| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345544 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/30/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Asbury Health and Rehabilitation Center** | **3211 Bishops Way Lane , Charlotte, North Carolina, 28215** |

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| E0000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 09/22/25 through 09/25/25. Additional information was obtained offsite through 09/30/25, therefore, the exit date was changed to 09/30/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D6E2F-H1. | E0000 | | 10/13/2025 |
| F0000 | INITIAL COMMENTS<br><br>A recertification and complaint survey were conducted on 09/22/25 through 09/25/25. Additional information was obtained offsite through 09/30/25 therefore, the exit date was changed to 09/30/25. The following intakes were investigated: 2605611, 2609383 and 741250.<br><br>2 of the 5 complaint allegations resulted in a deficiency. Event ID # 1D6E2F-H1. | F0000 | | 10/13/2025 |
| F0550<br>SS = D | Resident Rights/Exercise of Rights<br><br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br><br>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.<br><br>§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.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, 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 | F0550 | 1) Residents #17 and #92 were observed during subsequent meals to ensure that dignified feeding practices were followed. Care plans were reviewed for residents #17 and #92 to ensure appropriate items were listed regarding their dining needs, such as level of assistance needed and interventions to ensure a dignified dining experience. This was completed on 9/25/2025 by the Assistant Director of Nursing.<br><br>2) Nurse Aide #5, an agency staff member, was immediately counseled and removed from direct dining assistance duties. This was completed on 9/25/2025 by the Assistant Director of Nursing.<br><br>3) Care plans were reviewed to identify all residents in the facility that require assistance with their dining experience. A facility-wide dining observation audit was completed for all residents requiring mealtime assistance. No other instances of undignified feeding practices were identified during that immediate observational audit. This was completed on 9/26/2025 by the Assistant Director of Nursing, RN Supervisor, Director of Health Services, and Associate Director. | 10/11/2025 |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0550 SS = D | Continued from page 1<br>payment source.<br><br>§483.10(b) Exercise of Rights.<br><br>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.<br><br>§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.<br><br>§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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review and staff interviews, the facility failed to promote a dignified dining experience for 2 of 3 residents who required assistance with meals (Resident #17 and Resident #92). Nurse Aide #5 was observed standing at a table beside Resident #17 and across the table from Resident #92 while providing the residents with assistance with eating. A reasonable person expects to be treated with dignity and would not want staff to stand over them while assisting them with eating.<br><br>Findings included:a. Resident #17 was admitted to the facility on 1/13/25. A review the quarterly Minimum Data Set (MDS) assessment dated 7/15/25 revealed Resident #17 was assessed as severely cognitively impaired. The assessment indicated Resident #17 required substantial assistance from staff for eating and was on a mechanically altered diet. b. Resident #92 was readmitted to the facility on 8/4/25. A review of the admission MDS dated 8/10/25 revealed Resident #92 was assessed as having unclear speech and severe cognitive impairment. The assessment indicated Resident #92 required substantial assistance from staff for eating. During a continuous lunch meal observation on 9/22/25 from 11:45 AM to 11:50 AM, Resident #17 was observed sitting at a table in the resident dining room and Nurse Aide (NA) #5 was observed standing beside Resident #17, leaning over and assisting Resident #17 with eating. Resident #92 was observed sitting across the table from Resident #17 in the resident dining | F0550 | Continued from page 1<br><br>4) All staff—including agency personnel—were re-educated on Asbury's Dignified Dining Policy, emphasizing the requirement to sit when assisting residents during meals. This was completed on or before 10/10/25 by the Director of Nursing and interim Assistant Director of Nursing.<br><br>5) The Dining and Feeding Assistance Policy was revised to include mandatory seated feeding unless medically contraindicated. Additionally, all staffing agency are required to complete pre-assignment training on Asbury's Resident Rights and Dignity Standards. This was completed on 9/28/2025 by the Assistant Director of Nursing and RN Supervisor.<br><br>6) Unannounced mealtime audits will be conducted three (3) times per week for four (4) weeks, then weekly for two (2) months until it is decided by the organization's Quality Assurance Performance Improvement Committee (QAPI) that substantial compliance has been achieved. This will be started, with ongoing audits scheduled, the week of 9/28/2025, by the interim Assistant Director of Nursing, RN Supervisor, or designee.<br><br>7) Audits will be brought to the quarterly QAPI committee meetings. The QAPI committee will review the results of the audit tools quarterly and identify trends, actions taken, and discuss the need for and/or frequency of continued monitoring until substantial compliance is achieved (as determined by the QAPI committee). This will be completed on 9/29/2025 with an ad-hoc QAPI meeting attended by the administrator, director of nursing, assistant director of nursing, medical director, Director of Health Services, and Associate Director, with audit reviews with the full QAPI committee ongoing. | |

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| F0550<br>SS = D | Continued from page 2<br>room. NA #5 leaned across the table and assisted Resident #92 with eating while standing. NA #5 continued to assist Resident #92 and Resident #17 with eating at varying intervals as the residents sat across from each other. There were empty chairs at the table. During a telephone interview on 9/25/25 at 2:27 PM, NA #5 indicated the Resident #17 needed assistance with eating and he would help set her up for meals by covering her clothing. He stated he often stood when providing feeding assistance to residents. NA #5 stated when he assisted in feeding two residents, he typically would sit down in between them on the same side of the table. He stated another Nurse Aide walked away from the table and he reached over to continue feeding Resident #92, while standing next to Resident #17. NA #5 indicated both residents needed total assistance with eating and he didn't think about sitting down while assisting Resident #17 and Resident #92 with eating their meals. An interview with the Assistant Director of Nursing (ADON) on 9/25/25 at 3:07 PM revealed all staff received training in feeding assistance. She stated NA #5 was from a staffing agency, and he would not have received the training from the facility. The ADON had the expectation that all nursing staff would provide dignity in dining and if someone from nursing management had observed a staff member assisting a resident with eating while standing up, it would have been immediately corrected. An interview with the Administrator on 9/25/25 at 3:09 PM revealed she expected all residents to have a dignified dining experience and that facility staff would not assist residents with eating while standing and reaching across the table. She stated she would work with the staffing agency to ensure all staff would have training on feeding assistance and dignified dining to include sitting while assisting residents with their meals. | F0550 | | |
| F0607<br>SS = D | Develop/Implement Abuse/Neglect Policies<br><br>CFR(s): 483.12(b)(1)-(5)(ii)(iii)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and | F0607 | 1) The facility immediately ensured the safety of Resident #79. The resident was assessed for pain and injury after complaints of leg pain, with notification of the practitioner, new medication orders received, and X-ray order received. This was completed on 8/30/2025 by the nurse on duty.<br><br>2) After X-ray results were received, the resident was transferred to the hospital for further evaluation. This was completed on 8/31/2025 by the nurse on duty.<br><br>3) An investigation was commenced to determine the cause of the fracture of unknown origin, with the fracture reported to the Department of Health and Human | 10/11/2025 |

