STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	**1000 Tandal Place , Knightdale, North Carolina, 27545**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/29/25 through 10/02/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D794D-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	E0000		12/01/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/29/25 through 10/02/25. Event ID#1D794D-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance. The following intakes were investigated 872605, 872606, 872607, 872609, 2562795, 2620450, 2620252 and 2631617. 1 of the 16 complaint allegations resulted in deficiency.	F0000		12/01/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, and resident and staff interviews, the facility failed to place a resident's call light device within reach to allow for the resident to request assistance as needed for 1 of 1 dependent resident reviewed for accommodation of needs	F0558	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Speech Therapist put the call bell in reach for resident #13 on 10/2/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice.	12/01/2025

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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F0558 SS = D	Continued from page 1 (Resident #13). Findings included: Resident #13 was readmitted to the facility on 7/29/25 with diagnoses of multiple sclerosis (a chronic autoimmune disease affecting the central nervous system that leads to disruption of nerve signals traveling to the muscles of the body), and post-polio syndrome (a condition that can develop in people who previously had polio leading to a gradual decline in muscle function). Review of Resident #13's quarterly Minimum Data Set (MDS) Assessment dated 8/4/25 revealed the resident was moderately cognitively impaired and was dependent on staff for all activities of daily living (ADL). Review of Resident #13's care plan last revised on 8/5/25 revealed a focus of the resident being at risk for falls with interventions including to be sure the call light is within reach and to encourage Resident #13 to use it to call for assistance if needed. An observation and interview were conducted with Resident #13 on 9/29/25 at 12:15 PM. Resident #13 was lying in her bed on her back. The resident's pancake call bell was clipped to her upper right chest between the shoulder and the breast. During the observation, Resident #13 stated her call bell was not in the right position as she could only use it if it is directly under the side of her neck. Resident #13 revealed that due to having multiple sclerosis and having had polio as a child, she had control of only her neck muscles so she could tilt her head slightly and press the pancake bell with the side of her jaw. Resident #13 indicated she was able to yell out to staff passing by, but her voice was not very loud due to the symptoms of multiple sclerosis. A continuous observation of Resident #13 was conducted on 10/1/25 starting at 1:39 PM. The resident was lying in her bed on her back. The bed was positioned so the head of the bed was pulled away from the wall and was facing the door. The bed was on the door side of the room, and Resident #13 did not have a roommate although there was another bed in the room. Resident #13's pancake call bell was lying on the floor between the bed and the wall. At 2:00 PM, Nurse #14 entered Resident #13's room. While in the room she checked the	F0558	Continued from page 1 On 10/2/2025, the facility Administrator, Social Services Director completed an audit to ensure all call lights were in reach of the residents. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. All staff was in serviced by the Administrator and Director of Nursing on checking for call light placement to be in reach of the resident when entering the resident room or placing the call bell where the resident wanted it on 10/2/25. The Administrator, Social Services Director, and , Interdisciplinary Team Members and Weekend Manager will audit 5 residents rooms for call light placement daily for 2 weeks to include 1 weekend day, once weekly for 2 weeks then once monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Ongoing compliance will be monitored by the QAPI committee. Any issue from the audit will be corrected immediately and attached to the audit. All findings or trends discovered during the audits will be brought to the monthly QAPI. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. QAPI committee for review at the monthly for 3 months.	

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F0558 SS = D	Continued from page 2 level of urine in Resident #13's catheter bag and proceeded to empty it. Nurse #14 then gave Resident #13 a drink that she requested. At 2:04 PM Nurse #14 left the room without having checked if Resident #13 had her call bell available. At 2:22 PM two staff members entered the room. The staff members were the Speech Therapist (ST) and Resident #13's assigned Nursing Assistant (NA #1). The ST went to the side of the bed where the pancake call bell was lying on the floor, she picked it up and positioned it on Resident #13 under her jaw on the right side and clipped it in place on the resident's nightgown. NA #1 was entering the room with the mechanical lift. In a follow-up interview with Resident #13 on 10/2/25 at 9:17 AM, she revealed staff left the room without ensuring she had her call bell correctly placed at least once daily. Resident #13 further revealed that being without her call bell made her feel "terrible and helpless, like the staff don't care". In an interview with NA #1 on 10/1/25 at 2:24 PM she stated she had dressed Resident #13, left the room and took the lunch cart back to the kitchen and was planning to come right back with the mechanical lift to get Resident #13 out of bed to attend activities. NA #1 revealed she sat down for a few minutes to rest after returning the lunch cart to the kitchen but did not think she was gone that long, and Resident #13 could have yelled out for help if needed. NA #1 indicated she had been trained to make sure a dependent resident had their call bell within reach before she left a resident's room. In an interview with Nurse #14 on 10/1/25 at 2:54 PM, she stated she did not look to see if Resident #13 had her call bell within reach when she was in the room emptying her catheter. Nurse #14 further stated she was nervous at the time and did not look for the call bell. Nurse #14 revealed she had been trained to ensure a dependent resident had their call bell within reach before she left a resident's room. The ST was interviewed on 10/1/25 at 3:04 PM. The ST stated she made it a habit to check if residents have their call bells in reach as she walked through the facility. She further stated she noticed Resident #13 did not have her call bell readily available and entered the room for the purpose of locating it and placing it where Resident #13 could use it.	F0558		

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F0558 SS = D	Continued from page 3 In an interview with Unit Manager (UM #1) on 10/1/25 at 3:09 PM she stated all staff who entered a resident's room should ensure the resident had their call bell within reach before leaving that resident's room, even if the staff member believed they would be right back. UM #1 further stated Resident #13 was capable of yelling out for help if needed. The Director of Nursing (DON) was interviewed on 10/2/25 at 8:44 AM. The DON stated residents should have their call bell in reach at all times, even if there was a staff member in the room with the resident and especially if a staff member left the room. In an interview with the Administrator on 10/2/25 at 9:14 AM, she stated residents should have their call bell in reach at all times. She further stated that even if a resident was capable of yelling out for help, they shouldn't have to do so.	F0558		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty	F0641	What corrective action was accomplished for the resident found to have been affected by the deficient practice. The PASARR, Level II for resident #43 was corrected by the MDS Coordinator to reflect Level II on 10/3/2025. Resident #4 MDS corrected to reflect the resident is receiving an antiplatelet medication; a chewable Aspirin 81 mg daily on 10/3/2025 by the MDS Coordinator Resident #53 MDS was reviewed and corrected to reflect she had a fall with injury on 10/03/2025 by the MDS Coordinator How will other residents who may have the potential to be affected be identified? All residents have a PASARR can be affected and all residents that receive antiplatelet and with falls with injuries can have the potential to be affected. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur. The Regional MDS coordinator educated MDS coordinators on PASSAR II coding, the coding of antiplatelet medications and ; the coding of falls with injury on 10/06/2025 How will the corrective action(s) be monitored to	11/25/2025

