1. Resident #14's Resident Detail Report listed an admission date of 11/26/24.

2. Resident #22's Resident Detail Report listed an admission date of 8/6/24.

3. Resident #54's Resident Detail Report listed an admission date of 10/17/24.

4. Resident #59's Resident Detail Report listed an admission date of 1/4/25.

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 257	Continued From page 2 The facility Iowa Department of Veterans Affairs Resident Eligibility form lacked documentation of the above residents submitted to the VA for potential VA benefits prior to 4/9/25. On 4/9/25 at 9:06 a.m., the Regional Director of Nursing (DON) stated she expected the facility to submit veterans to the VA within 30 days of admission. On 04/09/25 at 10:43 a.m. the Regional DON stated the facility did not have a policy related to the process of VA admissions.	L 257		

Silver Oak Nursing and Rehabilitation Plan of Correction

The Plan of Correction does not constitute an admission or agreement by Silver Oak Nursing and Rehabilitation of truth, or the facts alleged, or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Silver Oak Nursing and Rehabilitation credible allegation of compliance.

F550 Resident Rights/Exercise of Rights

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #30 is now receiving care per assessed needs and support for her ADL care to include toileting, grooming, dressing, transfers, hygiene and bathing.
Resident #49 is now receiving care per assessed needs and support for her ADL care to include toileting, grooming, dressing, transfers, hygiene and bathing.
Resident #51's dignity and right to privacy is being maintained.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A quality system review audit will be completed for the past 30 days to identify other residents with concerns with ADL care. Issues or concerns will be addressed as they are identified.
A quality system review audit will be completed for the past 30 days to identify other residents with concerns with Dignity and privacy. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The DON/designee will educate nursing staff of following the Kardex to provide care as resident needs have been assessed as appropriate to include assistance with ADL i.e. toileting, grooming, dressing, transfers, hygiene and bathing. Any newly hired nursing and agency nursing staff will receive education on the Kardex and provide care as appropriate to include assistance with ADL i.e. toileting, grooming, dressing, transfers, hygiene and bathing.
All staff will be educated on Promoting/Maintaining Resident Dignity by the Director of Clinical Services, Administrator or Designee. Any newly hired staff will receive education in orientation and any contract staff prior to working a shift in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place
The DON/designee will monitor that ADL is provided with dignity per identified needs on Kardex with sample of 10 residents twice weekly x 4 weeks, then 5 residents weekly x 8 weeks. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.
The Administrator/Designee will complete QCR of residents via interview to ensure dignity and privacy 10 residents x 4 weeks then 5 residents x 8 weeks. The findings will be reported to the

Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F578 Request/Refuse/Discontinue treatment; Formulate Advanced Directives

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 now has an order for Full Code and Ipost signed, uploaded to electronic medical record and Ipost book at Nursing station.
Resident #10's Ipost is in the EMR as well as an appropriately labeled area in the binder at the nurse's station.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
Quality Care Review (QCR) was completed of all residents in the facility to validate a current copy of advance directive (IPOST)in the electronic medical record with orders and in the nurse's stations books. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services to provide education to the Director of Nursing, Social Services Director, and Administrator in relation to Advanced Directives to include the process of obtaining Advanced Directive (IPOST) in the EMR upon Admission, MD/ARPN order, and placing in IPOST book at nurse's station in appropriately labeled area.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee QCR validating the IPOST in EMR, MD/APRN order in EMR and Nurse's station in appropriately labeled area will be conducted on each new admission and 5 residents weekly x 2 weeks, then each new admission and 5 residents every other week x2 weeks, then monthly x 2 months The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F602 Free from Misappropriate/Exploitation

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
The Administrator present during the survey is no longer employed. The Interim Administrator was educated on 4/28/2025 on Abuse, Neglect, Exploitation Policy as well as Abuse Reporting requirements by the Director of Clinical Services.
Staff Nurse M is no longer employed, termination date 11/23/2024.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

All residents had the potential to be effected by the alleged deficient practice.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
All staff will be educated on Abuse, Neglect, Exploitation Police to include Reporting on by the Director of Clinical Services, Administrator or Designee. New hires will receive the education in new hire orientation and any contract staff will receive education prior to working in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Director of Clinical Services will review any allegation, complaint, concern, or grievance with the Administrator daily x 4 weeks, then 3 times weekly x 4 weeks then monthly x 4 weeks.
The Regional Human Resource Director will complete a Quality System Review Tool twice weekly x 8 weeks, then weekly x 4 weeks.
The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F609 Reporting of Alleged Violations