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| F0607<br>SS = D | Continued from page 3<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.<br><br>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.<br><br>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, and staff and Medical Director interviews, the facility failed to implement their abuse policy and procedure in the areas of reporting to Adult Protective Services (APS) and thoroughly investigating an injury of unknown source for a dependent resident who sustained an acute comminuted (broken in multiple pieces), mildly displaced (misaligned) and impacted (the ends of the broken bone jam together) left femur (thigh bone) fracture for 1 of 3 residents reviewed for accidents (Resident #79).<br><br>The findings included:<br><br>A review of the facility's abuse, neglect and exploitation policy and procedure dated 4/29/24 indicated the following:<br><br>-The facility will have written procedures to assist staff in identifying the different types of abuse. Possible indicators of abuse include but are not limited to: Physical injury of a resident, of unknown source.<br><br>-An immediate investigation is warranted when suspicion or reports of abuse, neglect or exploitation occur. The procedures for investigations include: | F0607 | Continued from page 3<br>Services. This was completed on 8/31/2025 by the RN Supervisor and Director of Nursing.<br><br>4) All incident reports in 2025 were reviewed to ensure that there were no other current residents with an injury of unknown origin that did not have a thorough investigation performed. This review was completed on 9/25/2025 by the Associate Director and Director of Health Services, with no further residents identified.<br><br>5) The Abuse, Neglect, and Exploitation Policy was reviewed to ensure the inclusion of explicit direction for reporting injuries of unknown source to Adult Protective Services (APS), in addition to the state survey agency. The policy also now includes a defined process for consulting with the Medical Director, and reviewing hospital documentation (when applicable), as part of any abuse or injury investigation. This was completed on 10/6/2025 by the Director of Nursing and interim Assistant Director of Nursing.<br><br>6) Re-education was performed for administrative and nursing leadership (Director of Nursing, Assistant Director of Nursing, RN Supervisors, LPN Supervisors, and MDS Nurse) emphasizing that all injuries of unknown origin must be reported to APS in accordance with facility policy and regulatory expectations. Education was also performed on how to complete a thorough investigation, including Medical Director involvement, hospital documentation review, and more thorough staff interviews. This was completed on or before 10/10/2025 by the Director of Health Services, Associate Director, and Director of Nursing.<br><br>7) Incident reports will be reviewed in the daily clinical meeting to ensure that any incident of unknown origin is followed up on according to policy, with the appropriate investigation commenced, as well as the appropriate reporting notifications to external agencies. This was completed on 9/25/2025 and ongoing by the Director of Nursing, Assistant Director of Nursing, MDS Nurse, Director of Rehab, and participants of the daily clinical meeting.<br><br>8) Results of these incident report reviews will be discussed during the quarterly QAPI meetings, with continued monitoring thereafter as determined by the committee. Any noncompliance identified will result in immediate corrective action and staff re-education. The | |

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| F0607 SS = D | Continued from page 4<br>1. Identifying staff responsible for the investigation.<br><br>2. Exercising caution in handling evidence that could be used in criminal investigation (e.g., not tampering or destroying evidence).<br><br>3. Investigating different types of alleged violations.<br><br>4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.<br><br>5. Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and cause.<br><br>6. Providing complete and thorough documentation of the investigation.<br><br>-The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes<br><br>1.Reporting 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.<br><br>Resident #79 was admitted to the facility on 6/07/21.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 8/16/25 revealed Resident #79 was cognitively intact and dependent on staff for assistance with activities of daily living (ADL).<br><br>The x-ray report dated 8/31/25 revealed Resident #79 had a non-displaced fracture of the left distal (lower) femur.<br><br>The emergency department (ED) report dated 8/31/25 revealed Resident #79 was evaluated due to an x-ray obtained at the facility indicating a left femur fracture with no reports of a fall or trauma and the source of injury was unknown. X-rays and a computed tomography (CT) scan obtained in the ED confirmed Resident #79 had an acute comminuted mildly displaced | F0607 | Continued from page 4<br>committee will discuss and determine the need for and/or frequency of continued monitoring until substantial compliance is achieved. This will be completed on 9/29/2025 with an ad-hoc QAPI meeting attended by the administrator, director of nursing, assistant director of nursing, medical director, Director of Health Services, and Associate Director, with additional reviews with the full QAPI committee ongoing. | |

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| F0607 SS = D | Continued from page 5<br>and impacted left femur fracture.<br><br>A review of the initial allegation report dated 8/31/25 indicated Resident #79 had a left femur fracture and the source of the injury was unknown and was reported to the state survey agency however no report was made to APS. The 5-day investigation report dated 9/05/25 completed by the Director of Nursing (DON) revealed Resident #79 and nursing staff were interviewed and denied any trauma or falls occurring that would have caused injury it was determined the left femur fracture was likely due to her medical diagnoses including vitamin D deficiency and osteopenia noted in the x-ray results, both of which increased her risk of fractures.<br><br>A phone interview conducted with the Medical Director on 9/25/25 at 8:41 PM revealed that a comminuted, displaced and impacted fracture, as described in Resident #79's ED x-ray and CT scan results, was likely caused by a fall or trauma and was not pathological in nature. The Medical Director stated that Resident #79's cognition was better some days than others, but she was cognitively intact with no diagnosed cognitive impairment however her memory and ability to recall events varied from day to day.<br><br>A phone interview with the DON on 9/29/25 at 7:38 AM indicated she was notified at approximately 7:00 AM on 8/31/25 that Resident #79 was transferred to the hospital due to an x-ray obtained in the facility indicating a left femur fracture. The DON stated an initial allegation report was submitted to the state survey agency on 8/31/25 within 2 hours of becoming aware of the injury of unknown source but was not reported to APS because she was unaware that was required. She stated statements were obtained from staff that worked on 8/30/25 and there were no reports of any incidents or accidents that may have caused the fracture and Resident #79 also denied a fall or incident had occurred. The DON revealed she did not review Resident #79's hospital records nor did she consult with the Medical Director for further information regarding the fracture. She stated she determined that Resident #79's fracture was pathological due to no reports of an incident or accident occurring and based on the x-ray obtained at the facility noting diffuse osteopenia. She stated on 9/07/25 after Resident #79 returned to the facility the family was requesting more information as to how the fracture occurred. The DON indicated she re-interviewed staff to obtain more details but did not document the | F0607 | | |