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F0641 SS = D	Continued from page 4 of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Pre-Admission Screening and Resident Review (PASARR) status, medication, and falls for 3 of 22 resident MDS assessments reviewed (Resident #43, Resident #4, Resident #53). Findings included: 1. Resident #43 was admitted to the facility on 8/25/25. Her active diagnoses included cerebral infarction. Review of Resident #43's PASARR Level II Determination Notification letter dated 8/21/25 revealed an expiration date of 9/20/25. Review of Resident #43's admission MDS assessment dated 8/31/25 revealed she was coded as not currently considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 9/30/25 at 1:36 PM the Social Worker stated on 8/21/25 Resident #43 had a Level II PASARR determination which expired on 9/20/25. She was reassessed and currently had a Level II PASARR determination with no end date. During an interview on 9/30/25 at 1:40 PM MDS Nurse #2 stated Resident #43's MDS dated 8/31/25 was marked in error and should have been coded as having a Level II PASARR determination. During an interview on 9/30/25 at 3:14 PM the Administrator stated the PASARR status should be accurately reflected in resident MDS assessments. 2. Resident #4 was admitted to the facility on 12/24/21 with diagnoses that included history of cerebrovascular accident (CVA, stroke).	F0641	Continued from page 4 ensure the deficient practice will not reoccur and what QA program will be put into place? Lead MDS coordinator /designee audits all new admissions and quarterly MDS assessments for accuracy of the PASSAR, coding of antiplatelets. Also all falls will be reviewed for injury and accurate coding of any injury. All audits will be reviewing weekly by the Administrator weekly for 3 months; and QAPI for 3 months.	

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F0641 SS = D	Continued from page 5 Review of Resident #4's physician orders revealed an order dated 3/25/25 for Aspirin oral tablet chewable 81 milligrams (mg) to be given one time a day for CVA. Review of Resident #4's August 2025 medication administration records (MAR) revealed Aspirin chewable 81 mg was given daily. Review of Resident #4's Annual Minimum Data Set (MDS) assessment dated 8/20/25 revealed the resident was not coded as receiving an antiplatelet medication. In an interview with MDS Nurse #1 on 9/30/25 at 12:11 PM she stated Resident #4's MDS assessment should have been coded as receiving antiplatelet medication as Aspirin fell in that category of medications. MDS Nurse #1 further stated the error in coding was made due to human oversight. In an interview with the Administrator on 9/30/25 at 3:44 PM, she stated the MDS assessment should have been coded correctly, showing the resident received antiplatelet medication (Aspirin). 3a. Resident #53's Pre-Admission Screening Resident Review (PASRR) Level II Determination Notice dated 9/17/24 revealed in part her Level II screening determined Nursing Facility Placement was appropriate. Resident #53 was admitted to the facility on 10/9/24 with a diagnosis of progressive neurological (nervous system) condition. Resident #53's Admission Minimum Data Set (MDS) assessment dated 10/15/24 revealed she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. On 10/1/25 at 10:18 AM an interview with the facility's Regional Director of Clinical Reimbursement indicated the MDS Nurse who coded Resident #53's admission MDS assessment dated 10/15/24 no longer worked for the facility. She reported the coding on Resident #53's admission MDS assessment was not accurate. b. A nursing progress note for Resident #53 dated 7/19/25 at 11:17 PM written by Nurse #10 revealed	F0641		

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F0641 SS = D	Continued from page 6 Resident #53 was found on the floor in her bathroom. She had a small laceration to her forehead. She was sent to the hospital emergency room (ER) for an evaluation. A nursing progress note for Resident #53 dated 7/20/25 at 12:21 PM written by Nurse #11 revealed Resident #53 returned from the hospital ER. The laceration to her forehead had been repaired with sutures. Resident #53's discharge Minimum Data Set (MDS) assessment dated 8/11/25 revealed she had no falls since her prior MDS assessment. On 10/1/25 at 8:12 AM an interview with MDS Nurse #2 indicated she coded the falls section of Resident #53's discharge MDS assessment dated 8/11/25. She reported she would have reviewed nursing progress notes to assist with coding the section. She stated Resident #53's fall with injury on 7/19/25 should have been captured on her discharge MDS assessment. MDS Nurse #2 stated she had missed this and did not know why. She went on to say the coding that Resident #53 had no falls since her prior MDS assessment would not be accurate. On 10/2/25 at 1:21 PM an interview with the Administrator indicated resident's MDS assessments should be coded accurately.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F0644	"Past Noncompliance - no plan of correction required"	11/24/2025

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F0644 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to obtain further approval and screening through a Level II evaluation process in accordance with the Pre-Admission Screening and Resident Review (PASRR) Level II Determination Notification. This was for 1 of 2 residents (Resident #53) reviewed for PASRR. Findings included: Resident #53's Pre-Admission Screening Resident Review (PASRR) Level II Determination Notice dated 9/17/24 revealed Nursing Facility Placement was appropriate for a limited nursing facility stay, lasting no more than thirty (30) calendar days. The PASRR expiration date was 10/17/24. Resident #53 was admitted to the facility on 10/9/24 with a diagnosis bipolar affective disorder (a chronic mental health condition characterized by extreme mood swings). Resident #53's current comprehensive care plan revealed a focus area dated as initiated on 3/24/25 for Level II PASRR. The goal was for Resident #53 to show no change in mental status through the next review. An intervention was to monitor for and document any changes in mental status. Resident #53's PASRR Level II Determination letter dated 4/10/25 revealed nursing facility placement was appropriate for Resident #53. The letter had no expiration date. No specialized services were required. On 9/29/25 at 2:25 PM an interview with Resident #53 indicated she was receiving all the care she needed in the facility. She reported she didn't have any concerns. On 10/01/2025 at 9:53 AM an interview with the Social Worker (SW) indicated although Resident #53 was admitted with a Level II PASRR, the letter itself didn't get scanned into Resident #53's electronic record, so she did not realize it had an expiration date. She reported she did a 100 percent (%) audit of PASRRs at the end of March 2025 or the first of April 2025, which she does periodically, and she discovered Resident #53's PASRR was expired so she then initiated a new Level II review for Resident #53. The SW stated she would have been responsible for tracking all resident's PASRR statuses ensuring they were current	F0644		