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
The Administrator present during the survey is no longer employed. The Interim Administrator was educated on 4/28/2025 on Abuse, Neglect, Exploitation Policy as well as Abuse Reporting requirements by the Director of Clinical Services.
Staff Nurse M is no longer employed, termination date 11/23/2024.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
All resident had the potential to be effected by the alleged deficient practice.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Interim Administrator was educated on Abuse, Neglect, Exploitation Police to include Reporting on by the Director of Clinical Services on start date of 4/28/2025.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Director of Clinical Services will review all allegation, complaint, concern, or grievance with the Administrator daily x 4 weeks, then 3 times weekly x 4 weeks then monthly x 4 weeks.
The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Completion: 4/28/2025

F610 Investigate/Prevent/Correct Alleged Violation

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
The Administrator present during the survey is no longer employed. The Interim Administrator was educated on 4/28/2025 on Abuse, Neglect, Exploitation Policy as well as Abuse Reporting requirements by the Director of Clinical Services.
Staff Nurse M is no longer employed, termination date 11/23/2024.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
All resident had the potential to be effected by the alleged deficient practice.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services will review all alleged violations with the Administrator. The employee(s) will be removed from the facility immediately upon any allegation to protect the resident. A full investigation will be conducted. Any new Administrator will receive education on Abuse, Neglect, Exploitation Policy as well as Abuse Reporting requirements.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Director of Clinical Services will complete a QCR of all allegations prior to final determination and/or returning employee to work, validating a full investigation has been conducted and all reporting appropriately. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

Completion date: 4/25/2025

F623 Notice Requirements Before Transfer/Discharge

(1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #31 no longer resides at the facility.
Resident #43 and #70 reside at the facility.
A notification to the Ombudsman will be completed for each of the 3 sample residents.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR will be completed for past 3 months that have transferred/Discharged. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

The Social Service Director will be educated on the requirements of transfer/discharge to include notification of the Ombudsman.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee will audit each month that the Ombudsman has been provided with the listing of residents that have transferred/discharged x 3 months. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

F625 Notice of Bed Hold/Policy Before/Upon Transfer

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #31 returned to the facility after ER visits but no longer resides at the facility as he passed
Resident #43 and #70 both returned to the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
Residents that were transferred to the hospital had potential to be affected.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Nursing/designee will educate Nurses on ensuring Bed Hold Notice is provided explained to the resident and/or Responsible party and provided in writing. New hires will receive the education in new hire orientation and any contract staff will receive education prior to working in the facility.

Administrator/Designee will educate Social Service Director to follow up on decision with the resident and/or Responsible party on the next business day.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee will complete a QCR of transfer/discharge to the hospital each resident x 2 weeks, then 3 residents weekly x 6 weeks to validate bed hold notice was provided, documented and signed by the resident and/or Responsible party. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

F658 Services Provided Meet Professional Standards

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #49 is now receiving medications timely and as ordered. The Director of Nursing will interview the resident for preferred times to administer her medications/treatments and contact the MD or extender to obtain order to change any times to her preference if MD or extender in agreement.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR will be completed with residents that are currently in the facility. Social Service will interview competent residents for any concerns with medication timeliness. The DON will perform QCR for all residents. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
Nurses and certified Medication aids will be educated by the DON/designee on administering medications timely. New hire nurses will receive the education in new hire orientation and any contract nurses will receive education prior to working in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The DON/designee will perform QCR of Medications administered by MD orders to include timeliness with a sample of 10 residents weekly x 2 weeks, then 5 residents x 4 weeks then 3 residents x 2 weeks. Issues will be addressed as they are identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F677 ADL Care Provided for Dependent Residents

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 is now being offered her shower/bath twice per week on requested schedule. #10 is receiving ADL care to meet her grooming needs to include combing of her hair. #13 is now being offered her shower/bath twice per week on requested schedule. #30 is now receiving oral care, toileting hygiene, transfers, and bathing per plan of care, #46 is now being offered assistance with her showers twice per week on requested schedule and receiving assistance as per plan of care, #49 is now receiving showers twice weekly per plan of care. Resident #71 and #231are no longer residing at the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR of current residents will be conducted to ensure grooming, bathing, oral care, toileting, hygiene and transfers is occurring. Issues will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