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| F0607<br>SS = D | Continued from page 6<br>interviews or obtain updated written statements. She revealed when interviewing NA #1 she reported NA #2 assisted with transferring Resident #79 the morning of 8/30/25, but when she interviewed NA #2 she really would not say that she did or did not assist with the transfer. She stated it was suspected that NA #1 transferred Resident #79 using the mechanical lift alone however she did not investigate further since NA #1 reported that no accident or incident occurred resulting in injury. The DON revealed that the cause of Resident #79's fracture remained unknown.<br><br>An interview conducted with the Administrator on 9/25/25 at 11:23 AM revealed she was notified on 8/31/25 at approximately 7:00 AM that Resident #79 was transferred to the hospital due to a femur fracture and the cause of the injury was unknown. She indicated the DON submitted an initial allegation report within two hours to the state survey agency but did not report to APS. The Administrator indicated she was unsure that a report to APS was warranted since they did not suspect abuse as the source of the injury. She stated the DON initiated an investigation obtaining statements from staff and there were no reports of an incident or accident that would have caused the injury and based on the x-ray obtained in the facility noting osteopenia the fracture was determined to be pathological. The Administrator indicated due to Resident #79's family requesting more information regarding what may have occurred the DON re-interviewed staff and it was suspected NA #1 transferred Resident #79 using the mechanical lift without a second person however it was not investigated further since NA #1 reported no incidents or accidents occurred during the transfers. She revealed there were also safety concerns related to Resident #79 operating the motorized wheelchair but also no reports of an incident or accident. The Administrator revealed the investigation into the source of Resident #79's injury should have been more thorough including reviewing the hospital records, consulting with the Medical Director and taking a deeper look at any safety concerns related to the mechanical lift transfers and the motorized wheelchair to determine if they contributed to Resident #79's injury. | F0607 | | |
| F0689<br>SS = G | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that - | F0689 | 1) Resident #79 was assessed and medicated for initial complaints of right leg pain. This was completed on 8/30/2025 by the nurse on duty.<br><br>2) Resident #79 was reassessed after complaints of left leg pain with new orders received for X-ray. Family | 10/11/2025 |

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| F0689 SS = G | Continued from page 7<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review, and resident, staff and Medical Director interviews, the facility failed to provide safe transfers using a mechanical lift. Resident #79 was dependent on staff and required the use of a mechanical lift for transfers. On 8/30/25 Nursing Assistant (NA) #1 transferred the resident twice. Resident #79 complained of left leg pain with notable swelling to her left leg and knee. X-rays obtained in the facility indicated Resident #79 had a fracture of the left distal femur (lower thigh bone near the knee joint) and she was transferred to the emergency department (ED) for further evaluation. An x-ray and computed tomography (CT) scan obtained in the ED revealed Resident #79 had an acute comminuted (broken in multiple pieces) mildly displaced (misaligned) and impacted (the broken ends of the bone jam together) fracture of the left distal femur. Resident #79 was admitted to the hospital and surgery was performed on 9/02/25 to repair the fracture. The deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #79).<br><br>The findings included:<br><br>Resident #79 was admitted to the facility on 6/07/21 with diagnoses including multiple sclerosis, quadriplegia, vitamin D deficiency and essential hypertension.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 8/16/25 revealed Resident #79 was cognitively intact, always incontinent of bowel and bladder, dependent on staff for activities of daily living (ADL) including toileting hygiene, bathing, and transfers. Resident #79 was coded for having upper and lower extremity impairment on both sides and used a motorized wheelchair with set up assistance. The MDS further revealed Resident #79's speech was unclear but usually understood. | F0689 | Continued from page 7<br>updated on new orders and presentation. This was completed on 8/30/2025 by the nurse on duty and RN supervisor.<br><br>3) Continued reports of pain, prior to X-ray results, was reported to the on-call provider. New medication orders were received, in addition to an order to not move Resident #79 or provide showers until X-ray results were obtained. These orders were obtained and processed on 8/30/2025 by the nurse on duty.<br><br>4) X-ray results processed and communicated to the on-call provider, with orders to send resident #79 to emergency department for further evaluation. This was completed on 8/31/2025 by the nurse on duty.<br><br>5) Resident #79 transferred to the hospital for appropriate surgical care via Emergency Medical Services (EMS). This was completed on 8/31/2025 by the nurse on duty and LPN Supervisor.<br><br>6) Injury of unknown origin reported to the Department of Health and Human Services. This was completed on 8/31/2025 by the RN Supervisor.<br><br>7) An investigation was conducted to determine the cause of the injury of unknown origin, with staff statements obtained, camera footage reviewed, and medical record reviewed. A follow-up report was sent to the Department of Health and Human Services with the investigation results. This was completed on or before 9/5/2025 by the Director of Nursing, Director of Health Services, and Associate Director.<br><br>8) NA involved (Nurse Aide #1) was suspended, pending investigation, after discovering that policy was not followed and inaccuracies were given by NA#1 during the initial investigation. This was discovered during the annual survey when NA #2 shared with the survey team that she was not the second person present during use of the mechanical lift on Resident #79 on 8/30/2025, at 7:30 AM and 11:00 AM. The Associate Director and Director of Health Services then spoke with NA#1 on 9/25/2025, who admitted that she had transferred against the company's mechanical lift policy. This interview and suspension were completed on 9/25/2025 by the Associate Director and Director of Health Services. | |

