STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 10/24/2024

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/21/24 through 10/24//24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V4U511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/21/24 through 10/24/24. Event ID# V4U511. The following intakes were investigated NC00218659, NC00216966, NC00222697, and NC00216478. Two of thirteen complaint allegations resulted in deficiencies.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		11/21/24

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

Electronically Signed | 11/15/2024

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F 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to protect resident privacy by leaving an unattended resident roster with personal health information (PHI) on top of a medication cart in the hallway and visible to the public. This was for 1 of 3 medication carts (700 Hall Medication Cart) reviewed for privacy and confidentiality. This deficient practice had the potential of effecting 22 residents on the 700 hall (Resident #98, #12, #96, #54, #82, #90, #97, #57, #33, #204, #88, #203, #55, #99, #91, #13, #83, #7, #20, #51, #35, and #60). The findings included: A continuous observation was completed on 10/21/2024 from 8:40 AM to 9:02 AM of the 700 Hall Medication Cart. Nurse #8 was working the medication cart, walked away from the cart, and left the resident roster unattended on top of the cart which had PHI and entered a resident's room. Two residents and one visitor were observed to pass by the medication cart. One resident was walking, and the other resident was	F 583	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Pake Nursing Rehabilitation Center□s response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. On 10/24/2024, the roster containing	

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F 583	Continued From page 2 propelling herself in a wheelchair. The visitor walked by the unattended medication cart. The resident roster was composed of room numbers, names, code status, history of diagnoses, and report items for 22 residents: Resident # 98, Resident # 12, Resident # 96, Resident # 54, Resident #82, Resident # 90, Resident # 97, Resident # 57, Resident # 33, Resident # 204, Resident # 88, Resident # 203, Resident # 55, Resident # 99, Resident # 91, Resident # 13, Resident # 83, Resident # 7, Resident # 20, Resident # 51, Resident # 35, and Resident # 60. During the continuous observation on 10/21/24 from 8:40 AM to 9:02 AM, Nurse #8 came back to the medication cart and was interviewed about the resident roster. The Nurse stated she was supposed to turn the resident roster paper over before she left the cart, but she just forgot. Then Nurse #9 approached the medication cart and was shown the resident roster that contained the PHI that was left visible to the public. Nurse #9 indicated the roster should not have been left visible to the public because it was a violation of the residents' privacy. An interview conducted with Unit Manager (UM) #10 at 12:48 PM on 10/23/2024 indicated nurses were expected to maintain resident privacy by turning over any PHI in view of the public. An interview conducted with Interim Director of Nursing (DON) on 10/24/2024 at 10:05 AM indicated the nurses were expected to turn the resident roster paper upside down on the medication carts or to take it with them when leaving the medication carts to protect the privacy	F 583	protected health information on the 700 Hall Medication Cart was turned over and covered by Unit Manager to ensure resident privacy and confidentiality is protected. Nurse #8 was educated on Residents' Rights, with an emphasis on residents' health protected information, by Staff Development Coordinator 11/1/2024. On 10/24/2024, Unit Managers checked all of the facility medication carts to ensure resident Protected Health Information is not in view and resident privacy and confidentiality is being protected. No concerns were identified. November 1, 2024, the Director of Nursing initiated education on resident rights, with an emphasis on resident's health protected information for all facility Nursing staff, to include agency. The education will be completed by 11/21/2024. Any Nursing staff member, including agency staff who have not received the education by 11/21/2024 will be provided the education on their next shift. All newly hired staff and new agency staff will be educated on resident rights with an emphasis on health protected information during orientation. Unit Managers will complete a random audit of two carts/nursing stations/units one time a week x 4 weeks then 1 time a week x 2 months. The Director of Nursing will forward the results of the audit for Health Protected Information to the Quality Assurance and	

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F 583	Continued From page 3 of the residents.	F 583	Process Improvement Committed (QAPI) x three months. The QAPI Committee will meet monthly x 3 months and review the audits for Health Protected Information to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the type of discharge on a Discharge Minimum Data Set (MDS) assessment for 1 of 4 sampled residents reviewed for discharge planning (Resident #102). The findings included: Resident #102 was admitted to the facility from the hospital on 7/16/24 for short-term rehab services. A 7/23/24 5-day MDS assessment indicated the overall goal for Resident #102 was to discharge to the community. A 7/25/24 10:22 AM Nurse Practitioner progress note recorded Resident #102 was admitted to the facility for rehab and assessed for discharge home with home health services as planned. A 7/25/24 2:49 PM nurse progress note recorded	F 641	On 11/8/2024. Resident #102's Discharge Minimum Data Set (MDS) was modified by the MDS nurse related to the type of discharge. On 11/5/24 the MDS Consultant completed an audit of section A0310G for all residents discharged in last 90 days to ensure all MDS Discharge Tracking is completed are coded accurately. The MDS nurse completed modifications for all concerns identified during the audit. The required modifications were completed by the MDS Nurse on 11/8/2024. On 11/7/24 the MDS Consultant educated the MDS Coordinator and MDS Nurse related to ensuring MDS Assessments and Coding are completed per the Resident Assessment Instrument (RAI) Manual with emphasis on completion of	11/21/24

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F 641	Continued From page 4 Resident #102 discharged home with family from the facility at 2:20 PM with home health arrangements, prescriptions and personal items and medications and discharge instructions were reviewed. A 7/25/24 Discharge MDS recorded the type of discharge as unplanned. During an interview on 10/23/24 at 9:46 AM, the Social Worker (SW) stated she completed the discharge section of the 7/23/24 5-day MDS and confirmed that the goal on admission was for Resident #102 to discharge home with family after her rehab services were completed. The SW stated Resident #102 expressed on admission to the facility that she came with the intentions to discharge home with family, which was discussed from the beginning of her stay and that home health services would be needed at discharge. MDS Coordinator #1 stated in an interview on 10/24/24 at 1:16 PM, that she reviewed the medical record for Resident #102 and did not see anything to support that the discharge for Resident #102 was unplanned. She stated that the MDS was coded in error. MDS Coordinator #2 stated in an interview on 10/24/24 at 1:17 PM, that Resident #102's discharge was planned, and it was coded as unplanned in error. The Interim Director of Nursing and Administrator were interviewed on 10/24/24 at 12:24 PM. The Interim DON stated the anticipated discharge plan should be initiated and carried out.	F 641	Discharge Tracking accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be required to complete this education during orientation. The MDS Coordinator and/or the MDS Nurse, MDS Coordinator or Director of Nursing will complete audits of at least five resident discharge tracking MDS assessments weekly X 4 weeks and monthly X 2 months to ensure discharge tracking MDS assessments continue to be completed as required. The MDS Coordinator and DON will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary modifications of resident's MDS as necessary. The Administer will review and initial the MDS audit weekly x 4 weeks then monthly x 1 month to ensure any area of concerns were addressed. The DON will forward the results of the MDS audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The QAPI Committee will meet monthly x 3 months and review the MDS audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 655	Continued From page 5	F 655		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655		11/21/24