Nursing staff will be educated on providing care by the plan of care to include grooming to (combing hair and oral care) showering/bathing and transfers. The Nursing staff will be educated on how to utilize Kardex to know what needs and preferences are for each resident and emphasis also on documenting the care provided. New hires nursing staff will receive the education in new hire orientation and any contract Nursing staff will receive education prior to working in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
A QCR will be conducted to validate ADL care provided per plan of care via visual observation and documentation of 10 residents weekly x 4 weeks, then 5 residents weekly x 8 weeks. Issues will be addressed when identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

F684 Quality of Care

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #63 is now receiving accurate weekly skin assessments by the treatment nurse. Residents #71 and #232 no longer reside at the facility. The facility has hired a full-time treatment nurse to perform skin assessments.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR will be completed for current residents in the facility. Issues will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The nurses will be educated that the treatment nurse/designee will perform each weekly skin assessment. Should the treatment nurse/designee not be in the facility for a weekly skin assessment, the floor nurse will perform the weekly skin assessment by inspecting the skin head to toe and document findings, if any new areas of skin impairment are noted then the MD/extender for treatment orders and resident/RP will be notified. New hire nurses will receive the education in new hire orientation and any contract nurses will receive education prior to working in the facility.

The newly hired treatment nurse was educated on 4/29/2025 by the Director of Clinical Services of the requirement to complete head to toe assessment every 7 days as well as with any newly developed or reported skin impairment.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.

The DON/designee will perform QCR of skin assessments are accurate and performed every 7 days to include 10 residents x 6 weeks, then 5 residents x 6 weeks. Issues will be addressed as they are identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #71 no longer resides at the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

A QCR will be performed of all residents in the facility with pressure ulcers to ensure treatments, assessments and appropriate staging are in place. Issues will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

The facility now has a designated treatment nurse who is completing her wound care certification with Vohra wound care. The treatment nurse will perform wound treatments that are scheduled Monday through Friday that are daily. The treatment nurse will assess the wound and document conduction on the Weekly Wound Evaluation of EMR. The floor nurses will be educated on performing treatments per MD orders in absence of the treatment nurse and/or treatments that are more than once daily and on the weekends. New hire nurses will receive the education in new hire orientation and any contract nurses will receive education prior to working in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.

The DON/designee will perform a QCR to validate appropriate treatment, assessment and on 3 residents weekly x 6 weeks then 2 residents weekly x 6 weeks. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

F689 Free of Accident Hazards/Supervision/Devices

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #41 has foot pedals for when she requires assistance of being pushed in her wheelchair.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

A quality system review audit will be completed of current residents to validate other residents that may need assistance being pushed in wheelchairs to validate foot pedals being utilized. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The DON/designee will educate all staff when pushing a resident in a wheelchair that foot pedals must be applied. Any new hire nursing and agency nursing staff will receive education on use of foot pedals when pushing a resident in a wheelchair.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The DON/designee will audit residents being pushed in a wheelchair to validate foot pedals are in place with a sample of 10 residents x 4 weeks, then 5 residents x 8 weeks. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F725 Sufficient Nursing Staff

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 is now being offered her shower/bath twice per week on requested schedule. #10 is receiving ADL care to meet her grooming needs to include combing of her hair. #13 is now being offered her shower/bath twice per week on requested schedule. #30 is now receiving oral care, toileting hygiene, transfers, and bathing per plan of care, #46 is now being offered assistance with her showers twice per week on requested schedule and receiving assistance as per plan of care, #49 is now receiving showers twice weekly per plan of care. Resident #71 and #231are no longer residing at the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR of current residents will be conducted to ensure grooming, bathing, oral care, toileting, hygiene and transfers is occurring. Issues will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
1. The facility has utilized supplemental agency staff until facility staff were hired and trained.
2. Nursing staff will be educated on providing care by the plan of care to include grooming to (combing hair and oral care) showering/bathing and transfers.
3. The Nursing staff will be educated on how to utilize Kardex to know what needs and preferences are for each resident and emphasis also on documenting the care provided. Any contract staff will receive education prior to working in the facility.

4. The Regional Director of Human Resources is now having classroom orientation to ensure training is completed to include expectations.

5. The newly hired CNAs are training with specific CNAs and included completion of competencies prior to working independently.
6. The Assistant Director of Nursing/designee will train newly hired nurses and complete competency before working independently.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
1. A QCR will be conducted to validate ADL care provided per plan of care via visual observation and documentation of 10 residents weekly x 4 weeks, then 5 residents weekly x 8 weeks. Issues will be addressed when identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

2. The Regional Director of Human Resources, Administrator, and Director of Nursing will review staffing at a minimum of 3 times weekly, if insufficient staffing concerns are identified it will be reported to the Director of Clinical Services for additional actions.