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| F0689 SS = G | Continued from page 8<br>The care plan dated 8/16/25 indicated Resident #79 had limited physical mobility due to a diagnosis of multiple sclerosis, utilized a powered wheelchair for mobility and required 2-person assistance and the use of a mechanical lift for all transfers.<br><br>An interview conducted with NA #1 on 9/24/25 at 9:16 AM revealed she was working on the 400-hall and assigned to Resident #79 during first shift (7:00 AM to 3:00 PM) on 8/30/25. She stated Resident #79 was dependent on staff for all care, was non-ambulatory and was transferred with the mechanical lift. She stated Resident #79 made no attempts to get up on her own and she was not aware of any recent falls or incidents. NA #1 revealed on 8/30/25 at approximately 7:00 AM Resident #79 was in bed and she assisted her with morning care. She indicated at approximately 7:30 AM NA #2 assisted her with transferring Resident #79 from the bed to her motorized wheelchair using the mechanical lift and Resident #79 drove herself to the dining room for breakfast. She indicated at approximately 11:00 AM she and NA #2 used the mechanical lift to transfer Resident #79 to the bed to provide incontinent care and then back into the wheelchair. NA #1 revealed at approximately 11:30 AM Resident #79 went to lunch in the dining room with her Responsible Party and was with her RP until she went to Bingo around 1:30 PM. She stated Resident #79 remained in Bingo until after her shift ended at 3:00 PM and she did not provide any care for Resident #79 after 11:30 AM. NA #1 revealed she was not aware of any staff training or safety interventions that were put in place regarding Resident #79 using the motorized wheelchair.<br><br>An interview with NA #2 on 9/24/25 at 11:20 AM revealed she was working on the 400-hall during first shift on 8/30/25 but was not assigned to Resident #79. She stated Resident #79 was dependent on staff for care and was unable to roll in bed or get up without assistance. NA #2 revealed that Resident #79 was transferred using the mechanical lift and required the assistance of two people. She stated on 8/30/25 NA #1 did not ask for her assistance with transferring Resident #79 at any time during her shift, nor did she assist with any of Resident #79's care. She stated at approximately 1:15 PM the RP requested for Resident #79 to lay down before Bingo, so she went with Nurse #2 to assist with the transfer. NA #2 revealed when they went to Resident #79's room the Activities Director arrived a few minutes later to take her to Bingo so they did not transfer her, and she remained in her motorized wheelchair. | F0689 | Continued from page 8<br><br>9) The employee (NA#1) was addressed in accordance with the organization's Human Resources policies and procedures. This was completed on 9/29/2025 by the Director of Health Services and Associate Director.<br><br>10) All incident reports in 2025 were reviewed to ensure that there were no other current residents with an injury of unknown origin that did not have a thorough investigation performed. This review was completed on 9/25/2025 by the Associate Director and Director of Health Services, with no further residents identified.<br><br>11) Incident reports will be reviewed in the daily clinical meeting to ensure that any incident of unknown origin is followed up according to policy, with the appropriate investigation commenced, as well as the appropriate reporting notifications to external agencies. This was completed on 9/25/2025 and ongoing by the Director of Nursing, Assistant Director of Nursing, MDS Nurse, Director of Rehab, and participants of the daily clinical meeting.<br><br>12) The Abuse, Neglect, and Exploitation Policy was reviewed to ensure the inclusion of explicit direction for reporting injuries of unknown source to Adult Protective Services (APS), in addition to the state survey agency. The policy also now includes a defined process for consulting with the Medical Director, and reviewing hospital documentation (when applicable), as part of any abuse or injury investigation. This was completed on 10/6/2025 by the Director of Nursing and interim Assistant Director of Nursing.<br><br>13) Re-education was performed for administrative and nursing leadership (Director of Nursing, Assistant Director of Nursing, RN Supervisors, LPN Supervisors, and MDS Nurse) emphasizing that all injuries of unknown origin must be reported to APS in accordance with facility policy and regulatory expectations. Education was also performed on how to complete a thorough investigation, including Medical Director involvement, hospital documentation review, and more thorough staff interviews. This was completed on or before 10/10/2025 by the Director of Health Services, Associate Director, and Director of Nursing.<br><br>14) Resident care assignments were reviewed to ensure | |

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| F0689 SS = G | Continued from page 9<br><br>A follow-up interview was conducted with NA #1 on 9/25/25 at 12:03 PM. She stated on 8/30/25 at approximately 7:30 AM she transferred Resident #79 from the bed into the wheelchair using the mechanical lift without the assistance of another staff member. She revealed at approximately 11:00 AM she transferred Resident #79 from the wheelchair to the bed to provide incontinent care and then transferred her from the bed back to the wheelchair using the mechanical lift without the assistance of a second person. She stated no incidents or injuries to Resident #79 occurred during the transfers nor did she complain of any pain or discomfort. NA #1 indicated she should have requested a second person assist her with the transfers however she felt comfortable transferring Resident #79 using the lift alone and did not request assistance from any other staff members.<br><br>A phone interview with the Activities Director on 9/24/25 at 10:14 PM revealed on 8/30/25 at approximately 1:30 PM she went to Resident #79's room to take her to Bingo. She stated NA #2 and Nurse #2 were in Resident #79's room and were going to transfer her into bed however Resident #79 remained in her motorized wheelchair. The Activity Director stated she walked beside Resident #79 as she drove her motorized wheelchair to Bingo and at approximately 3:00 PM she walked beside Resident #79 as she drove her motorized wheelchair back to her room. The Activity Coordinator indicated Resident #79 had no incidents while at Bingo nor did she have any complaints of pain.<br><br>An interview conducted with NA #3 on 9/18/25 at 12:32 PM indicated she was working on the 400-hall and assigned to Resident #79 during second shift (3:00 PM to 11:00 PM) on 8/30/25. She stated at approximately 3:00 PM Resident #79 complained of leg pain but she did not recall which leg she reported having pain. NA #3 revealed she notified Nurse #3, and she assessed Resident #79 and administered pain medication. She stated Resident #79's private caregiver arrived around 4:30 PM and assisted her with eating dinner. NA #3 indicated at approximately 7:00 PM she and Nurse #3 transferred Resident #79 into bed, assisted her with incontinence care and an x-ray was obtained. She revealed the x-ray technician instructed them not to transfer Resident #79 out of bed until the x-ray results came back. NA #3 indicated her shift ended at 11:00 PM prior to the x-ray results returning. | F0689 | Continued from page 9<br>adequate staffing is provided to complete safe transfers. This includes assurance of at least two mechanical lift trained nursing team members available to perform a mechanical lift transfer at all times, including weekends. This review was completed on 9/26/2025, and will continue to be completed weekly, of all upcoming nursing schedules, by the RN Supervisor, Assistant Director of Nursing, Director of Nursing, and Staffing Coordinator.<br><br>15) The Mechanical Lift Policy reviewed for accuracy and best practice with no changes needed. This was completed on 9/24/2025 by the Associate Director.<br><br>16) Mechanical lifts were immediately assessed to ensure no concerns were noted, with ongoing monthly preventative maintenance performed as part of our already-in-place preventative maintenance program. This was completed on 9/25/2025, with ongoing preventative maintenance performed monthly, by the Facilities Maintenance Technician, or designee.<br><br>17) Nursing leadership, including the Assistant Director of Nursing, RN Supervisors, and designees, along with the Director of Rehab, immediately re-educated all nursing staff, including any current agency nurses and NAs, on the facility's two-person Mechanical Lift Policy, with return demonstration and competency required of the two-person mechanical lift. Staff members (NAs, RNs, LPNs, and Medication Aides) were educated on where to find transfer status for a resident within the Kardex (NAs) and care plans (RNs, LPNs, Medication Aides) within the electronic medical record. Staff members not receiving the education and validation of competency must receive the education prior to their next worked shift. This education was completed on or before 9/27/2025, by the Assistant Director of Nursing, RN Supervisors, Director of Rehab, or designee.<br><br>18) All nursing staff members (RNs, LPNs, NAs, and Medication Aides) will have a skills validation performed to ensure that they can perform the mechanical lift appropriately. Any nursing staff (RNs, LPNs, NAs, or Medication Aides) that do not receive the education and skills validation by 9/27/2025, must receive the education and perform the skills validation before their next worked shift. The skills validation was developed from our policy and in conjunction with an external compliance resource. This validation and | |