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F 655	Continued From page 6 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, family member and staff interviews, the facility failed to provide residents with a summary of their baseline care plan within 48 hours of admission that included initial goals based on admission orders, physician orders, and a summary of services or treatments to be administered by the facility. This was for 4 of 4 residents reviewed for baseline care plan (Resident #203, Resident #33, Resident #88, and Resident #99). The findings included: a. Resident #203 was admitted to the facility on 10/18/24. The admission Minimum Data Set assessment was not completed. Review of Resident #203's medical record revealed no baseline care plan had been provided to the resident or her family. A baseline care plan dated 10/18/24 addressed Resident #203's potential for falling and potential for pain due to fracture with interventions in place. A phone interview was conducted with Resident #203's family member on 10/22/24 at 9:20 AM and the family member reported she had not been provided with initial goals, summary of Resident #203's medications, and a summary of	F 655	Resident # 33 was discharged home from the facility on 10/27/2024. Unable to complete baseline care plan review prior to discharge. Resident # 88 discharged home from the facility on 11/7/2024. Unable to complete baseline care plan review prior to discharge. On 11/13/2024, Resident #203 baseline care plan was reviewed with the resident and responsible party by the Social Services Director and Unit Manager. On 11/14/2024, Resident #99 baseline care plan was reviewed with resident's responsible party by the Social Services Director and Unit Manager. On 11/11/2024, an audit of new admissions baseline care plans in the last 30 days was reviewed by the Social Services Director to ensure baseline care plan were completed within 48 hours, reviewed with the resident and/or the responsible party and that a copy of the baseline care plan was offered to the resident/responsible party at the time of the review. Any resident who did not have evidence that a review of the care plan was completed, reviewed and a copy	

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F 655	Continued From page 7 services or treatments to be administered by the facility. b. Resident #33 was admitted to the facility 7/5/24 and readmitted 10/4/24. The admission Minimum Data Set assessment dated 10/11/24 assessed Resident #33 to be severely cognitively impaired. A baseline care plan dated 7/5/24 addressed Resident #33's potential to fall, develop skin breakdown, and experience pain with interventions in place. A review of Resident # 33's medical record revealed no baseline care plan had been provided to Resident #33 or to her family. An interview was conducted with Resident #33's family member on 10/21/24 at 3:28 PM and the family member reported she had not been provided with initial goals, summary of Resident #33's medications, and a summary of services or treatments to be administered by the facility. c. Resident #88 was admitted to the facility on 9/12/24. The admission Minimum Data Set assessment dated 10/8/24 assessed Resident #88 to be cognitively intact. Review of Resident #88's medical record revealed no baseline care plan had been provided to the resident or to her family. A baseline care plan dated 9/12/24 addressed Resident #88's potential for falling and potential for pain due to fracture with interventions in place.	F 655	offered will have their care plan reviewed with the resident/responsible party and offered a copy of the care plan. On 11/11/2024, the Administrator educated the Interdisciplinary Team which consists of Nursing, MDS, Social Services, Dietary, and Activities related to ensuring that baseline care plans are being completed within 48 hours of admission, reviewed with resident and/or responsible party and that the resident/responsible party is offered a copy of the baseline care plan. All IDT members not educated by 11/21/2024 will be educated prior to their next shift worked. The Administrator will educate all newly hired IDT members related to baseline care plans during orientation. Social Services will complete an audit of the new admission baseline care plans weekly X 4 Weeks and monthly X 2 months to ensure that baseline care plans continue to be completed with 48 hours of admission and reviewed with the resident and/or the responsible party, and a copy of the baseline care plan is offered to the resident and/or responsible party. The Director of Nursing will forward the results of the baseline care plan audit monthly x 3 months to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI Committee will meet monthly x 3 months to review the baseline care plan audit to determine trends and/or issues that may need further interventions put into place and to determine the need for	

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F 655	Continued From page 8 An interview was conducted with Resident #88 on 10/21/24 at 11:43 AM and she reported she had not been provided with the initial goals, summary of her medications, and a summary of services or treatments to be administered by the facility. d. Resident #99 was admitted to the facility 10/4/24. The admission Minimum Data Set assessment dated 10/11/24 assessed Resident #99 to be severely cognitively impaired. Review of Resident #99's medical record revealed no baseline care plan had been provided to Resident #99 or her family. A baseline care plan dated 10/18/24 addressed Resident #99's potential for falling and potential for pain due to fracture with interventions in place. Resident #99's family member was interviewed on 10/21/24 at 3:09 PM and she reported she had not been provided with initial goals, summary of Resident #99's medications, and a summary of services or treatments to be administered by the facility. The Social Worker (SW) was interviewed on 10/23/24 at 3:30 PM. The SW revealed she had been in her position for 4 ½ months and had not provided any residents with a baseline care plan summary during that time. The SW reported the admission nurse initiated the baseline care plan, and she was responsible for the facility welcome meetings with the residents, their family members, and department managers, but she had never given a baseline care plan summary and was not aware she needed to provide	F 655	further and/or frequency of monitoring.	

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F 655	Continued From page 9 residents with a baseline care plan. The Administrator was interviewed on 10/24/24 at 2:05 PM. The Administrator reported the SW was new and there was a lot of information she had not learned to implement. The Administrator reported he expected all new admission residents to receive a summary of their baseline care plan with initial goals, summary of the resident's medications, and a summary of services or treatments to be administered by the facility.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to offer a bed bath for two days, provide nail care, and shave a resident dependent on staff for activities of daily living (ADL). This failure occurred for 1 of 4 sampled residents reviewed for ADL (Resident #63). The findings included: Resident #63 was admitted to the facility on 3/23/22. Diagnoses included heart failure, dilated cardiomyopathy, presence of automatic cardiac defibrillator, and shortness of breath. A care plan revised 9/5/24 identified Resident #63 was dependent on staff for ADL and refused care at times. Interventions included staff would	F 677	On 10/23/2024, Resident #63 was provided nail care by CNA on Medical Unit. Resident #63 refused the shower on 10/23/2024. On 10/24/2024, Resident #63 accepted a shower and was provided a shower from CNA on Medical Unit. On 11/1/2024, an audit of the current residents was completed by the Unit Managers to ensure residents receive showers, nail care and are shaved as required. The result of the findings revealed that 100% of ADL care was provided, one resident refused d/t not feeling well. Resident requested and was provided on the next day.	11/21/24

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F 677	Continued From page 10 provide personal hygiene, inspect skin and notify nurse of any abnormal changes. Additionally, staff were to inform Resident #63 of ADL care to be provided ahead of time, give options of times care would be done to allow for flexibility and accommodate his mood, and if refused, reattempt at another time. A 9/13/24 significant change MDS recorded Resident #63 had adequate hearing and vision, clear speech, able to be understood by others and able to understand, and his cognition was intact. Review of Resident #63's Shower, Tub, Bath Sheets revealed the following: - 10/3/24, documented Resident #63 refused a shower, received a bath instead, but it did not indicate if nails were cleaned or clipped or if the nurse was notified of his refusal. The form was not signed by staff. - 10/7/24, documented Resident #63 refused a shower, it did not indicate if nails were cleaned or clipped. The form was not signed by staff. - 10/10/24, documented Resident #63 refused a shower, received a bath instead, but it did not indicate if nails were cleaned or clipped or if the nurse was notified of his refusal. The form was not signed by staff. - 10/14/24, documented Resident #63 refused a shower, but it did not indicate if the nurse was notified of his refusal. - 10/17/24, documented Resident #63 refused a shower because that day was not his assigned shower day and that he wanted a shower on the next day. The document did not indicate if his nails were cleaned or clipped. - 10/21/24 documented Resident #63 refused a shower, but did not indicate if a bed bath was	F 677	On 11/1/2024, the Director of Nursing (DON) initiated education to the nursing staff which includes licensed nurses, certified nursing assistants, certified medication aides, and prn Nursing staff to include agency staff, to ensure resident shower sheets are completed and signed and residents receive showers/bed baths as scheduled, nail care, and are shaved the in-service will be completed by 11/21/20214. Any Nursing Staff that has not completed the education by 11/21/2024 will receive the education on their next scheduled shift. Any newly hired nursing staff will complete the education during orientation. The Director of Nursing/Unit Manager and/or designated staff will complete audits of at least 10 resident shower sheets and observe the10 residents to ensure that showers/bed baths are being provided as scheduled and shower sheets are completed and signed as well as residents receive nail care and are shaved as needed weekly X 4 weeks and monthly X 2 months to ensure continual compliance. The findings of the audit will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Director of Nursing x 3 months. The Director of Nursing will review the findings in the monthly Quality Assurance Performance Improvement (QAPI) meeting and update the plan as needed.	