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F0644 SS = D	Continued from page 8 and addressing any that had expiration dates. She reported a corrective action plan had been initiated to ensure this didn't happen again. On 10/1/25 at 10:04 AM an interview with the Administrator indicated the facility should be monitoring for all resident's PASRR status, verifying that each resident's PASRR status was accurate, and if there was an expiration date, ensuring that rescreening was done in a timely manner. On 10/2/25 at 2:25 the facility provided the following corrective action plan: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/3/25, resident #53's PASRR was found to be expired. The facility submitted the PASRR Preadmission Screening and Resident Review) for resident #53 on 4/3/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. On 4/3/25 the facility made the decision to conduct a 100% audit on all residents to include Preadmission Screening and Resident Review (PASRRs); to ensure proper level of care and quality was being provided to all residents by ensuring each resident had a current PASRR and no expired PASRR existed in the facility. Findings of the audit revealed that there were no other residents identified without a current PASRR. No others expired PASRRs were found during the audit. The audit was completed by the Assistant Director of Nursing on 4/3/25. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur: The Assistant Director of Nursing educated the Social Worker and Admissions Director to check PASRRs on admission and check all current PASRRs monthly to make sure no PASRR is expired. This education was completed on 4/3/25. The Assisted Director of Nursing will educate any new Social Worker and Admissions Director upon hire; to	F0644		

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F0644 SS = D	Continued from page 9 check PASRRs on admission and check all current PASRRs monthly to make sure no PASRR is expired. Indicate how the facility plans to monitor it's performance to make sure that solutions are sustained: The Assistant Director of Nursing will do monthly PASRR audits to make sure there are no expired PASRRs for 3 months. The Executive Director will present these findings to the QAPI committee, monthly for 3 months. Corrective action plan completion date: 4/4/25. On 10/2/25 at 2:30 PM the facility's corrective action plan was validated through a review of the facility's initial 100% audit, a review of the facility's education in-service training record dated 4/3/25 titled "PASSR", interviews with the SW, the Assistant Director of Nursing and the Admissions Director, the facility's monthly audits, and the facility's QAPI meeting minutes. The corrective action plan completion date of 4/4/25 was validated.	F0644		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F0656	Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice; On October 2, 2025 the MDS Comprehensive Care Plan was corrected for resident #53 related to residents' care plan not reflecting the residents' PASRR Level 2 status by the MDS coordinator. On October 2, 2025 the MDS assessment was corrected for resident #43 related to residents' assessment not reflecting the accurate PASRR Level status coding in Section A by the MDS coordinator. On October 2, 2025 the MDS Comprehensive Care Plan was corrected for resident #8 to reveal a focus area, goal, and intervention regarding Hospice Care Services by the MDS coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; To identify other residents that have the potential to be affected, a 90 day look back of all residents PASRR Levels and hospice delegation have been entered into the resident's profile and hard copy uploaded to confirm current PASRR Level status to ensure accuracy of coding.	12/01/2025

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F0656 SS = D	Continued from page 10 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that included Pre-Admission Screening Resident Review (PASRR) Level II (Resident #53 and Resident #43) and hospice (Resident #8) for 3 of 20 comprehensive care plans reviewed. Findings included: 1. Resident #53's Pre-Admission Screening Resident Review (PASRR) Level II Determination Notice dated 9/17/24 revealed in part her Level II screening determined Nursing Facility Placement was appropriate. Resident #53 was admitted to the facility on 10/9/24 with a diagnosis of progressive neurological (nervous system) condition. Resident #53's admission Minimum Data Set (MDS) assessment dated 10/15/24 revealed she was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #53's current comprehensive care plan revealed	F0656	Continued from page 10 On 10/6/2025 the Regional MDS Coordinator in serviced the MDS Coordinators regarding the coding of Level 2 PASARR change processes and care coding of Hospice Care. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; To monitor and maintain ongoing compliance, the MDS Nurse will audit all new admissions to confirm PASARR level status and Hospice delegation status; are present and correct in the comprehensive assessment and in the care plan. MDS Coordinator will audit comprehensive care plans in the area of PASARR status weekly for 4 weeks, and monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The results of these audits will be brought to QAPI monthly times 3 months for review and recommendation.	

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F0656 SS = D	Continued from page 11 her Level II PASRR status was not reflected in her care plan until a focus area was initiated by the facility's Social Worker (SW) on 3/24/25. On 10/1/25 at 10:26 AM an interview with MDS Nurse #1 indicated the Social Worker (SW) would be responsible for ensuring a resident's Level II PASSR status was reflected in the comprehensive care plan. On 10/1/25 at 10:56 AM an interview with the SW indicated she normally was not responsible for ensuring that a resident's Level II PASRR status was included in their comprehensive care plan. She reported the MDS Nurses did this. She stated she might have added this to Resident #53's care plan on 3/24/25 because she had not seen it there. On 10/1/25 at 11:24 AM an interview with the Assistant Director of Nursing indicated that because the SW was responsible for overseeing the facility's PASRR process, she would be responsible for ensuring a PASRR Level II status was reflected on a resident's comprehensive care plan. On 10/2/25 at 1:21 PM an interview with the Administrator indicated Resident #53 was admitted to the facility with a Level II PASRR. She reported this should have been reflected in her comprehensive care plan before 3/24/25. 2. Resident #43 was admitted to the facility on 8/25/25. Her active diagnoses included cerebral infarction. Review of Resident #43's Level II PASARR Determination Notification letter dated 8/21/25 revealed an expiration date of 9/20/25. Resident #43's Level II PASARR Determination Notification letter dated 9/22/25 revealed it had no expiration. Review of Resident #43's care plan dated 9/4/25 revealed no care plan for the Level II PASARR. During an interview on 10/1/25 at 2:43 PM MDS Nurse #1 stated Level II PASARR should be in the care plan, and it was not for Resident #43. She stated that ensuring Level II PASARR was on the care plan was the responsibility of both MDS and Social Work. During an interview on 10/1/25 at 2:49 PM the Social Worker stated Resident #43 had a Level II PASARR determination which should be captured on the care plan. She stated when the Level II PASARR determination notification letter came to the facility it was not	F0656		