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| F0689 SS = G | Continued from page 10<br>A phone interview was conducted with the Private Caregiver on 9/23/24 at 4:17 PM. She indicated she was a licensed occupational therapy assistant and had been working with Resident #79 for approximately 4 years. She revealed 5 to 6 days a week she arrived around 4:30 PM, assisted Resident #79 with range of motion (ROM) exercises and if able would assist Resident #79 to a standing position for 2 to 3 minutes to bear weight on her legs. The Private Caregiver stated she also assisted Resident #79 with eating dinner and getting ready for bed but did not assist with incontinent care or transfers. She indicated 8/30/25 she was starting ROM exercises at approximately 5:00 PM when Resident #79 started yelling out in pain and reported her left leg was painful with movement. She stated Resident #79's left leg was notably swollen but there was no bruising or redness. She revealed Resident #79 was cognitively intact but was forgetful and her ability to communicate and recall events varied from day to day. The Private Caregiver stated she asked Resident #79 if there was an incident that caused injury to her leg, but she was unable to say what or if anything had occurred. The Private Caregiver indicated she immediately notified Nurse #3. She revealed after assessing Resident #79, Nurse #3 notified the on-call provider and received an order to obtain an x-ray in the facility and to apply ice to Resident #79's left leg. The Private Caregiver stated she left the facility prior to the x-ray being obtained and was notified by the family that Resident #79 had a left femur fracture and was admitted to the hospital for surgery. She indicated she worked with Resident #79 on the evening of 8/29/25 and during ROM exercises she reported no pain or discomfort.<br><br>A nurse's note dated 8/30/25 at 5:41 PM written by Nurse #3 revealed at approximately 3:00 PM Resident #79 reported leg pain and as needed pain medication was administered. At approximately 5:10 PM the private caregiver reported Resident #79 was complaining of left leg pain and upon assessment her left leg was noted to be swollen and painful to touch. The on-call provider was notified and gave an order for an x-ray to be obtained in the facility and to apply ice, on for 10 minutes and off for 10 minutes for 72 hours. The RP was notified of change in condition and order to obtain an x-ray.<br><br>During a phone interview with Nurse #3 on 9/29/25 at 12:39 PM she indicated she was assigned to Resident #79 on 2nd shift 8/30/25. She stated at approximately 3:00 PM NA #3 informed her that Resident #79 was complaining | F0689 | Continued from page 10<br>tracking of completion/compliance was completed on or before 9/27/2025 by the Assistant Director of Nursing, Director of Nursing, RN Supervisors, Staffing Coordinator, and/or designee.<br><br>19) All new hires for the nursing team, including RNs, LPNs, NAs, and Medication Aides that do (or could) perform a mechanical lift transfer will be educated upon hire (with skills competency performed) on the mechanical lift process. This was completed on 9/27/2025, with new hires educated ongoing, by the Assistant Director of Nursing/Staff Development Coordinator, or designee, before the new hire is allowed to take an assignment.<br><br>20) All staff will be educated with skills competency performed on the mechanical lift policy on an annual basis. This will occur annually at the December annual skills fair (or at an annual time determined by nursing leadership). Staff members found to be non-compliant with the annual training will not be allowed to return to work until compliance with education is reached. This will be completed annually by the Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, or designee.<br><br>21) A review of all residents in the building was conducted to determine who required a mechanical two-person lift for transfers, identifying twenty-seven people who require a two-person mechanical lift for their transfers. The Kardex, which is the electronic summary of a resident's plan of care used by the NAs, as well as the care plan, for each of these twenty-seven residents was checked to ensure their transfer status was documented correctly. This was completed on 9/25/2025 by the RN Supervisor, Assistant Director of Nursing, Associate Director, and household nurses.<br><br>22) A review of all residents residing in the building that required the use of power wheelchair was completed, revealing two residents who utilize a power wheelchair. The two identified residents were educated on the motorized wheelchair policy, with signature received to confirm receipt of policy. This audit was performed to ensure the appropriateness of residents using a powerchair, as the injury of unknown origin for Resident #79 could have been misuse of her powerchair. This audit was completed on 9/25/2025 by the Director of Rehab, Director of Health Services, and Associate | |

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| F0689 SS = G | Continued from page 11<br>of leg pain. She indicated she assessed Resident #79 and she reported having pain in her leg and was pointing to her right leg. Nurse #3 revealed she assessed Resident #79's right leg but there was no visible injury, and she administered acetaminophen. She stated at approximately 5:00 PM Resident #79's private caregiver reported to her that Resident #79 was complaining of left leg pain and that it was swollen. Nurse #3 revealed she assessed Resident #79 and noted her left was visibly swollen and painful to touch. She indicated the on-call provider was notified and gave an order to obtain an x-ray in the facility and apply ice to the left leg. Nurse #3 revealed Resident #79 denied any incidents had occurred causing injury to her leg. Nurse #3 indicated at approximately 7:00 PM NA #3 assisted her with transferring Resident #79 into bed so the x-ray could be obtained, and they were instructed by the x-ray technician not to transfer Resident #79 again until the x-ray results returned. Nurse #3 revealed Resident #79 had continued complaints of pain after the x-ray and additional orders were obtained by the on-call provider for a pain-relieving topical cream and ibuprofen. She stated the x-ray results returned indicating a left femur fracture and Resident #79 was transferred to the ED for further evaluation.<br><br>A review of Resident #79's physician orders and medication administration record (MAR) revealed the following:<br><br>11/30/23 acetaminophen 500 milligrams (mg) give 2 tablets by mouth every 24 hours as needed for pain. The MAR indicated it was administered on 8/30/25 at 4:00 PM and pain level was 4 (1-10).<br><br>8/30/25 obtain x-ray of the left femur and knee.<br><br>8/30/25 ibuprofen 600 mg tablets give 1 tablet by mouth every 6 hours as needed for left leg pain for 3 Days. The MAR indicated it was administered on 8/30/25 at 9:45 PM and pain level was 4.<br><br>8/30/25 menthol topical analgesic gel 4% apply topically to the thigh down to knee every 6 hours as needed for left leg pain. The MAR revealed it was applied on 8/30/25 at 9:46 PM.<br><br>8/30/25 acetaminophen 500 milligrams (mg) give 2 | F0689 | Continued from page 11<br>Director.<br><br>23) All new residents who request or require the use of a power wheelchair will be assessed upon admission or initial use of the power wheelchair before being allowed to use the device. Annual assessments, or upon significant health event, will occur thereafter. This will be completed ongoing by the Director of Rehab or designee.<br><br>24) The motorized wheelchair policy was reviewed to ensure the policy matches the facility's practice around motorized wheelchairs. This was completed on 9/25/2025 by the Associate Director.<br><br>25) Audits will be performed on a weekly basis X 3 months to ensure all new hires (that could perform a mechanical lift transfer) have been educated on the mechanical lift policy. After 3 months, audits will continue monthly until the QAPI committee deems substantial compliance has been achieved. This audit is to ensure educational compliance and competency for new hires . This first audit was completed on or before 9/29/2025 by the Nursing Supervisor, Assistant Director of Nursing, Director of Nursing, or designee, and ongoing (as outlined) thereafter.<br><br>26) Random audits will occur with a selection of 5 nursing team members (who could perform a mechanical lift transfer) to return demonstrate the appropriate mechanical lift transfer. This audit will occur on a weekly basis X 3 months, and then quarterly thereafter, until the QAPI committee deems substantial compliance has been achieved. This first audit was completed on or before 9/29/2025 by the Nursing Supervisor, Assistant Director of Nursing, Director of Nursing, or designee, and ongoing (as outlined) thereafter.<br><br>27) Audits will be performed monthly to ensure assessments have been completed on residents who are utilizing a power wheelchair. This will be completed ongoing, with the first audit completed 9/25/2025 by the Director of Rehab, or designee.<br><br>28) Audits of the new hires and competencies, existing hires and competencies, and power wheelchair audits will be brought to the Quality Assurance quarterly meetings for review. The incident report reviews and | |