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offered, if his nails were cleaned or clipped or if the nurse was notified of his refusal.

Resident #63 was observed in bed and interviewed on 10/21/24 at 11:31 AM. He stated, "Look at my fingernails, how long they are, they need to be trimmed, and I need a shave." Resident #63 was observed with a thick beard that extended from both cheeks to his chin. The fingernails on each hand were observed extended over the skin. He stated that he was taken to the shower room on Monday, 10/21/24, for a shower, but that the shower room was full, he was cold, so he asked staff to bring him back to his room and to give him a shower on Friday, 10/25/24. He said "no" when asked if he was offered a bed bath, or to have his fingernails trimmed.

Resident #63 was observed in bed on 10/23/24 at 9:21 AM with a thick beard that extended from both cheeks to his chin and the fingernails on each hand were observed extended over the skin.

During a 10/23/24 9:23 AM observation with Medication Aide (MA) #1 of Resident #63 in bed, his fingernails and facial hair was observed. MA #1 stated each of his fingernails were long and asked Resident #63 if he wanted them trimmed, and if he wanted to be shaven, Resident #63 stated "yes".

During a 10/23/24 9:25 AM interview with Nurse Aide (NA) #6, he stated he was a regular NA for Resident #63 and offered him a shower on Monday, 10/21/24, but he refused and did not want to be bothered. NA #6 stated he reported the refusal to the nurse, but did not offer Resident

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#63 a bed bath, to have his fingernails trimmed or to be shaven because Resident #63 said he did not want to be bothered.

Nurse #7 observed Resident #63 on 10/23/24 at 9:29 AM at the request of the surveyor. Nurse #7 stated during the observation that the fingernails of Resident #63 were long and asked him if he wanted to have his nails trimmed, and if he wanted to be shaven. Resident #63 replied "Yes" and further stated that his fingernails were too long.

During a 10/23/24 1:20 PM interview with Unit Manager #2 (UM #2), she stated that the NA should report to the nurse if a resident refused ADL care. She further stated that fingernails should be trimmed by the NA and if the resident refused, the NA should report to the nurse so that the nurse could go to the resident to encourage care and provide the care if necessary. UM #2 stated that ADL care did not have to be provided when a resident received a shower but should be provided when needed. UM #2 stated the nurse should check the resident's nails during weekly skin checks and provide nail care as needed. UM #2 stated she was the charge nurse for Resident #63 on Monday, 10/21/24 and that she was not notified that he refused care.

During a 10/23/24 3:53 PM interview with NA #7, she stated she was a new NA, she was the assigned NA for Resident #63 on Tuesday, 10/22/24, which was her second assignment since her training. NA #7 stated on Tuesday, 10/22/24 she thought that another team member was assigned to give showers/bed baths to residents, so that was the reason she did not offer him a shower/bed bath, to be shaven or nail

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care.

The Scheduler stated in a 10/23/24 5:37 PM interview that on Tuesday, the NA schedule was updated before 7:00 AM that between 11:00 AM to 2:00 PM, NA #8 would take as many residents as she could to activities and assist as many residents as she could to be shaven. The Scheduler stated that the original plan was to have a shower team on Tuesday, but that was changed on the schedule before 7:00 AM and since Tuesday was not a scheduled shower day for Resident #63, ADL care should have been provided by NA #7.

A 10/23/24 5:55 PM interview with NA #8 revealed she came in at 11:00 AM, Tuesday 10/22/24 and that she was assigned to take residents to activities, assist with showers, and to shave as many residents as she could until 2:00 PM. NA #8 stated that she did not make it to all the halls, and that she did not make it to Resident #63 on Tuesday, 10/22/24 to offer him ADL care.

A 10/23/24 4:42 PM interview with the Interim Director of Nursing (DON), she stated a NA could trim the fingernails of residents and she expected the nurse to include nail assessments on weekly skin check audits. The Interim DON stated that fingernail care, and shaving should be provided when the staff identified that a resident needed this care. She further stated that staff did not have to wait until the resident received a shower to provide the ADL care that was needed. The Interim DON stated that the ADL care refusals should be reported to the nurse and the nurse should go and talk to the resident and offer the care again, so that care was offered about 3 times to give the resident an opportunity to

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F 677	Continued From page 14 receive the care. The Interim DON further stated that fingernail care should be provided as needed, especially if the resident refused a shower/bath. The Interim DON stated that if a resident refused a shower, the NA should inform the nurse, and the nurse should offer the resident alternatives like a different shower/bath schedule and offer a bed bath if the resident declined a shower.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to provide an ongoing individual activity program per resident's preference (Residents #49 and #76) and an ongoing group activity program per Resident Council (Residents #1, #5, #77 and #88) when residents expressed a request to play more "Resident-led" bingo. This failure occurred for 6 of 6 sampled residents reviewed for individual and group activities. The findings included:	F 679	On 11/13/2024, Activities Director updated the facility activity calendar to include Resident-led BINGO per resident preferences of Residents # 49, 76, 1, 5, 77, and 88. The residents will be re-assessed and care plans updated as appropriate, by the Activities Director to assure the activities provided meet the resident's needs. On 11/13/2024, Activities Director interviewed residents with a BIMS of 13 and above to ensure that resident	11/21/24

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F 679	Continued From page 15 1a. Resident #49 re-admitted to the facility 6/13/24. A 2/19/24 annual Minimum Data Set (MDS) assessment indicated Resident #49 had adequate hearing/vision, clear speech, able to understand and be understood, intact cognition and that it was very important to participate in her favorite activities and participate in group activities. A care plan revised 9/3/24, recorded Resident #49 was able to structure her day and enjoyed both individual and group activities. Interventions included to encourage individual activities of interest and to notify of group activities of interest which included bingo. Resident #49 was observed on 10/21/24 and 10/24/24 at 1:30 PM participating in bingo. Resident #49 attended a Resident Council Meeting on 10/22/24 at 1:30 PM with the state surveyor. During the meeting Resident #49 stated that residents expressed during a Resident Council meeting a few months ago that they wanted to play bingo more often, and would prefer to play it daily, but they were told that twice per week was the limit. She stated that the residents expressed they offered to "call" bingo themselves, if it would allow them to play more often and then "Resident-led bingo" was added to the activity calendar on Saturdays, but that wasn't enough. She expressed residents still wanted to play more, daily if possible and would be willing to "call" bingo themselves, but when they expressed this during Resident Council, they were told three times per week was enough.	F 679	preferences are being honored. The activity calendar will be reviewed monthly by the resident council related to presences being met. Newly admitted residents will have their activity preferences reviewed, and care planned as appropriate to assure the activities provided meet their needs. On 11/11/2024, education was provided to the Activities Director by the Administrator related to honoring residents' preferences for Activities. Any newly hired Activity Director will be provided with education related to honoring residents' preferences during orientation. The Director of Nursing will complete audits weekly X 4 weeks and monthly X 2 months of five residents with BIMS of at least 13 to ensure residents' activity preferences continue to be honored. The Administrator will review the findings in the monthly Quality Assurance Performance Improvement (QAPI) meeting and update the plan as needed.	