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F0656 SS = D	Continued from page 12 uploaded into the system, which was possibly why it was missing on the care plan. During an interview on 10/1/25 at 2:54 PM the Administrator stated Level II PASARRs should be care planned. 3. Resident #3 was admitted to the facility on 3/24/25 with diagnoses that included dementia. Review of the hospice provider notes indicated Resident #8 was accepted into hospice care services on 7/30/25. Resident #8's care plan last revised on 8/5/25 did not reveal a focus area, goal, or intervention regarding hospice care services. Review of the Minimum Data Set (MDS) dated 8/12/25 revealed Resident #8 was receiving hospice care services. An interview on 9/30/25 at 2:30 PM was held with MDS Nurse #2, she stated hospice care services should have been included in the care plan for Resident #8. MDS Nurse #2 indicated she was responsible for this task and should have added it to the care plan. During an interview with the Director of Nursing on 9/30/25 at 2:45 PM, she revealed her expectation would have been that hospice care services were included in the care plan for Resident #8. An interview was conducted with the Administrator on 9/30/25 at 2:55 PM. She stated she would have expected the care plan to have been updated by the MDS Nurse when the family agrees to hospice care services for any resident.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/02/2025, the MDS Coordinator corrected the care plan for resident #12's code status, the area of resident #13's pressure ulcer, and discontinuing bed rails for resident #7.	12/01/2025

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F0657 SS = D	Continued from page 13 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to revise the comprehensive care plan to accurately reflect the code status (Resident #12), a pressure ulcer (Resident #13) and the discontinuation of bed rails (Resident #7). This was for 3 of 20 comprehensive care plans reviewed. 1. Resident #12 was admitted to the facility on 12/30/22 with diagnoses that included end stage renal disease dependent on hemodialysis. Review of Resident #12's medical record revealed an advance directive physician's order dated 4/27/25 indicating he was a full code, meaning he wished to have cardiopulmonary resuscitation (CPR) performed should his heart stop. Review of a hard copy of Resident #12's advance directive kept in a book at the nurses' station indicated Resident #12 was made a full code on 5/1/25.	F0657	Continued from page 13 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On ------10/02/2025, the MDS Coordinator performed an audit on all current resident's care plan in the area of code status's to ensure they are coded per Physicians order, audited all residents who have pressure ulcer's to ensure they are care planned correctly, and audited all residents who have bed rails and residents who did not have bed rails to ensure the care plan was based on the current residents plan of care. No other deficient practice was noted. An ADHOC Quality Assurance Performance Improvement Committee was held on -----10/06/2025 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. The MDS Coordinator was re-educated by the Regional MDS Coordinator on 10/02/2025 to ensure all resident care plans are patient centered and accurate in the areas of code status's, pressure wounds, and bed rails. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The MDS Coordinator/designee will audit (3) current residents to ensure the code status is accurately coded on the care plan, (3) residents who have pressure wounds that they are care planned accurately, and (3) residents with or without bed rails to ensure it is care planned accurately for 12 weeks. The Facility will review the Performance Improvement Plan monthly during the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for a period of 3 months. Findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) monthly, and Quality monitoring audits will be updated as indicated.	

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F0657 SS = D	Continued from page 14 Review of Resident #12's care plan, last revised 6/11/25 revealed his code status as being Do Not Resuscitate (DNR), meaning he would not want CPR performed should his heart stop. Review of Resident #12's Annual Minimum Data Set (MDS) assessment dated 6/11/25 revealed he was moderately cognitively impaired. In an interview with Unit Manager #1 (UM #1) on 10/1/25 at 11:58 AM she stated the MDS Nurses were responsible for keeping the code status in a resident's care plan updated. In an interview with MDS Nurse #1 on 10/1/25 at 12:03 PM she stated the Social Worker (SW) would have been responsible for updating Resident #12's code status on the care plan. An interview was conducted with the Assistant Director of Nursing (ADON) on 10/1/25 at 12:18 PM. The ADON indicated the MDS Nurses were responsible for updating a resident's code status on their care plan. In an interview with the Director of Nursing (DON) on 10/1/25 at 12:25 PM she stated the MDS Nurses were responsible for updating the code status in a resident's care plan. The DON further stated the care plan should have included the correct code status for Resident #12. In an interview with the SW on 10/1/25 at 1:46 PM she stated the MDS Nurses were responsible for changing a resident's code status on the care plan. The SW further stated she could change it if she noticed it was incorrect. An interview was conducted with the Administrator on 10/1/25 at 3:41 PM. The Administrator indicated the MDS Nurses were responsible for changing or updating a resident's care plan to reflect the accurate code status. She was unaware Resident #12's care plan had an inaccurate code status. The Administrator stated that a resident's care plan should include the most up to date code status for a resident.	F0657		

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F0657 SS = D	Continued from page 15 2. Resident #13 was readmitted to the facility on 7/29/25 with diagnoses that included a Stage 4 pressure ulcer of the sacrum. Review of Resident #13's quarterly MDS assessment dated 8/4/25 indicated she was at risk to develop pressure ulcers. Review of Resident #13's comprehensive care plan last revised 8/5/25 revealed a focus of having had actual impairment to skin integrity related to impaired mobility to include a stage 4 pressure ulcer to her sacrum and a post-surgical abdominal wound. The goal was for Resident #13 to maintain or develop clean and intact skin by the review date. Interventions included treatments as ordered. The care plan did not include a stage 3 pressure ulcer to the right buttocks. Review of Resident #13's physician's orders revealed an order dated 7/29/25 for wound care to the stage 3 pressure wound on the right buttocks that read: cleanse wound with wound cleanser, place iodoform packing strips in collagen powder, pack wound, cover with large sacral dressing, apply skin prep around wound every day shift and as needed. In an interview with MDS Nurse #1 on 10/1/25 at 12:31 PM she stated the stage 3 pressure wound to the right buttock should have been added to the impairment in skin integrity care plan with the stage 4 pressure ulcer to her sacrum and the abdominal surgical wound. She further stated MDS Nurses were responsible for this update after they learned of new wounds in morning meeting. MDS Nurse #1 was unsure why the stage 3 pressure ulcer was not added to Resident #13's care plan. In an interview with the ADON on 10/1/25 at 12:55 PM she stated the stage 3 pressure ulcer to right buttock should have been added to the impairment in skin integrity care plan with the other two wounds. The ADON indicated the MDS Nurses would be responsible for this addition to the care plan. In an interview with the Administrator on 10/1/25 at 12:58 PM, she stated the stage 3 pressure ulcer to the right buttock should have been added to the skin integrity care plan with the stage 3 pressure ulcer and	F0657		