F728 Facility Hiring and Use of Nurse Aide

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Staff J was terminated on 4/9/2025 as he was not qualified as a CNA

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
All CNA and license nurses have been validated to ensure licensure in place to appropriate position. Issues or concerns will be addressed as identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services educated the Regional Human Resource Manager on the validation of certification for CNAs.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Regional Human Resource Director will validate to ensure no expiration of CNA or Nursing license monthly and report to Administrator and Director of Clinical Services. Issues or concerns will be addressed as identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F730 Nurse Aide Perform Review

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Staff J (CNA) was terminated on 4/9/2025 as not qualified for the position, thus no review performed nor could 12 hours of training be completed.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

The Regional Director of Human Resources will audit employee file to identify other CNAs that have not had evaluation completed as well as 12 hours of training by the annual hire date. Issues will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
A tracker of all Certified Nursing Assistant (CNAs) has been created with hire dates and date in-services are due for completion, followed by the date when completed. The Regional Director of Human Resources will monitor and update the tracker as in-service/training are completed.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Director of Clinical Services will complete a QCR of education and evaluations due for the month are completed for 5 CNAs weekly x 2 weeks then 5 CNAs every other week x 4 weeks, then monthly thereafter. The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring

F755 Pharmacy Services/Procedures/Pharmacist/Records

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #17 is available, administered and documented.
Resident #13 is available, administered and documented.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR of current residents will be completed to validate whether medications are available, being administered and documented. Issues will be addressed as identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Nursing/designee will educate nurses to call the pharmacy if/when or medication is not available to administer to contact the pharmacy to stat delivery, notify the MD/extender for orders and resident/RP if the medication is administered late or missed and the new orders. New hire nurses will receive the education in new hire orientation and any contract nurses will receive education prior to working in the facility.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Director of Nursing/designee will perform a QCR to validate medications are available, administered and documented with appropriate action taken if not available of 10 residents for 4 weeks, then 5 residents x 8 weeks. Issues or concerns will be addressed as identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F803 Menus Meets Resident Needs/Prep in Adv/Followed

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Residents receiving puree diet are now receiving puree bread as well.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
A QCR will be conducted to ensure nutritional needs are met for puree diet. Issues will be addressed as identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Registered Dietician will educate dietary staff to include Dietary Manager, cooks and dietary aids on providing puree diets to meet residents' nutrition needs with emphasis on bread provided puree.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee will perform QCR of residents receiving puree diets to validate the meal meets nutritional needs 5 trays per week x 4 weeks then 2 trays per week x 8 weeks. Issues or concerns will be addressed as identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F 804 Nutritive Value/Appear, Palatable/Prefer Temp

(1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
1. Resident # 13 is now receiving her meal at appropriate temperature.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
The Dietary Manager/Designee will conduct a Quality Care Review (QCR) to ensure that Food Temps are safe and palatable for residents residing in the facility by testing the temperature of

both hot and cold foods from each dining room and last meal tray to rooms. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services will educate the Administrator and the Dietary Manager on the Regulatory Requirements of F804 with emphasis on food safety and temperatures.
The Registered Dietician and/or Dietary Manager will provide current Dietary staff with education/re-education on the importance of maintaining safe, palatable temperatures of foods served during mealtimes. Newly hired employees in the department will receive education in orientation. The satellite kitchen will be completed and serving East Hall residents to ensure meals are appropriate temperature both hot and cold.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee will conduct QCR on Dietary meal service to include temperatures of both cold and hot foods three times per week x 4 weeks, then twice weekly x 4 weeks then twice weekly for 4 weeks to ensure continued compliance. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F 812 Food Procurement, Store/Prepare/Serve-Sanitary

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

1. The back of the ice machine has been cleaned and no longer has a dust buildup.
2. The spigots of the fire suppression system above the stove burners has been cleaned and longer has dust particles.
3. The shelf to the right of the three-compartment sink has been cleaned and no longer has a film of dust and hair.
4. The ceiling about the prep area where staff wrap silverware has been cleaned and no longer has dust hanging down.
5. The sprinkler system above the prep sink has been cleaner and no longer has dust.
6. The ceiling panels above the steam table and the vent above the right-hand side of the steam stable have been cleaned and no longer has dust.

A full deep clean of the kitchen was performed.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.

Quality Care Review (QCR) was completed of any other dietary areas with sanitation concerns. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.