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1b. Resident #76 was admitted to the facility 4/22/22.

A 1/23/24 annual MDS assessment indicated Resident #76 had adequate hearing/vision, clear speech, able to understand and be understood, intact cognition and that it was very important to participate in her favorite activities and participate in group activities.

A care plan revised 7/25/24, recorded Resident #76 was able to structure her day and enjoyed both individual and group activities. Interventions included to encourage individual activities of interest and to notify of group activities of interest which included bingo.

Resident #76 was observed on 10/21/24 and 10/24/24 at 1:30 PM participating in bingo.

Resident #76 attended a Resident Council Meeting on 10/22/24 at 1:30 PM with the state surveyor. During the meeting Resident #76 agreed when residents expressed that during a Resident Council meeting a few months ago residents stated that they wanted to play bingo more often, and would prefer to play it daily, but they were told that twice per week was the limit. She agreed that the residents expressed they offered to "call" bingo themselves, if it would allow them to play more often and then "Resident-led bingo" was added to the activity calendar on Saturdays, but that wasn't enough. She expressed that she still wanted to play more, daily if possible and that the residents would be willing to "call" bingo themselves, but when they expressed this during Resident Council, they were told three times per week was enough.

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1c. Review of 2/8/24 Resident Council Meeting minutes, recorded by the Activity Director (AD) revealed the residents in attendance expressed they wanted to play more bingo, but the AD let them know "two is our limit per week."

Review of the 4/10/24 Resident Council Meeting minutes, recorded by the AD revealed the residents in attendance expressed they wanted to play more bingo. The AD recorded in the minutes that they would try "Resident-led" bingo on Saturdays two to three times per month.

Review of the activity calendars February 2024 to April 2024 revealed bingo was offered twice per week. Review of the activity calendars May 2024 to October 2024 revealed bingo was offered three times per week; twice during the week and once on Saturdays.

A Resident Council Meeting occurred with the state surveyor on 10/22/24 at 1:30 PM. Residents #1, #5, #77 and #88 voiced during the meeting that they expressed a few months ago that they wanted to play bingo more often, and would prefer to play it daily, but they were told that twice per week was the limit. The Residents expressed they offered to "call" bingo themselves, if it would allow them to play more often and then "Resident-led bingo" was added to the activity calendar on Saturdays. The Residents expressed they appreciated being able to play bingo three times per week, but that they still wanted to play more, daily if possible and would be willing to "call" bingo themselves, but when they expressed this during Resident Council, they were told three times per week was enough.

The AD was interviewed on 10/22/24 at 3:14 PM.

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F 679	Continued From page 18 He stated he facilitated Resident Council Meetings and recorded the minutes. The AD stated that Residents expressed during a Resident Council Meeting in February 2024 that they wanted bingo more often, so a "Resident-led" bingo activity was added in May 2024 on Saturdays to offer bingo three times per week. The AD stated he asked Residents during the June 2024 Resident Council Meeting "how did they like having a third bingo" and they said they liked it. He further stated, "some of the residents would play bingo every day if they could, but I want them to have a variety of activities and I think bingo three times a week is enough." During an interview on 10/24/24 at 12:01 PM with the Administrator and Interim Director of Nursing (DON), the Interim DON stated the activity program should be reasonable and based on resident preference. The Administrator stated that residents should be allowed to play bingo daily if they wanted and especially if they were willing to lead the activity.	F 679		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.	F 687		11/21/24

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F 687	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews, the facility failed to ensure residents' toenails were trimmed and podiatry services were arranged for 3 of 4 residents (Resident #28, Resident #1 and Resident #63) reviewed for foot care. Findings included: 1. Resident 28 was admitted to the facility 08/07/24 with diagnoses that included diabetes type 2, and vascular dementia. An annual Minimum Data Set (MDS) assessment dated 08/14/24 revealed Resident #28 had no cognitive impairment. He was independent for eating and oral hygiene. He required moderate assistance to toilet and maximum assistance with bed mobility. Care plans reviewed for Resident #28 initiated 08/15/23 and revised on 08/27/24 included Resident #28 required assistance to put on and remove his socks and shoes related to a decline in functional status. Another care plan included that Resident #28 had diabetes type 2, was at risk for complications, had an intervention to monitor skin integrity and report abnormalities to the nurse or physician. On 10/22/24 at 8:01 AM an observation and interview conducted with Resident #28 revealed he was seated in his wheelchair with socks and shoes on both feet. Resident #28 reported he had not been seen by the facility podiatrist since admission and he needed his toenails clipped.	F 687	Resident #28 and #1 was scheduled for podiatry services on November 5, 2024. Resident #63 was put on schedule per his maintenance program with the Podiatrist. He was scheduled for an appointment to see the Podiatrist on 9/2/2024 but he was in the hospital. He was moved to next date which was scheduled on 11/12/2024 and 11/13/2024. On 10/23/2024, Unit Managers assessed the current residents to identify residents that need their toenails trimmed and/or podiatry services. Any resident identified as needing toenail care will have toenail care provided at the time of the assessment. Any resident requiring podiatry services will be placed on the podiatrist list for the next visit, which will occur on 11/12/2024 and 11/13/2024. If there are residents who require podiatry services be performed prior to this date, the facility will arrange a podiatry appointment for the resident. Starting 11/1/2024, the Director of Nursing and/or Unit Manager educated the licensed nurses, certified nursing assistances, Certified medication aides, prn and agency nursing staff on ensuring that residents' toenails are trimmed and residents that require podiatry services are placed on the podiatry list by social services. The education will be completed by 11/21/2024. Any Nursing staff to includes new hires, agency, and prn staff not educated by 11/21/2024 will be	

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F 687	Continued From page 20 On 10/23/24 at 3:00 PM Nurse Aide (NA) #3 removed the shoe and sock on Resident #28's left foot. The observation revealed Resident #28 had dry scaly skin on his left foot, his toenails were thick and extended over the ends of each toe. Resident #28 revealed that the toenails on his right foot looked the same and his skin was dry. Resident #28 verbalized he had not had a podiatry consult and he really needed one, but his toenails did not cause pain. NA #3 reported she had never observed Resident #28's toenails but she would have reported the condition of his toenails to the nurse. NA #3 explained that NAs were not able to cut or clip any resident's finger or toenails. On 10/24/24 at 10:31 AM Nurse #1 was interviewed. Nurse #1 reported that NAs were not allowed to provide finger or toenail care to any resident and were supposed to report nail care concerns to the nurse. Nurse #1 revealed she had not received any report of Resident #28 needing any nail care. A phone interview with Nurse #2 conducted on 10/23/24 at 3:14 PM revealed she had completed weekly skin checks of Resident #28 on 10/15/24 and 10/22/24. Nurse #2 revealed she did not identify any concerns with the toenails of Resident #28 and reported if she did have concerns they would have been reported to the physician and Social Worker (SW) to obtain a podiatry consult. An interview with the Social Worker on 10/23/24 at 9:36 AM revealed nurses were responsible to give her a referral for a podiatry consult for each resident and then she forwarded the resident information to the consulting podiatrist who would	F 687	provided the education prior to their next scheduled shift. All newly hired nursing staff to include agency will be provided with the education during orientation. The Unit Managers will complete audits of 10 residents weekly x 4 weeks and monthly x 2 months to ensure resident's toenails are trimmed as appropriate and that resident's podiatry needs are being met to ensure continual compliance. The Director of Nursing will review the findings of the audits weekly x 4 weeks and then monthly x two months. The Director of Nursing will forward the results of the audit tool in the monthly for three months to the Quality Assurance Performance Improvement (QAPI) Committee for three months. The QAPI Committee will review the audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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schedule a podiatrist consult on the next visit to the facility which was scheduled at the beginning of November. The SW revealed she did not recall a podiatry consult referral from nurse staff for Resident #28 to be seen by the podiatrist. The SW confirmed the podiatrist was expected to be at the facility monthly.