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| F0689 SS = G | Continued from page 12<br>tablets by mouth every 8 hours as needed for left leg pain. The MAR revealed it was administered on 8/30/25 at 9:51 PM and pain level was 4.<br><br>The radiology x-ray results report dated 8/31/25 at 12:05 AM revealed Resident #79 had a non-displaced fracture of the left distal femur (lower thigh bone near the knee joint). The report further noted diffuse osteopenia (weakening of the bone) and swelling in the left leg.<br><br>A nurse's note dated 8/31/25 at 5:49 AM revealed Resident #79's x-ray results indicated a left femur fracture. The on-call provider was notified and ordered for Resident #79 to be transferred to the ED for further evaluation. The RP (Responsible Party) was notified and at 1:15 AM Resident #79 was transferred by emergency medical services to the ED for further evaluation.<br><br>The initial allegation report submitted by the facility on 8/31/25 at 8:43 AM revealed Resident #79 had an injury of unknown source reported left leg pain and mild swelling was noted. An x-ray was obtained in the facility and then Resident #79 was transferred to the hospital for further evaluation. Resident #79 was cognitively intact and denied a fall, trauma or other wrongdoing occurred.<br><br>The 5-day investigation report dated 9/05/25 completed by the Director of Nursing revealed Resident #79 and nursing staff were interviewed and denied any trauma or falls occurring that would have caused injury it was determined the left femur fracture was likely due to her medical diagnoses including vitamin D deficiency and osteopenia noted in the x-ray results, both of which increased her risk of fractures.<br><br>The ED report and hospital records from 8/31/25 through 9/07/25 revealed Resident #79 was evaluated in the ED on 8/31/25 due to an x-ray obtained in the facility indicating a left femur fracture with no reported falls, trauma or cause of injury. Resident #79 was assessed with no signs of head trauma, or abdominal bruising but did have a deformity of the left lower leg. X-ray and computed tomography (CT) scans obtained in the ED revealed Resident #79 had an acute comminuted, mildly displaced and impacted left distal femur fracture with moderate fluid in the knee joint | F0689 | Continued from page 12<br>adequate staffing reviews will also be brought to the Quality Assurance quarterly meetings for discussion. This was completed on 9/29/2025 at an ad-hoc QAPI meeting that was attended by the Director of Nursing, Assistant Director of Nursing, Medical Director, Director of Health Services, Associate Director, Director of Rehab, and RN Supervisor. | |

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| F0689 SS = G | Continued from page 13<br>and marked osteopenia (reduced bone density) but no suspicious bone lesions noted. The orthopedic consultation note indicated Resident #79 had a left lower extremity injury sustained from a ground level fall and was noted to be non-ambulatory at baseline. The RP reported Resident #79 was able to stand at times for a few minutes with assistance. Operative versus non-operative treatments were discussed, the RP desired to proceed with surgical repair to prevent non-weight bearing status long term and to manage pain, and Resident #79 was admitted to the hospital. Resident #79 was discharged back to the facility on 9/7/25 with orders for occupational therapy and a follow-up appointment scheduled with the orthopedic surgeon on 10/16/25.<br><br>An interview was conducted with Resident #79 on 9/22/25 at 2:05 PM. Resident #79 stated she fractured her left leg when she “fell going to the bathroom” but was unable to recall any other details related to the incident. Resident #79 indicated she was transferred with the mechanical lift and at times only one NA assisted but was unable to recall a specific date this occurred or the name of the NA involved.<br><br>A phone interview conducted with the Medical Director on 9/25/25 at 8:41 PM revealed that a comminuted, displaced and impacted fracture, as described in Resident #79’s ED x-ray and CT scan results, would not have been caused by her engaging in ROM exercises or standing with assistance to bear weight for a few minutes. The Medical Director indicated that the type of fracture Resident #79 sustained was likely caused by a fall or trauma and not pathological in nature. The Medical Director stated that Resident #79’s cognition was better some days than others, but she was cognitively intact with no diagnosed cognitive impairment however her memory and ability to recall events varied from day to day.<br><br>During a phone interview with the DON on 9/29/25 at 7:38 AM indicated she was notified at approximately 7:00 AM on 8/31/25 that Resident #79 was transferred to the hospital due to an x-ray obtained in the facility indicating a left femur fracture. She stated statements were obtained from staff that worked on 8/30/25 and there were no reports of any incidents or accidents occurring that may have caused the fracture. She stated an initial allegation report was submitted due to Resident #79 having an injury of unknown source. The DON revealed after reviewing the x-ray obtained in the | F0689 | | |

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| F0689<br>SS = G | Continued from page 14<br>facility which noted diffuse osteopenia and interviews with staff not indicating an incident occurred to cause injury, she determined the source of the injury was due to Resident #79's diagnoses which increased her risk of fractures. The DON indicated that there were concerns related to Resident #79 safely operating the motorized wheelchair and incidents of her running into things and getting stuck in her bathroom. She revealed the family was resistant to her transitioning to a manual chair and there were on-going discussions as to what interventions would be implemented prior to her discharge to the hospital on 8/31/25. She stated on 9/07/25 after Resident #79 returned to the facility the family was requesting more information as to how the fracture occurred. She indicated NA #1 reported NA #2 assisted with transferring Resident #79 the morning of 8/30/25 however NA #2 really would not say that she did or did not assist with the transfer. The DON revealed she did not investigate the inconsistent statements from NA #1 and NA #2 but that it was suspected that NA #1 transferred Resident #79 using the mechanical lift alone. She stated even if NA #1 transferred Resident #79 alone, she denied an incident occurred resulting in injury and the cause of Resident #79's fracture remained inconclusive. The DON stated that staff should have a second person assisting when using the mechanical lift to transfer a resident for safety.<br><br>An interview conducted with the Administrator on 9/25/25 at 11:23 AM revealed she was notified on 8/31/25 at approximately 7:00 AM that Resident #79 was transferred to the hospital due to a femur fracture. She stated the cause of the injury was unknown and the DON initiated an investigation to determine if an incident or accident had occurred. The Administrator indicated the inconsistent statements given by NA #1 and NA #2 should have been investigated further and that transferring a resident using the mechanical lift without a second person was not safe. The Administrator indicated Resident #79 also had several incidents involving the motorized wheelchair and there was question if she had run into something while driving her chair that caused the injury. The Administrator revealed the cause of Resident #79's leg fracture was still unknown. | F0689 | | |
| F0761<br>SS = D | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>Drugs and biologicals used in the facility must be | F0761 | 1) The topical steroid cream at Resident #69's bedside and the nystatin and miconazole powder in Resident #21's bathroom was immediately removed and secured in the respective locked medication cabinets. Both residents were monitored, and no misuse, ingestion, or adverse outcomes were noted. This was completed on 9/25/2025 by the Assistant Director of Nursing and | 10/11/2025 |