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F0657 SS = D	Continued from page 16 abdominal surgical wound by the MDS Nurse. 3. Resident #7 was admitted to the facility on 3/22/2018 with a diagnosis of stroke. Resident #7's current comprehensive care plan revealed a focus area for the use of bed rails. The goal dated as last revised on 2/11/25 by Minimum Data Set (MDS) Nurse #1 was for Resident #7 to be free from injury and to improve in positioning with bed rails through the next review date. Resident #7's significant change MDS assessment dated 8/10/25 revealed bed rails were not used in bed as a restraint. On 9/29/25 at 10:30 AM Resident #7 was observed in bed. No bed rails were observed on his bed. On 9/30/25 at 8:10 AM Resident #7 was observed in bed. No bed rails were observed on his bed. On 10/1/25 at 8:46 AM an interview with Nurse Aide (NA) #7 indicated she cared for Resident #7 on 9/29/25 and 9/30/25 on the 7AM-3PM shift. She stated she did not usually care for him. She reported Resident #7 did not have bed rails. On 10/1/25 at 8:48 AM an interview with Nurse Aide #8 indicated she regularly cared for Resident #7 on the 7AM-3PM shift 5 days per week for the last 4 to 5 months. She reported she did not recall Resident #7 having bed rails. On 10/1/25 at 10:32 AM an interview with MDS Nurse #1 indicated Resident #7 would have been due for a care plan review in August 2025. She stated if a resident had bed rail use reflected on their comprehensive care plan and the bed rails were removed, nursing could communicate this with her and she could revise the care plan, or nursing could do this themselves. She did not indicate that she recalled a discussion regarding the removal of Resident #7's bed rails. On 10/1/25 at 11:19 AM an interview with the Assistant Director of Nursing (ADON) indicated Resident #7 did have bed rails at one time. She reported on 9/22/25, she made the determination that Resident #22 was no longer able to utilize the rails, and they were no longer appropriate for him. She indicated she had asked for maintenance to remove the bed rails. She stated she shared this at the morning meeting on 9/23/25 with the Interdisciplinary Team. The ADON went on to say the MDS	F0657		

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F0657 SS = D	Continued from page 17 Nurses were present at that meeting, and she would have thought MDS would have updated Resident #7's comprehensive care plan to reflect Resident #7 no longer using bed rails. On 10/2/25 at 1:21 PM an interview with the Administrator indicated Resident #7 used bed rails at one time, but his cognition had changed, and he could no longer safely use these. She stated once this decision had been made, and the rails were removed from his bed, his comprehensive care plan should have been updated to accurately reflect this.	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident, staff, and Nurse Practitioner (NP) interviews the facility failed to remove a topical pain patch in accordance with the physician's order. This was for 1 of 2 residents (Resident #82) reviewed for professional standards. Findings included: Resident #82 was admitted to the facility on 9/24/25 with a diagnosis of pain. The nursing Admission Data Collection form for Resident #82 dated 9/24/25 at 6:02 PM completed by Nurse #10 revealed Resident #82 was alert and oriented times 4 (to person, place, time and situation). A physician's order for Resident #82 dated 9/26/25 revealed lidocaine (topical pain medication) patch 4 percent (%) apply to shoulders and chest topically one time a day for pain apply 3 patches – one on each shoulder and chest and remove per schedule. There was no physician's order for Resident #82 to self-administer medications. On 9/29/25 at 11:10 AM an observation was conducted in conjunction with an interview with Resident #82. During the observation, Resident #82 used both hands to pull	F0658	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Nurse immediately removed patch from resident #82 and notified the Physician on 09/29/2025 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing audited all residents who had an order for a patch to ensure all patches were removed as ordered by the Physician on 09/29/2025. An ADHOC Quality Assurance Performance Improvement Committee will be held on 10/06/2025 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 09/29/2025 the Director of Nursing educated nursing staff to remove all patches as ordered by Physician. The Director of Nursing will educate all new hires on following Physician orders to remove all patches as ordered by the Physician. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing will conduct random audits on residents who have orders for patches 3 times a week	12/01/2025

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F0658 SS = D	Continued from page 18 down the front of her gown in response to a question from the surveyor regarding whether or not she had any wounds or skin conditions. This revealed one lidocaine topical patch on her chest and one on each shoulder, for a total of 3 lidocaine patches, dated 9/28/25 with the initials of Nurse #11. In an interview at that time Resident #82 stated she received the patches once daily. She reported they were supposed to be on for 12 hours, and then off for 12 hours. She indicated the nurse put the patches on in the morning, and then she took them off herself whenever. Resident #82's Medication Administration Record (MAR) revealed documentation indicating that on 9/28/25 and 9/29/25 at 9:00 AM Nurse #11 applied lidocaine 4% patches topically to Resident #82's shoulders and chest in accordance with the physician's order. It further revealed documentation indicating that on 9/28/25 at 8:59 PM Nurse #10 removed the lidocaine 4 % patches from Resident #82's shoulders and chest in accordance with the physician's order. On 9/29/25 at 1:58 PM a telephone interview with Nurse #10 indicated when she had gone in to remove the lidocaine patches from Resident #82's chest and shoulders on 9/28/25, Resident #82 told her she would remove them herself. Nurse #10 stated she had never gone back to check to be sure Resident #82 had actually removed them. On 9/29/25 at 1:30 PM an observation of Resident #82 revealed one lidocaine topical patch on her chest and one on each shoulder dated 9/29/25 with the initials of Nurse #11. On 9/29/25 at 1:38 PM an interview with Nurse #11 indicated she applied the lidocaine 4% patches topically to Resident #82's shoulders and chest on 9/28/25 in the morning. She reported she dated and initialed the patches. She stated she also applied the patches to Resident #82 on 9/29/25, and initialed and dated the patches. Nurse #11 went on to say when she applied the patches to Resident #82 on 9/29/25, she noticed that the patches she applied on 9/28/25 were still on. She stated she recalled this happening before, and she had notified Unit Manager #1 because the patches were supposed to be removed from Resident #82 each evening. Nurse #11 reported she had not notified Unit Manager #1 on 9/29/25. On 9/29/25 at 1:45 PM an interview with Unit Manager #1 indicated she did not recall Nurse #11 ever notifying her that Resident #82's lidocaine patches were not being removed in the evening in accordance with the	F0658	Continued from page 18 for 12 weeks to ensure all patches are removed as ordered by the Physician. The Director of Nursing will provide the results of the quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality audits will be updated as indicated.	