A follow up interview with the SW conducted 10/23/24 at 3:46 PM revealed Resident #28's name was not listed on the podiatrist lists for September 2024 or October 2024. The SW reported she would notify Unit Manager (UM #2) and physician that Resident #28 requested a podiatry consult and she would add Resident #28's name to the November schedule.

An interview with nurse Unit Manager (UM) #2 on 10/23/24 at 1:20 PM included that only licensed nurses were to provide any nail care to residents. UM #2 revealed that the nurse would check the resident's toenails during weekly skin checks and the NAs were to report the need of resident nail care on resident shower days and either clip the nails or notify the SW that the resident needed a podiatrist consult. UM #2 revealed that on review of Resident #28's weekly skin checks completed by Nurse #1 dated 09/09/24, 10/15/24, and 10/22/24 there were no finger or toenail concerns. UM #2 revealed she was not certain if Resident #28 had ever been consulted by the podiatrist.

The facility physician was interviewed at 11:55 AM on 10/23/24. He revealed he was not aware that Resident #28 needed podiatry care. The physician explained the facility did have standing orders for residents to have podiatry consults. He was not aware that Resident #28 needed to be seen by the podiatrist, and he would follow up

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with Unit Manager #2.

On 10/23/24 the Director of Nurses (DON) revealed during an interview at 4:39 PM that both NAs and nurses could provide finger and toenail care to Residents if the Resident did not have diabetes Type 2. The DON provided shower sheets dated 10/01/24 and 10/10/24 signed by an NA for Resident #28. No finger or toenail concerns were documented on the shower sheets.

A follow up interview conducted with the DON on 10/24/24 at 11:41AM revealed both NAs and nurses could perform finger and toenail care to any resident if the resident had no diabetes type 2 diagnosis. The DON reported the nurse was responsible to notify the SW nail care was needed by the podiatrist for any reason. The DON expected the nurse staff to include toenail assessments on weekly skin check reports and make referrals for toenail care as indicated.

2. Resident #1 was admitted to the facility 1/9/24. Diagnoses included atherosclerotic heart disease, cerebrovascular accident, chronic kidney disease, stage 4, chronic pain, and neuromuscular disorder.

An 8/5/24 quarterly Minimum Data Set (MDS) assessment, indicated Resident #1 had adequate hearing and vision, clear speech, able to be understood by others and able to understand, and his cognition was intact.

A care plan revised 8/29/24 identified Resident #1 was dependent on staff for activities of daily living (ADL) and at risk for a decline in skin integrity due

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to his diagnoses of a neuromuscular disorder. Interventions included staff would provide personal hygiene and weekly evaluation/assessment of skin with notification to the nurse or physician as necessary.

A review of weekly Skin Check records dated 10/2/24, 10/9/24 and 10/16/24 completed by Nurse #7 recorded Resident #1's assessments were completed with no new skin concerns documented.

A review of the medical record for Resident #1 revealed no documentation of podiatry services or for a podiatry referral.

Resident #1 attended a Resident Council meeting with the state surveyor on 10/22/24 at 1:30 PM. During the meeting, Resident #1 stated that he had not received podiatry services since his admission and that he needed his toenails trimmed. He stated that staff looked at his skin and feet weekly but had not offered him podiatry services.

A 10/23/24 11:00 AM observation with Nurse #7 of Resident #1 in his room revealed he was seated in his wheelchair with bilateral leg braces in place and both feet rested on the footrests on his wheelchair. When asked by Nurse #7 to assess his feet, Resident #1 agreed. Nurse #7 stated that she last observed his feet during a skin audit on 10/16/24, but that she did not recall the specific length of his toenails. During the assessment of the left foot, Resident #1 expressed that the left great toenail was painful. After assessing his left foot, Nurse #7 stated that the left great toenail was thick and long and could be trimmed. The left great toenail was observed

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to extend over the skin and curled towards his skin. Nurse #7 assessed the right foot and stated that the fourth toenail on the right foot was long and should be trimmed. The toenail was observed to extend over the skin and curled towards the skin. Nurse #7 stated that his toenails were the same length as she saw when she completed the skin assessments on 10/2/24, 10/9/24 and10/16/24, but that she did not offer to trim his nails or offer a podiatry referral because she was new to the facility and to the facility's process. She stated that due to the thickness of his nails and his complaints of pain he should be referred for podiatry services. Nurse #7 stated when she completed the skin audit for Resident #1 on 10/16/24 it was after 6:30 PM and the social worker (SW) had already left. Nurse #7 further stated that she did not communicate the need for a podiatry referral for Resident #1 to the SW, but that was the process. Nurse #7 stated that staff should communicate to the SW if staff observed that a resident needed podiatry services, but that she was new to the facility, and still learning the process. She stated that she should have left a note for the SW about the length of Resident #1's toenails so that the SW could add Resident #1 to the list for podiatry services, and stated, "But I did not do that." Resident said "yes" when asked if he wanted a podiatry referral. He stated that his toenails were last trimmed by a nurse over a month ago, but he did not recall exactly when that was. He stated he did not know the podiatrist was in the facility in September 2024, so he did not ask to be seen.

An interview with the Social Worker (SW) on 10/23/24 at 9:36 AM revealed nurses were responsible to give her a referral for a podiatry consult for each resident and then she forwarded

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the resident information to the consulting podiatrist who would schedule a podiatrist consult on the next visit to the facility. The SW confirmed the podiatrist was expected to be at the facility monthly. The SW reviewed the list of residents seen by the podiatrist in September 2024, and confirmed Resident #1 was not included. The SW stated she was not informed that Resident #1 needed a podiatry referral and so Resident #1 was not on the podiatry list for the next podiatry visit planned at the facility for 11/12/24 and 11/13/24, but he would be added.

During a 10/23/24 1:20 PM interview with Unit Manager (UM) #2, she stated that only licensed nurses were to provide any nail care to residents. UM #2 revealed that the nurse should check the resident's toenails during weekly skin checks and notify the SW if a resident needed a podiatrist consult.

A 10/23/24 12:30 PM interview with the physician revealed he was not aware that Resident #1 needed podiatry care, but that the facility did have standing orders for residents to have podiatry consults.

A 10/23/24 4:42 PM interview with the Interim Director of Nursing (DON), she stated the nurse was responsible to notify the SW if podiatry care was needed. The DON expected the nurse to include toenail assessments on weekly skin check audits and make referrals for toenail care as indicated. The DON stated she could not find any record that Resident #1 had been referred for podiatry services. She stated that Resident #1 was not a diabetic, but if his toenails were thick, long and painful and required podiatry services then the SW and MD should be informed so that

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that the referral paperwork could be completed, and a referral for services made to the provider.

3. Resident #63 was admitted to the facility on 3/23/22. Diagnoses included onychomycosis (fungal infection of the nails), mild hammertoe, and peripheral vascular disease.