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| F0761 SS = D | Continued from page 15<br>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record reviews, observations, and resident and staff interviews, the facility failed to store lidded containers of prescription topical medicated cream and medicated powder in a secure locked storage area for 2 of 3 residents observed with medicated cream and medicated powder at the bedside and bathroom (Resident #69 and Resident #21).<br><br>The findings included:<br><br>1.Resident #69 was admitted to the facility on 05/26/22 with diagnoses including hemiplegia (paralysis or weakness on one side of the body) and weakness.<br><br>The quarterly Minimum Data Set (MDS) dated 08/14/25 revealed Resident #69 cognitively intact requiring limited assistance of one staff member for most activities of daily living (ADL). Resident #69 was assessed as having no skin conditions during the assessment period.<br><br>On 09/22/25 at 2:25 PM Resident #69 was observed to have a lidded container of prescription topical medicated steroid cream that treats inflammation, | F0761 | Continued from page 15<br>nurse on duty.<br><br>2) A facility-wide audit of all resident rooms was conducted to identify and remove any unsecured medications. All prescription creams, ointments, powders, and other medications were either secured in locked storage areas or returned to the pharmacy per protocol. No additional unsecured medications were identified. This was completed on 9/26/2025 by the Assistant Director of Nursing and nurse supervisor.<br><br>3) All licensed nurses and nurse aides were re-educated on the facility's Medication Storage Policy, with specific emphasis on topical and over-the-counter prescriptions. A "Medications at Bedside" checklist was added to the weekly room inspection process to ensure continued compliance. The Resident Self-Administration Assessment Tool was reviewed and reimplemented to ensure that residents capable of safely managing their own medications are evaluated with this tool. The policy was further clarified to prohibit unsecured prescription medications in resident rooms or bathrooms without documented physician approval and a completed self-administration assessment tool. This was completed on or before 10/9/2025 by the Director of Nursing, interim Assistant Director of Nursing, and RN Supervisors.<br><br>4) The Resident Handbook was reviewed to add language around prohibition of medications at the bedside unless the resident has been assessed and deemed appropriate, along with a practitioner's order and locked location identified/secured. This will also be reiterated in the Resident Town Council. This was completed on 10/9/2025 by the Associate Director and Director of Health Services.<br><br>5) Weekly audits will be conducted of all resident rooms to identify any violation of the Medication Storage Policy for four (4), followed by biweekly audits for two (2) months. The first audit was completed on 10/10/2025, with future audits ongoing, by the interim Assistant Director of Nursing or designee.<br><br>6) Results of the room audits will be discussed during the quarterly QAPI meetings, with continued monitoring thereafter as determined by the committee. Any noncompliance identified will result in immediate corrective action and staff re-education. The committee | |

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| F0761 SS = D | Continued from page 16<br>redness and itching on her bedside dresser. Resident #69 stated, "The nurses put it on my back because of dry skin." Resident #69 explained she had the cream while being a resident in the facility and that it was prescribed to her a couple of months back. The interview revealed the medicated cream was typically left on the bedside dresser and not placed in the medication cabinet.<br><br>During an observation of Resident #69's room on 09/25/25 at 8:50 AM the lidded container of prescription topical medicated cream that treats inflammation, redness and itching remained on her bedside table.<br><br>An interview and observation were conducted on 09/25/25 at 9:10 AM with the Assistant Director of Nursing (ADON). The interview revealed she was not aware of any medication on Resident #69's bedside dresser. She explained that no residents in the facility were allowed to keep medications at the bedside and that was why there was a locked medication cabinet in each resident room. The ADON was observed to go into Resident #69's room and pick up the lidded container of prescription topical medicated cream and place it into the resident's locked medication cabinet.<br><br>On 09/25/25 at 11:50 AM an interview was conducted with Nurse #1. During the interview she stated she was not aware Resident #69 had the lidded container of prescription topical medicated cream on her bedside dresser and when she went into the room this morning to administer medications, she noticed it in the medication cabinet and asked the ADON why it was in there. She stated the ADON explained the surveyor had identified it on the resident's bedside dresser and brought it to her attention, so she placed it into the locked cabinet.<br><br>The Director of Nursing (DON) was unable to be interviewed during the survey due to being on leave.<br><br>On 09/25/25 at 12:22 PM an interview was conducted with the Administrator. She stated she expected the nurses to be observant of medication at bedside and if they saw any medication at the bedside to immediately remove it. | F0761 | Continued from page 16<br>will discuss and determine the need for and/or frequency of continued monitoring until substantial compliance is achieved. This will be completed on 9/29/2025 with an ad-hoc QAPI meeting attended by the administrator, director of nursing, assistant director of nursing, medical director, Director of Health Services, and Associate Director, with additional reviews with the full QAPI committee ongoing. | |

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| F0761 SS = D | Continued from page 17<br>2.Resident #21 was admitted to the facility on 04/04/25 with diagnoses including diabetes mellitus and protein calorie malnutrition.<br><br>The quarterly Minimum Data Set (MDS) dated 7/8/25 revealed Resident #21 was cognitively intact requiring supervision to substantial assistance from one staff member for most activities of daily living (ADL). Resident #21 was assessed as needing ointment medications for his skin.<br><br>A review of Resident #21's physician's orders revealed an order dated 4/5/25 for miconazole nitrate powder 2% (a medicated powder to treat fungal skin infections) to be applied to the affected area topically, two times daily for rash and irritation.<br><br>Further review of Resident #21's physician's order 8/26/25 for nystatin external ointment 100,000 unit/gram (a medicated cream to treat fungal skin infections) to be applied to the abdomen topically every day and night shift for 10 days, starting 8/26/25 to 9/5/25.<br><br>On 9/23/25 at 12:12 PM Resident #21 was observed to have a tube of nystatin ointment and a container of miconazole powder on the counter in the bathroom both labeled with prescription labels for Resident #21.<br><br>During an observation of Resident #21's room, conducted in conjunction with an interview with Resident #21, on 9/25/25 at 9:13 AM the tube of nystatin ointment and the container of miconazole powder were present on his bathroom counter. Resident #21 stated he liked those medications kept in there so when he needed them, he could use them.<br><br>A telephone interview with Nurse Aide (NA) #6 on 9/30/25 at 10:42 AM revealed Resident #21 liked to apply the cream medication as well as the powder medication by himself. She stated she had not witnessed him applying the medication as he was independent with a lot of his ADL. NA #6 stated she had seen the two medications laying out on his bathroom counter for a while. She stated she generally understood all medications should be stored in the locked medication cabinets in each resident room. | F0761 | | |