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F0658 SS = D	Continued from page 19 physician's order. On 9/29/25 at 1:49 PM an interview with the Director of Nursing indicated Nurse #10 should have removed Resident #82's lidocaine patch herself in accordance with the physician's order. On 10/02/2025 at 12:20 PM an interview with NP #1 indicated that while no harm would have occurred to Resident #1 from not having her lidocaine patch removed, there was a reason the physician's order for the lidocaine patch included a removal time. She reported the patch was only effective for a certain amount of time. She stated Nurse #10 should have removed Resident #82's lidocaine patch in accordance with the physician's order. On 10/2/25 at 1:21 PM an interview with the Administrator indicated Nurse #10 should have removed Resident #82's lidocaine patch herself in accordance with the physician's order.	F0658		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility applied a resting hand splint (a brace used to keep the hand, wrist, and fingers in a neutral position preventing stiffness and contractures) without a physician's order, therapy	F0688	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/01/25 the Occupational therapist immediately removed the resting right-hand splint from Resident # 38's room to keep it in the therapy room until released from therapy to nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/01/2025 the Executive Director conducted an audit and identified eight residents having splints. The Executive Director educated the Occupational Therapists to keep all splints in therapy until the residents are released to nursing for splint management. The Nursing Managers educated all nurses to not to apply any splints until ordered by the physician on 10/01/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 10/1/25, the Nursing Managers educated all nurses to not apply any splints until ordered by the physician.	12/01/2025

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F0688 SS = D	Continued from page 20 instructions or in accordance with a splint wearing schedule. This deficient practice was for 1 of 3 residents reviewed for position and mobility (Resident #38). Findings included: Resident #38 was admitted to the facility on 9/8/25 with a diagnosis of right-hand contracture. Resident #38's admission Minimum Data Set (MDS) assessment dated 9/14/25 revealed she was moderately cognitively impaired. She had functional limitation of range of motion on both sides of her upper and lower extremities. She received 2 days of occupational therapy beginning on 9/9/25. She was not in a restorative nursing program. Resident #38 did not receive splint or brace assistance. Resident #38's medical record did not reveal a physician's order for a resting hand splint. Resident #38's current comprehensive care plan revealed a focus area dated as initiated on 9/19/25 for alteration in musculoskeletal status related to contractures. The goal was for Resident #38 to remain free from injuries or complications from contractures through the next review. An intervention was to monitor and document as needed any sign or symptom or complication related to contracture formation or joint changes. On 9/29/25 at 3:01 PM Resident #38 was observed in her room. A resting hand splint was observed on her nightstand. An interview with Resident #38 at that time indicated she did not know what the splint was for or when she wore it. On 10/1/25 at 12:36 PM Resident #38 was observed in her room. A resting hand splint was observed on her nightstand. On 10/1/25 at 12:37 PM an interview with Nurse #11 indicated she was caring for Resident #38 that day and was familiar with her. She reported Resident #38 was admitted to the facility with a resting hand splint for her right hand that night shift applied to Resident #38. She stated Resident #38 had been wearing her splint when she took over her care this morning at 7:00 AM, but it was halfway off. Nurse #11 stated she reapplied the splint, but a short time later when she went back into Resident #38's room, Resident #38 had it off again. She reported she was waiting for Resident #38 to finish her lunch, and them she would reapply the	F0688	Continued from page 20 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing, Assistant DON or designee, will conduct random audits on all identified eight residents who require a splint as well as any new residents with splint orders. Monitoring will be done weekly for 12 weeks to ensure they are not in residents' room until the Physician has ordered the splint to be applied by nursing as well as being applied as per physician's order. The Director of Nursing will provide the results of the quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality audits will be updated as indicated.	

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F0688 SS = D	Continued from page 21 splint. She indicated Resident #38 was not being seen by therapy, because she was a long term care resident. Nurse #11 stated there was no physician's order for Resident #38's right hand splint, or any splint wearing schedule, but she just assumed that Resident #38 was supposed to be wearing the splint during the day and having it removed at night. On 10/2/25 at 8:13 AM a telephone interview with Nurse Aide (NA) #9 indicated she was assigned to care for Resident #38 on the shift beginning at 11:00 PM on 9/30/25 and ending at 7:00 AM on 10/1/25. She reported Resident #38 had been wearing a right hand splint during that shift, but she had not applied it to Resident #38. She reported she did not know who applied the splint. NA #9 stated if a resident was supposed to have a splint applied, it showed up as a task for her in the computer. She reported she did not recall seeing application of a splint for Resident #38. On 10/2/25 at 9:21 AM a telephone interview with Nurse #12 indicated she was assigned to care for Resident #38 on the shift beginning at 11:00 PM on 9/30/25 and ending at 7:00 AM on 10/1/25. She stated she really couldn't remember if she had applied a splint to Resident #38. She reported if a resident was supposed to wear a splint, it would appear for her on the resident's Treatment Administration Record (TAR) so she would know when to apply and remove it and could document the application and removal. A review of Resident #38's TAR did not reveal any information regarding the application or removal of a right resting hand splint. On 10/1/25 at 2:20 PM an interview with the Therapy Director indicated she was familiar with Resident #38 and had been working with Resident #38 since her admission. She reported Resident #38 was receiving Occupational Therapy services. She stated Resident #38 had been admitted to the facility with a right-hand contracture, but not a resting hand splint. She indicated she had ordered the resting hand splint for Resident #38 and been working with this during Resident #38's therapy sessions. The Therapy Director stated Resident #38 was not tolerating her splint and had only been wearing it for less than 30 minutes while supervised during therapy sessions. She reported until Resident #38 could tolerate the splint for more than 1 hour, Resident #38 would not be released to the restorative nursing program with a splint wearing schedule. She stated about a week before Resident #38 was released to wear the splint regularly, an order would be placed, she would train the nursing staff on	F0688		

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F0688 SS = D	Continued from page 22 the application of the splint, monitoring for any skin breakdown and provide a splint schedule that specified how many hours a day the splint was to be worn. The Therapy Director reported while it would not cause Resident #38 any harm for nursing to have applied the splint, Resident #38 had not been released to wear it except during therapy sessions. On 10/2/25 at 2:28 PM an interview with the Assistant Director of Nursing indicated Nurses and NAs should not be applying a splint to a resident without a physician's order and instructions on how to do so. On 10/1/25 at 2:42 PM an interview with the Administrator indicated she felt that having Resident #38's splint in her room was confusing to the nursing staff. She stated she felt that if Resident #38 had not been released by therapy to have her splint applied by nursing staff, therapy should keep the splint and not leave it Resident #38's room.	F0688		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews the facility failed to follow professional standards of practice and infection prevention measures when Unit Manager #2 (UM #2) failed to remove soiled gloves, perform hand hygiene and don clean gloves during tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) through the front of the neck to create an artificial airway and assist with breathing) care for 1 of 1 residents reviewed for tracheostomy care (Resident #17). Findings included: Resident #17 was admitted to the facility on 5/31/22 with a diagnosis of quadriplegia and tracheostomy status.	F0695	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Nursing immediately re-educated the Unit Manager #2 on following professional standards of practice with hand hygiene when performing Tracheostomy care for resident #17 on 10/02/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a tracheostomy have the potential to be affected by the alleged deficient practice. On 10/6/2025, the Director of Nursing observed tracheostomy care being rendered for Infection Control	12/01/2025