Podiatry consults dated 1/3/24 and 6/24/24 both recorded Resident #63 received follow-up podiatry services for routine footcare due to chronic onychomycosis. Both consults documented that conservative footcare was recommended due to marked limitation and pain from the thickening and dystrophy (tissue degeneration) of the affected nails. Both consults documented a care plan to maintain regular footcare visits as scheduled to decrease pressure and reduce pain and infection risk to his feet and toes.

A review of the list of residents who received podiatry services in the facility in August 2024 revealed Resident #63 was not included in the list of residents who received podiatry services.

A 9/3/24 podiatry consult recorded Resident #63 did not receive podiatry services because he was currently at the hospital.

A review of the list of residents who received podiatry services in the facility in September 2024 revealed Resident #63 was not included in the list of residents who received podiatry services due to a hospitalization.

A care plan revised 9/5/24 identified Resident #63 was dependent on staff for activities of daily living (ADL), at risk for a decline in skin integrity, and

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refused care at times. Interventions included staff would provide personal hygiene, inspect skin and notify nurse of any abnormal changes. Additionally, staff were to inform Resident #63 of ADL care to be provided ahead of time, give options of times care would be done to allow for flexibility and accommodate his mood, and if refused, reattempt at another time.

A 9/13/24 significant change MDS recorded Resident #63 had adequate hearing and vision, clear speech, able to be understood by others and able to understand, and his cognition was intact.

Review of Resident #63's Shower, Tub, Bath Sheets revealed the following:
- 10/3/24, documented Resident #63 refused a shower, received a bath instead, but it did not indicate if nails were cleaned or clipped or if there was a need for podiatry services. The form was not signed by staff.
- 10/7/24, documented Resident #63 refused a shower, it did not indicate if nails were cleaned or clipped or if there was a need for podiatry services. The form was not signed by staff.
- 10/10/24, documented Resident #63 refused a shower, received a bath instead, but it did not indicate if nails were cleaned or clipped or if there was a need for podiatry services. The form was not signed by staff.
- 10/17/24, documented Resident #63 refused a shower because that day was not his assigned shower day and that he wanted a shower on the next day. The document did not indicate if his nails were cleaned or clipped or if there was a need for podiatry services.
- 10/21/24 documented Resident #63 refused a shower, but did not indicate if his nails were

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cleaned or clipped or if there was a need for podiatry services.

Resident #63 was observed in bed and interviewed on 10/21/24 at 11:31 AM. He stated, "Look at my toenails, how long they are, they need to be trimmed." Each toenail on each foot was observed extended over the skin and curled towards his skin. He stated that he was taken to the shower room on Monday, 10/21/24, for a shower, but that the shower room was full, he was cold, so he asked staff to bring him back to his room and to give him a shower on Friday, 10/25/24. He said "no" when asked if he was offered a bed bath, or to have his toenails trimmed.

Resident #63 was observed in bed on 10/23/24 at 9:21 AM. The length of each toenail extended over the skin on each foot.

During a 10/23/24 9:23 AM observation with Medication Aide (MA) #1 of Resident #63 in bed, his feet were observed. MA #1 stated each of his toenails were long and asked Resident #63 if he wanted them trimmed, Resident #63 stated "yes".

During a 10/23/24 9:25 AM interview with Nurse Aide (NA) #6, he stated he was a regular NA for Resident #63 and offered him a shower on Monday, 10/21/24, but he refused and did not want to be bothered. NA #6 stated he reported the refusal to the nurse, but did not report that his toenails were long, because Resident #63 said he did not want to be bothered.

Nurse #7 observed the toenails of Resident #63 on 10/23/24 at 9:29 AM at the request of the surveyor. Nurse #7 stated during the observation

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that the toenails of Resident #63 were long and asked him if he wanted to have his nails trimmed, he replied "Yes, they are too long."

An interview with the Social Worker on 10/23/24 at 9:36 AM revealed nurses were responsible to give her a referral for a podiatry consult for each resident and then she forwarded the resident information to the consulting podiatrist who would schedule a podiatrist consult on the next visit to the facility. The SW confirmed the podiatrist was expected to be at the facility monthly. The SW reviewed the list of residents seen by the podiatrist in the facility in August 2024 and confirmed Resident #63 was not on the list, but stated she did not know why. The SW reviewed the list of residents seen by the podiatrist in September 2024, and confirmed Resident #1 was not included, because he was in the hospital. The SW stated that Resident #63 would have to wait for the next podiatry visit because the provider would not come back for one resident. The SW stated the next podiatry visit was scheduled for 11/12/24 and that Resident #63 would be added to the list to be seen.

During a 10/23/24 1:20 PM interview with Unit Manager #2 (UM #2), she stated that only licensed nurses were to provide any nail care to residents. UM #2 revealed that the nurse should check the resident's toenails during weekly skin checks and notify the SW if a resident needed a podiatrist consult.

A 10/23/24 12:30 PM interview with the physician revealed he was not aware that Resident #63 needed podiatry care, but that the facility did have standing orders for residents to have podiatry consults.

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F 687	Continued From page 30 A 10/23/24 4:42 PM interview with the Interim Director of Nursing (DON), she stated the nurse was responsible to notify the SW if podiatry care was needed. The DON expected nursing staff to include toenail assessments on weekly skin check audits and make referrals for toenail care as indicated. The DON stated she could not find any record that Resident #63 received podiatry services since June 2024.	F 687		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with a resident and staff, the facility failed to	F 692	On 11/8/24, Resident #73 dietary orders were updated by the Unit Manager to	11/21/24

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F 692	Continued From page 31 provide larger portions per physician order to a resident at risk for weight loss due to a history of weight loss (Resident #73). The findings included: Resident #73 admitted to the facility on 1/10/22. Diagnoses included Alzheimer's dementia, mild cognitive impairment, hyperlipidemia, and hypertension. Review of his medical record revealed Resident #73's monthly weight was assessed on 4/4/24 as 187.4 pounds. Review of his medical record revealed Resident #73's monthly weight was assessed on 5/10/24 as 180.6 pounds, approximately a seven-pound weight loss or approximately 3.7% weight loss in a month. A 5/16/24 Interdisciplinary Team progress note recorded Resident #73 was discussed for weight loss, decreased food intake, and disengagement with meals. A physician order was written to decrease the morning dose of Depakote (a mood stabilizer) to promote alertness and encourage food intake. Review of the medical record revealed a 7/3/24 physician order that recorded to provide 4 ounces of a high calorie nutritional supplement twice a day with breakfast and lunch. A nutrition care plan revised 7/12/24 documented Resident #73 at risk for nutritional decline due to weight loss related to a decline in intake. Interventions included to provide an appetite stimulant, high calorie supplements, encourage	F 692	include large portions. On 11/8/24, the Nutritional Consultant and the Registered Dietician (RD) completed an audit of resident diet orders and tray tickets to ensure dietary orders are being followed and any identified concerns were addressed by the RD and/or Nutritional Consultant. On 11/8/24, the Nutritional consultant-initiated education with the dietary staff related to tray card accuracy with emphasis on diet orders and large portions. The dietary staff who have not completed this education by 11/21/24 will be required to complete the education on their next scheduled shift. All newly hired dietary staff will receive this education in orientation. The dietary manager and/or assigned team member will complete audits of 10 resident diet orders and tray cards 3 x week for 4 weeks and month x 2 months to ensure resident diet orders and tray tickets continue to be accurate. The dietary manager will review the findings in the monthly Quality Assurance Performance Improvement (QAPI) meeting and update the plan as needed.	