The dietary staff were educated in sanitation and a cleaning schedule updated and verified daily by the Dietary Manager via visual inspection.
Newly hired employees in the department will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.

The Administrator and Dietary Manager will conduct joint QCR for sanitation twice weekly x 6 weeks, then weekly x 6 weeks and every other week ongoing.
The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F 880 Infection Control

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Infection control surveillance system will be implemented. An Assistant Director of Nursing has been hired with component of position designated to Infection Control.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
All residents had the potential to be effected by the alleged deficient practice.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Assistant Director of Nursing will receive education by the Director of Clinical Services to include surveillance, antibiotic stewardship, and tracking and trending. The Assistant Director of Nursing will complete Infection Preventionist training from CDC.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The DON/designee will complete a QRC of infections and appropriate follow-up with surveillance, antibiotic stewardship and tracking and trending every other week for 2 months. The Assistant Director of Nursing will review Infection Control findings to the QAPI team monthly. Issues or concerns will be addressed as identified. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F883 Influenza and Pneumococcal Immunizations

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
#2, #8, #10, and #63 will be offered Influenza Vaccine should they be in the facility when eligible for the fall 2025 season.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
All residents had the potential to be effected by the alleged deficient practice.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services will provide education to the DON and ADON on educating on Influenza vaccine, obtaining consent, if refused by the resident/RP to document. The education will include offering ongoing for new admits during the Influenza season.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
When eligible for fall 2025 Influenza season begins the ADON will report weekly of consents, education, refusal documentation to the DON/designee. The DON/designee will perform QCR of 10 residents weekly x 4 weeks then 5 residents x 8 weeks. The findings will be reported to the Quality Assurance/Performance Improvement Committee monthly once Influenza season for fall of 2025 begins until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

F887 Covid-19 Immunization

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
Resident #2 will be offered a Covid-19 Immunization education, obtain consent, if declines documented in the medical record, if consent will be administered.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
Quality Care Review (QCR) of current residents will be completed by the ADON/Designee to identify other residents that are eligible to receive a Covid-19 vaccine. Residents eligible for the vaccination, the resident/Responsible party will have education to include benefits and potential side effects of the Covid-19 vaccine by the ADON/designee. If consents the facility will administer the Covid-19 vaccine.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
The Director of Clinical Services will provide education to ADON/DON on Covid-19 vaccinations. During the initial care conference with the newly admitted resident and/or responsible party immunization status will be reviewed. Education will be provided to include benefits and potential side effects by the ADON/designee. Consent to be signed at that time. The ADON/designee will place the order and administer it upon receipt with applicable time frames.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The ADON/designee will conduct a QCR validate Covid-19 immunization records are current of 10 residents per week to include new admissions x 4 weeks, then 5 residents to include new

admissions x 8 weeks to ensure continued compliance. Corrections will be made as needed. The findings of these reviews will be reported to the facility's Quality Assurance/Performance Improvement Committee monthly until substantial compliance is maintained and recommends review every quarter.

F947 Required In-Service Training for Nurse Aides

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
CNA staff J is no longer employed by the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.
1.The Regional Human Resource Director/designee will complete a Quality Care Review (QCR) of all CNAs employed for a year for validation of 12 hours of in-service training to include dementia management training, resident abuse prevention training, and training addressing the areas of weakness as determined in nurse aides' performance reviews and facility assessment, and the care of the cognitively impaired.
2. The Regional Director of Human Resources/designee will complete a Quality Care Review (QCR) of all employees to validate Dependent Adult Abuse training is completed.
3. The Regional Director of Human Resources will validate competencies for nursing staff. Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur.
1. CNAs employed for a year for validation of 12 hours of in-service training to include dementia management training, resident abuse prevention training, and training addressing the areas of weakness as determined in nurse aides' performance reviews and facility assessment, and the care of the cognitively impaired will be completed.
2. The Regional Director of Human Resources/designee will maintain a tracker of employees with hire date and date in which Dependent Adult Abuse training must be completed.
3. A tracker of all Certified Nursing Assistant (CNAs) will be created with hire dates, competency completion, and date in-services are due for completion, followed by the date when completed. The Regional Director of Human Resources/Designee will monitor and update the tracker as components are completed.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place.
The Administrator/designee will complete a QCR of education due for the month is completed for 5 CNAs weekly x 2 weeks then 5 CNAs every other week x 4 weeks, then monthly thereafter. The Administrator/designee will complete a QCR of Dependent Adult Abuse weekly of 10 employees x 2 weeks then 5 employees x 8 weeks. The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Completion date: 5/9/2025