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F0695 SS = D	Continued from page 23 Resident #17's quarterly Minimum Data Set (MDS) assessment dated 9/16/25 revealed he was cognitively intact. Resident #17 was coded in the MDS as receiving tracheostomy care in the facility. Resident #17's care plan with a revision date of 6/22/25 revealed him to have a tracheostomy. A continuous observation of tracheostomy care was conducted on 10/2/25 starting at 8:14 AM. Unit Manager #2 (UM #2) entered the resident's room, performed hand hygiene and donned a gown and gloves. UM#2 then removed the soiled split gauze from behind the tracheostomy flange and threw it in the trash. UM#2 then opened the clean split gauze and placed it behind the tracheostomy flange. At 8:18 AM, UM#2 removed the soiled inner cannula and threw it away. She proceeded to open the new sterile inner cannula and insert it into the tracheostomy. UM #2 then removed the soiled gloves, performed hand hygiene, removed her gown, put it into the trash, removed the trash bag, tied it closed and removed it from the room. UM #2 proceeded to take the trash bag and dispose of it. In an interview with UM #2 on 10/2/25 at 8:27 AM, she indicated she thought she was performing tracheostomy care correctly. UM #2 was unaware she should have changed gloves and performed hand hygiene between soiled and clean parts of the procedure. In an interview with the Infection Preventionist (IP) on 10/2/25 at 8:45 AM The IP indicated she would expect Nurses to think critically about the procedures they were performing. In this case, UM #2 should have considered the possibility of spreading disease causing organisms to the resident's airway by not removing soiled gloves after handling the soiled split gauze and soiled inner cannula, performing hand hygiene and donning new gloves to place the clean split gauze and clean inner cannula. The Administrator was interviewed on 10/2/25 at 9:01 AM. The Administrator stated to decrease the risk of spreading disease causing organisms to the residents' airway, UM #2 should have split tracheostomy care into clean and soiled parts. She further stated UM #2 should have donned clean gloves, removed the soiled split	F0695	Continued from page 23 compliance and regarding glove donning and doffing, results were a successful trach care observation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed nursing staff were in-serviced on proper trach care and infection control. The Director of Nursing, Assistant Director, or designee will randomly observe tracheostomy care to ensure infection control practices are followed with the proper hand hygiene, and the donning and doffing of the gloves at the appropriate times. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing, Assistant Director or designee, will conduct tracheostomy care observations 3 times a week for 12 weeks on residents who require tracheostomy care to ensure professional standards of practice are followed including hand hygiene and infection prevention techniques are being followed. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F0695 SS = D	Continued from page 24 gauze and soiled inner cannula, removed the soiled gloves, performed hand hygiene, donned clean gloves and placed the clean split gauze and clean inner cannula.	F0695		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to attempt alternatives prior to installing side rails, complete a siderail assessment, assess entrapment risk, review the risks and benefits of side rails with the resident and obtain informed consent, complete a care plan for side rail usage and obtain a physician's order prior to siderail use for 1 of 3 residents (Resident #57) reviewed for side rails. Findings included: Resident #57 was admitted to the facility on 5/22/25 with diagnoses that included Parkinson's disease (a chronic, progressive neurological disorder that affects movement and other bodily functions).	F0700	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/01/2025, the Occupational Therapist completed an assessment on Resident #57 for bed mobility, risks and benefits of an assist bar. The Unit Manager completed an assessment, assessed for entrapment risk, reviewed risk and benefits of side rails with Resident # 57's responsible party, obtained a consent, and notified the Physician to obtain an order for the side rails on 10/01/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. On 10/01/2025 a thorough facility wide walkthrough and audit were conducted. All residents who had side rails were assessed by therapy for entrapment risk; and ability to safely move and care plans were updated by the IDT team and MDS, along with consents and education of the 17 residents affected. On 10/1/2025, the Director of Nursing reviewed 17 residents for bed mobility, risks and benefits of an assist bar. The review assessed for entrapment risk; and ability to safely use assist bar to successfully improve bed mobility. An ADHOC Quality Assurance Performance Improvement Committee will be held on 10/06/2025 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 10/02/2025 the Director of Nursing educated all licensed staff including therapy on side rails, ensuring that any resident who needed side rails for mobility be assessed for entrapment risk, risk and	12/01/2025

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F0700 SS = D	Continued from page 25 Review of Resident #57's quarterly Minimum Data Set (MDS) assessment dated 8/28/25 indicated Resident #57 was cognitively intact, did not have side rails as a restraint and was independent with bed mobility. Review of Resident #57's care plan last revised 9/8/25 revealed no care plan indicating the use of bilateral quarter length side rails. Review of Resident #57's medical record revealed no assessment for use of side rails, no assessment for entrapment risk, no signed consent reviewing the risks and benefits of side rail use, or physician's order for use of side rails. Resident #57 was observed lying in bed with bilateral quarter length side rails in the raised position on 9/29/25 at 10:50 AM. Resident #57 was observed lying in bed with bilateral quarter length side rails in the raised position on 10/1/25 at 2:27 PM. In an interview with Unit Manager (UM) #1 on 10/2/25 at 11:02 AM she stated Physical Therapy completed a side rail assessment and let the Director of Nursing (DON) know when someone was approved for the use of side rails and the DON had maintenance put them on the resident's bed. UM#1 indicated she had never completed a nursing side rail assessment for any resident. In an interview with the Assistant Director of Nursing (ADON), who was acting as Director of Nursing (DON) on 10/2/25 at 11:12 AM, she stated therapy should always evaluate a resident for side rail usage first. The ADON further stated that after therapy approved a resident for side rails, a Nurse would complete a nursing side rail assessment which included entrapment risk assessment, obtain consent from the resident or their responsible party, obtain a physician's order and add side rail usage to the resident's care plan. The ADON revealed she was unable to locate a side rail assessment including entrapment risk, signed consent form, physicians order or care plan for Resident #57's side rail usage. The ADON was unsure why Resident #57 was overlooked.	F0700	Continued from page 25 benefits were reviewed for side rail use, that a consent from the residents' responsible party or resident is obtained, and that the Physician is notified for an order for the side rails to be placed on the residents bed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and On 10/01/2025 to monitor and maintain compliance the Director of Nursing, Assisted Director of Nursing or designee will conduct weekly audits for 12 weeks on any resident who utilize side rails. The Director of Nursing/designee will conduct an audit weekly for 12 weeks on residents who require side rails that an assessment has been completed, risk and benefits have been explained to the responsible party or patient, a consent and an order has been obtained prior to placing side rails on any resident's bed for mobility. The Director of Nursing will provide the results of the quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality audits will be updated as indicated.	