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consumption of meals and provide a regular diet with double portions as ordered.

Review of his medical record revealed Resident #73's monthly weight was assessed on 7/16/24 as 183.6 pounds.

Review of his medical record revealed Resident #73's monthly weight was assessed on 8/7/24 as 178.6 pounds, a five-pound weight loss or 2.7% weight loss in a month and approximately 4.8% weight loss in four months.

A 10/2/24 quarterly Minimum Data Set assessment indicated Resident #73 had clear speech, adequate vision, adequate hearing, usually understood by others, usually understood others, severely impaired cognition, and fed himself after staff set-up assistance with meals.

Review of his medical record revealed Resident #73's monthly weight was assessed on 10/21/24 as 178.4 pounds or approximately 4.8% weight loss in six months.

Review of the facility's Diet Order Report dated 10/21/24 recorded Resident #73 received a regular diet with larger portions, milk, and a peanut butter sandwich with each meal.

Resident #73 was observed on 10/22/24 at 9:05 AM and 10/23/24 at 9:18 AM in his room, feeding himself breakfast. During each observation, he received a 4-ounce bowl of grits. The breakfast meal tray card recorded a diet order for larger portions. Resident #73 did not receive larger portions of grits for breakfast on 10/22/24 or 10/23/24. During each observation, Resident #73 was asked if he would like to receive a larger

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portion of grits, and he responded "yes" and stated that grits were the best part of his breakfast.

During a 10/23/24 12:00 PM interview with the Physician, he stated that Resident #73 required encouragement to eat because his nutritional status had declined due to his worsening dementia.

The Registered Dietitian (RD) was interviewed on 10/23/24 at 2:57 PM and stated that Resident #73 received an appetite stimulant, milk, and a peanut butter sandwich with each meal, a high calorie nutritional supplement twice a day and double portions for nutritional support due to his history of weight loss and dementia. She stated that in the last six months, Resident #73 had some weight loss, but had not experienced significant weight changes. The RD stated that residents with diet orders for larger/double portions should receive larger/double portions of vegetables, starches and meats. The RD stated that Resident #73 should have received an 8-ounce portion of grits for breakfast on 10/22/24 and 10/23/24 per his diet order.

The Certified Dietary Manager (CDM) was interviewed on 10/23/24 at 4:00 PM. The CDM stated that a resident with a diet order for larger/double portions should receive larger/double portions of meats, starches, and vegetables. She stated that a 4-ounce portion of grits was the standard portion, but that Resident #73 should have received an 8-ounce portion of grits for breakfast from the dietary staff. The CDM stated that it was an oversight that Resident #73 did not receive a double portion of grits on 10/22/24 and 10/23/24 and that the terminology

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F 692	Continued From page 34 on the tray cards would be changed from "larger" portions to "double" portions so that dietary staff would provide the correct portion. The Interim Director of Nursing stated on 10/24/24 at 12:22 PM that residents should receive the portion size of foods as ordered.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		11/21/24

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F 732	Continued From page 35 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to post daily nurse staffing data at the beginning of the shift for 1 of 4 days reviewed. The findings included: An observation of the nurse staffing data occurred on 10/21/24 at 9:18 AM and 10/21/24 at 9:45 AM and revealed nurse staffing data was posted for 10/20/24. An interview with the scheduler occurred on 10/24/24 at 9:38 AM. The Scheduler stated she worked at the facility since February 2024, and she worked Monday through Friday from 8:00 AM or 8:30 AM until 5:00 PM or 5:30 PM. The Scheduler stated she was responsible for posting nurse staffing data for the 7 AM to 7 PM shift. The Scheduler stated that when she arrived at work, she completed a facility round to verify staffing per the schedule, adjusted the staffing data as needed and then posted the nurse staffing data, usually by 9:00 AM, after completing her round. The Scheduler stated when she arrived at 8:00 AM or 8:30 AM, each morning the nurse staffing data was posted for the previous shift and updated after she arrived. The Scheduler stated she was not aware that the	F 732	On 10/23/24, the Staff Posting sheet was completed by the Scheduler to reflect the facility nursing staff information. On 10/23/24, the scheduler and receptionist were educated by Director of Nursing on ensuring staff posting sheets are posted at the start of each business day. New hire schedulers and receptionist will be required to complete this education in orientation. The Receptionist and/or scheduler will complete audits of the daily staff posting sheets 3 x week to include the weekend to ensure posting sheets continue to be posted daily. The Director of Nursing will review the findings Quality Assurance Performance Improvement (QAPI) meeting committee X 3 months for review and to update to update the plan needed. The Director of Nursing will present the audit findings to the Quality Assurance Performance Improvement (QAPI) meeting committee x 3 months for review and to update the plan as needed.	

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F 732	Continued From page 36 nurse staffing data should be posted at the beginning of the 7 AM shift. The Administrator and Interim Director of Nursing were interviewed on 10/24/24 at 12:26 PM. The Interim DON stated the facility staffed the nursing department based on a 12-hour shift schedule, 7 AM to 7 PM and 7 PM to 7 AM. The Administrator stated that the facility would have to adjust who was responsible for posting nurse staffing data to ensure it was posted at the beginning of the 7 AM shift.	F 732		
F 804 SS=E	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 a breakfast meal test tray observation, minutes from Resident Council meetings, a Resident Council meeting, resident and staff interviews, the facility failed to provide food that was palatable and had an appetizing temperature for 8 of 8 residents reviewed for palatable foods (Resident #5, Resident #1, Resident #88, Resident # 77, Resident # 76, Resident #95, Resident #63, and Resident # 34). The findings included:	F 804	On, 11/14/2024 of the person completed updated dietary preferences on Resident #5, #1, #88, #77, #76, #95, #63, #34. On 10/21/2024, the Certified Dietary Manager made sure no other metal pans were observed to be stacked wet. On 11/14/2024, the Certified Dietary Manager complete food preferences updates on residents with BIMs 13 and above. On 10/23/24, the Assistant Vice President (AVP) of Nutritional Services purchased 2	11/21/24

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F 804	Continued From page 37	F 804		

Resident #95 was interviewed on 10/21/24 at 10:43 AM and he reported he was on a regular diet with ground meat. The resident was not happy with the breakfast meat and it "had no taste."

Resident #63 was interviewed on 10/21/24 at 11:28 AM and when asked about the food in general, he reported the food "looks like [expletive] and tastes like it, too."

Resident Council Meeting minutes for 12/6/23, 1/10/24, 2/8/24, 6/12/24, and 7/10/24 identified issues with food and coffee temperatures, food texture, and flavor.

During the Resident Council meeting on 10/22/24 at 1:30 PM, 6 of 6 residents in attendance (Resident#1, #49, #88, #77, #5, and #76) identified ongoing issues with cold coffee and tough meat. The residents also noted the microwave was broken and they did not have coffee available at any time they wanted.

A breakfast test tray was requested on 10/23/24 at 8:05 AM. The plate was placed on an insulating bottom and had an insulating cover. The tray left the kitchen at 8:17 AM on an open cart. The coffee had a plastic lid over the cup and was in a plastic cup. The cart arrived at the 400/500 halls at 8:19 AM. Staff delivered the breakfast meal to residents on the 400/500 halls from 8:20 AM until 8:30 AM. During the observation of staff delivering resident trays, a staff member lifted the insulated lid on the test tray and then replaced it askew. The DM noted the lid was not on the test tray plate correctly and she replaced it. The test tray was sampled with the Dietary Manager (DM) at 8:32 AM. When the DM removed the insulated cases of ceramic plates and bowls and removed the plastic plates and bowls from circulation.
On 11/4/24, new menus were initiated by the Certified Dietary Manager (CDM).