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| F0761<br>SS = D | Continued from page 18<br><br>An interview with Nurse #5 on 9/25/25 at 10:40 AM revealed the facility typically kept all prescription medications including creams and powders in each resident's locked medication cabinet in their room. She stated Resident #21 used the cream and powder left on the counter in his bathroom and he did not like staff members touching or moving his belongings. Nurse #5 stated the tube of nystatin ointment and the container of miconazole powder were present on his bathroom counter and had been removed from Resident #21's bathroom and placed in the medication cabinet in his room a few minutes earlier by nursing management.<br><br>An interview was conducted on 9/25/25 at 11:18 AM with the Assistant Director of Nursing (ADON). She was made aware of Resident #21's tube of nystatin ointment and the container of miconazole powder that were present on his bathroom counter. She explained no residents in the facility were allowed to keep medications at the bedside and she would expect the medicated cream and powder to go in Resident #21's locked medication cabinet. The ADON explained once the medication order was completed, any medication should be sent back to the pharmacy.<br><br>The Director of Nursing (DON) was unable to be interviewed during the survey.<br><br>An interview with the Administrator on 9/25/25 at 12:23 PM revealed the medicated cream and powder were immediately removed from Resident #21's room earlier in the morning on 9/25/25. She stated she all prescribed medications were to be stored in each resident's locked medication cabinet.<br><br>On 9/25/25 at 2:57 PM an interview was conducted with Physician Assistant #1. He stated he was not familiar with Resident #21 but generally all medications that are prescribed by a provider should be locked in the medication cabinet. Physician Assistant #1 stated the medications were labeled with directions and there could be a risk present if the medication was used incorrectly. | F0761 | | |
| F0812<br>SS = D | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements. | F0812 | 1) All food items past their use-by dates were immediately discarded. This was completed on 9/22/2025 by the Dietary Manager and Culinary Supervisors. | 10/02/2025 |

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| F0812 SS = D | Continued from page 19<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations and staff interviews, the facility failed to ensure scoops were stored without the potential for cross-contamination, discard outdated prepared food items stored for use and utilize a facial hair covering while in the food preparation area. These practices occurred in the reach-in coolers (reach-in coolers # 4 and #5) and food preparation area in 1 of 2 kitchens (Kitchen #2) and the food preparation service line (Household #4) in 1 of 2 Households and had the potential to affect food served to residents.<br><br>The findings included: a. An initial tour of kitchen #2 occurred on 9/22/25 at 10:08 AM with the Dietary Manager (DM).-Scoops were left in the sugar and food starch bins with the handles touching the sugar and food starch in the food preparation area.-Items in reach in cooler #5 and reach in cooler #4 that were past the use by date included: -one plastic preparation container of pureed brussels sprouts with a use by date of 9/20/25. -one plastic preparation container of chicken gravy with a use by date of 9/21/25. b. The following concern was identified in the food preparation service line in Household #4 on 9/25/25 at 11:45 AM:An observation of the meal service on 9/25/25 at 11:53 AM revealed the DM taking temperatures of the food to be served to residents without a facial hair cover. The DM had facial hair about a quarter of an | F0812 | Continued from page 19<br>2) Scoops were removed from bins and sanitized. Proper storage hooks were implemented. This was completed on 9/22/2025 by the Dietary Manager.<br><br>3) Staff involved in food preparation were instructed to wear facial hair coverings immediately. This was completed on 9/22/2025 by the Dietary Manager and Culinary Supervisors.<br><br>4) A full audit of all food storage areas and preparation practices was conducted in both production kitchens and household kitchen areas. Any additional outdated food items were discarded. This was completed on 9/23/2025 by the Dietary Manager and Culinary Supervisors.<br><br>5) All dietary staff were reviewed for compliance with facial hair covering requirements. This was completed on 9/23/2025 by the Dietary Manager and Culinary Supervisors.<br><br>6) A revised labeling system was implemented to reflect the correct 7-day timeline for food storage. The culinary leadership (culinary supervisors, registered dietitian, dietary manager) were educated on the new labeling system. This was completed on 9/26/2025 by the Dietary Manager.<br><br>7) Scoop hooks were installed in all dry ingredient bins. Staff were trained in their use and importance for infection control. This was completed on 9/26/2025 by the Dietary Manager.<br><br>8) A policy requiring facial hair coverings for all food prep staff with facial hair was formally adopted and communicated. This was completed on 9/25/2025 by the Dietary Manager.<br><br>9) Audits of food storage and labeling practices, along with audits of the storage bin hooks utilization will be conducted weekly for 2 months, then monthly thereafter, until substantial compliance has been reached, as determined by the QAPI Committee. The first audit was completed on 10/1/2025, with future audits forthcoming, by the Dietary Manager, or designee. | |

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| F0812<br>SS = D | Continued from page 20<br>inch in length on the lower portion of his face. An interview with the DM on 9/25/25 at 3:54 PM was conducted. He explained the facility had updated their labeling system for the kitchen items. The DM stated the labeling system was supposed to reflect a seven-day timeline instead of a four-day timeline per the facility policy. He stated he controlled the timeline in the labeling system and had updated it to reflect the seven-day period since the kitchen tour. The DM expected the staff to look at the labels and either re-label the food items or throw them away. He stated he expected kitchen staff to utilize the scoop hooks in the sugar and food starch bins. The DM explained he had not worn a facial hair covering before but would implement their use. An interview with the Administrator on 9/25/25 at 4:26 PM was conducted. She stated she expected the scoops in the food bins to be stored properly and food left past the use by date needed to be thrown out. The Administrator stated she expected facial coverings to be used when staff members had facial hair. | F0812 | Continued from page 20<br>10) Staff compliance checks for PPE (including facial hair coverings) will be performed weekly for 2 months, then monthly thereafter, until substantial compliance has been reached, as determined by the QAPI Committee. The first audit was completed on 10/1/2025, with future audits forthcoming, by the Dietary Manager, or designee.<br><br>11) Results of the food storage/labeling practices, facial hair coverings, and storage hook utilization will be discussed during the quarterly QAPI meetings, with continued monitoring thereafter as determined by the committee. Any noncompliance identified will result in immediate corrective action and staff re-education. The committee will discuss and determine the need for and/or frequency of continued monitoring until substantial compliance is achieved. This will be completed on 9/29/2025 with an ad-hoc QAPI meeting attended by the administrator, director of nursing, assistant director of nursing, medical director, Director of Health Services, Associate Director, and Dietary Manager with additional reviews with the full QAPI committee ongoing. | |