On 11/8/2024 the Nutrition Consultant initiated an in-service with the Dietary Department regarding Meal Palatability with emphasis on (1) preparing meals according to the recipes (2) ensuring foods meet minimum holding temperatures (>135 degrees for hot items/<41 degrees for cold menus) (3) ensuring that all lids are securely placed on plates, bowls, mugs/cups. The in-service will be completed by 11/21/2024. After 11/21/2024, any dietary staff who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Meal Palatability.

The CDM will audit meal palatability and Resident meal satisfaction utilization by utilizing the Tray Assessment 3 times a week to include all meals x 4 weeks then monthly x 2 months. This audit is to ensure food was prepared per menus, to be well seasoned and palatable to taste, and served at a palatable temperature of at least 110 degrees. The CDM will address all concerns identified during the audit to identify palatable presentation, taste, and temperature. The Administrator will review the meal preparation audits 2 times a week x 4 weeks then monthly x 2 months to ensure all concerns are

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F 804	Continued From page 38 cover from the plate of food, no steam was noted to rise off the food. No steam came from the cup of coffee and the temperature was tepid to taste. The fried eggs were cool to the touch and taste, the pancakes were cool to the touch and were not warm, and the sausage links were cool to the touch and were not warm. The DM agreed the food temperature was not warm and reported she thought it was because the insulated lid had not been placed on the plate of food correctly, which allowed the heat to escape. The DM reported she expected food to be delivered covered correctly with the insulated lid to prevent loss of temperature. Resident #5 was interviewed 10/23/24 after the breakfast tray sample, and she reported that her breakfast was "not good; I don't like the eggs, the coffee was barely warm, and the pancakes were cold." Resident #34 10/23/24 was interviewed after the breakfast tray sample, and she reported her breakfast was "awful". Resident #34 was noted to have eaten approximately 10% of her meal and she had replaced the cover over her plate. The DM was interviewed on 10/24/24 at 2:15 PM and she explained she was surprised by the results of the test tray and felt that breakfast was the best meal of the day with the residents feeling pleased with that meal. The DM reported the staff performed test trays for palatability and temperature, and she attended Resident Council meetings to talk about food preferences and food issues. The DM reported she ate at least one meal per day at the facility and they did test trays "routinely" but was unable to provide information for when the last test tray had been completed.	F 804	addressed. The Administrator will review the findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting and update the plan as needed.	

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F 804	Continued From page 39 The DM reported she had responded to the Resident Council concerns by changing the coffee vendor, offering flavored creamers for coffee, having more staff pass out the trays so the trays did not sit for a long time, and providing education to the kitchen staff for complaints of over-cooked foods. The Administrator was interviewed on 10/24/24 at 2:05 PM and he reported he expected the food to be served at the correct temperature and to be palatable.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dry metal pans before being	F 812	On 10/21/2024 the Certified Dietary Manager (CDM) immediately washed,	11/21/24

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F 812	Continued From page 40	F 812		

stacked, clean 1 of 3 ice machines in 1 of 3 nourishment rooms (medical unit), and store dry goods off the floor. These failures had the potential to affect food served to residents.

The findings included:

a. The kitchen was toured on 10/21/24 at 9:28 AM with the Dietary Manager (DM). During the observation, the storage rack for metal pans was observed and 3 metal pans were noted to be stacked wet. Water was noted to drip down the sides of the pain when the pans were separated, and the interior of the pans felt wet. When asked, the DM reported the metal pans should have been air dried completely before stacking. The DM asked Cook #1 who stacked the pans and Cook #1 reported she did not know who stacked the pans while they were still wet.

b. The medical unit nourishment room was observed on 10/24/24 at 9:50 AM with the DM. The ice machine was observed to have wet, slimy, black material along the seal of the ice machine door. The DM explained the Maintenance Director was responsible for cleaning the ice machines.

The ice machine was observed with the Maintenance Director on 10/24/24 at 10:06 AM. The Maintenance Director explained he cleaned all ice machines once per month and he had cleaned the ice machine on the medical unit on 9/28/24. The Maintenance Director was able to rub the wet, slimy, black material off the seal and he stated it was mildew.

c. The storage shed was observed on 10/24/24 with the DM at 9:56 AM. The storage shed was

rinsed, and sanitized the 4 metal pans which were observed to be stacked wet.
On 10/24/2024 the Maintenance Director washed and sanitized the ice machine on the medical unit nourishment room.
On 10/24/2024 the CDM removed and discarded the items that were on the floor in the storage room: (1) jugs of water (2) rolled oats.

On 11/8/2024 the Nutritional Consultant initiated an in-service with the dietary staff regarding Food Procurement Storage and Sanitation with emphasis on following (1) Not wet nesting (2) sanitizing nourishment room ice machines daily (3) ensuring all food and beverage are stored at least 6 in off the floor the in-service will be completed by 11/21/2024. After 11/21/2024, any dietary staff who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Food Procurement Storage and Sanitation.

The CDM will conduct an audit 3 times a week to include (1) Observance of proper drying procedure (2) Ice machines are sanitized (3) No food/beverage is stored on the ground utilizing the Food Procurement Audit Tool for 4 weeks then monthly x 2 months. This audit is to ensure food safety measures are being met. The CDM and/or designee addressed all concerns identified during the audit to include proper drying procedures, ice machines are sanitized, and no food or beverages are stored on

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F 812	Continued From page 41 cluttered with boxed medical records, decorations, resident possessions, and dry food goods. There was not a clear path to the stored dry goods and the DM had to move things out of the way to get back to the stored dry goods. The DM reported the facility used the shed to store extra water and dry goods, and the emergency supplies of food were kept in the shed. Gallon jugs of water were noted to sit directly on the floor of the shed, and several were noted to be tipped over on their sides and appeared to be partially filled with water. A back support pillow was observed on top of the gallon jugs of water. The pillow was noted to have some yellow stains and was slightly dusty. A pallet of rolled oats was noted to be tipped over on its side and laying on the floor of the shed. The DM reported she had not been in the storage shed for a while, and the water and rolled oats should not have been directly on the floor. The DM reported the shed got very hot in the summer and this caused the water jugs to expand, which might cause the jugs to leak. The DM was interviewed on 10/24/24 at 2:15 PM and she reported she explained she had interviewed Cook #1 after the kitchen observation on 10/21/24 and Cook #1 reported she had stacked the metal pans with wet hands, and that's why the pans were stacked wet. The DM explained it had been a while since she had been in the storage shed to look at the food storage and she was not aware that it was cluttered with resident possessions, medical records, and decorations. The DM reported she expected all dry goods to be stored off the floor and the food storage area to be tidy and organized. The Administrator was interviewed on 10/24/24 at	F 812	the ground. The Administrator will review the Food Procurement Audit Tool 2 times a week x 4 weeks then monthly x 3 months to ensure all concerns are addressed. The Administrator will review the findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting and update the plan as needed.	

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F 812	Continued From page 42 2:05 PM. He reported the metal pans should be allowed to dry completely before they were stacked. The Administrator reported the ice machine had the potential to grow mildew because it was used often, and it was in a warm room and all ice machines should be checked for mildew growth. The Administrator reported the storage shed should be organized and the food stored off the floor of the shed.	F 812		