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F0700 SS = D	Continued from page 26 In an interview with Resident #57 on 10/2/25 at 11:25 AM he stated he had Parkinson's disease that caused him to have decreased muscle control. Resident #57 further stated he had side rails on his bed since admission and used them for positioning, mobility and the side rails were especially helpful when getting out of bed. A telephone interview was conducted with the Director of Therapy on 10/2/25 at 11:30 AM. The Director of Therapy stated she was under the impression side rails were not allowed in the building and therapy only assessed for side rails if a newly admitted resident had side rails at home. An interview was conducted with the Physical Therapist (PT) on 10/2/25 at 12:18 PM. The PT revealed she did not complete side rail assessments. The PT was unsure who was responsible for assessing residents for the safe use of side rails. In an interview with the Administrator on 10/2/25 at 12:45 PM she stated residents were assessed by therapy for the use of side rails. She further stated that after they were approved for side rails by therapy, nursing completed a nursing assessment, obtained a physician's order, reviewed risks and benefits with the resident or their responsible party and put in a request for maintenance to put side rails on the resident's bed. The Administrator was unsure why Resident #57 had bilateral quarter length side rails on his bed and had not been assessed for safe usage including entrapment risk by therapy or nursing, why no consent form was completed, no physicians order obtained, and no care plan entered regarding side rail usage.	F0700		
F0842 SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the	F0842		12/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = A	Continued from page 27 facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F0842		

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F0842 SS = A	Continued from page 28 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to accurately document the removal of a medicated topical pain patch for 1 of 1 resident reviewed for self-administration of medication (Resident #82). Findings included: Resident #82 was admitted to the facility on 9/24/25 with a diagnosis of pain. A physician's order for Resident #82 dated 9/26/25 revealed lidocaine (topical pain medication) patch 4 percent (%) apply to shoulders and chest topically one time a day for pain apply 3 patches – one on each shoulder and chest and remove per schedule. There was no physician's order for Resident #82 to remove the patches herself. On 9/29/25 at 11:10 AM an observation of Resident #82 revealed one lidocaine topical patch on her chest and one on each shoulder dated 9/28/25 with the initials "ps". In an interview at that time Resident #82 stated she received the patches once daily. She reported they were supposed to be on for 12 hours, and then off for 12 hours. She indicated the nurse put the patches on in the morning, and then she took them off herself whenever.	F0842		

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F0842 SS = A	Continued from page 29 On 9/29/25 at 1:30 PM an observation of Resident #82 revealed one lidocaine topical patch on her chest and one on each shoulder dated 9/29/25 with the initials “ps”. Resident #82’s Medication Administration Record (MAR) revealed documentation indicating that on 9/28/25 and 9/29/25 at 9:00 AM Nurse #11 applied lidocaine 4% patches topically to Resident #82’s shoulders and chest in accordance with the physician’s order. It further revealed documentation indicating that on 9/28/25 at 8:59 PM Nurse #10 removed the lidocaine 4 % patches from Resident #82’s shoulders and chest in accordance with the physician’s order. On 9/29/25 at 1:58 PM a telephone interview with Nurse #10 indicated when she had gone in to remove the lidocaine patches from Resident #82’s chest and shoulders on 9/28/25, Resident #82 had told her she would remove them herself. Nurse #10 indicated she documented on Resident #82’s MAR on 9/28/25 at 8:59 PM that she removed Resident #82’s lidocaine patches but she had never gone back to check to be sure Resident #82 had actually removed them. On 9/29/25 at 1:49 PM an interview with the Director of Nursing indicated Nurse #10 had documented on Resident #82’s MAR on 9/28/25 at 8:59 PM that she removed Resident #82’s lidocaine patches when she had not. She reported this documentation would not be accurate. On 10/2/25 at 1:21 PM an interview with the Administrator indicated Nurse #10 should not have documented on Resident #82’s MAR on 9/28/25 at 8:59 PM that she had removed Resident #82’s lidocaine patches when she had not.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and	F0880	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality	12/01/2025

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F0880 SS = D	Continued from page 30 control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 30 of care and services to our residents. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Executive Director immediately reeducated the Business of Manager that when touching a urinal to perform hand hygiene prior to setting up a food tray on 09/29/2025. The urinal was removed and emptied immediately by the Nurse Manager on 09/29/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing audited all residents who uses a urinal to ensure no urinal is bedside when food services are provided on 09/29/2025. All residents audited during a meal to ensure hand hygiene is being performed during delivery of meal trays on 09/29/2025. An ADHOC Quality Assurance Performance Improvement Committee held on 10/6/2025 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing will complete education to all staff to ensure proper use of standard and transmission-based precautions are used when providing food services and after removing urinals from bed side on 09/30/2025. The Director of Nursing will complete in services on all staff to ensure proper use of hand hygiene by 12/1/25. The Director of Nursing/designee will educate all new hires on hire to ensure proper use of standard and transmission-based precautions are used when providing food services and after removing urinals from bed side. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing will conduct random audits on staff to ensure they are using transmission based and standard precautions using hand hygiene when providing food services 5 days a week for 12 weeks. The Director of Nursing will provide the results of the quality	

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F0880 SS = D	Continued from page 31 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement their policies and procedures for hand hygiene when the business office manager failed to perform hand hygiene while passing a meal tray. This was for 1 of 8 staff members observed for hand hygiene practices (Business Office Manager). Findings included: A review of the facility policy titled Hand Hygiene with a review date of 2/5/21 stated in part: Hand hygiene should be performed after contact with inanimate objects (including medical equipment) in the immediate patient vicinity, and, before initiating a clean procedure. The policy definition of hand hygiene stated: cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). An observation was started on 9/29/25 at 11:51 AM. The facility Business Office Manager was observed entering a resident's room to deliver the resident's lunch tray. The Business Office Manager set the tray on the resident's overbed tray table next to a urinal with approximately 2 inches of straw-colored urine in it. The Business Office Manager then asked the resident if it was ok for the Business Office Manager to move the resident's urinal and the resident agreed. The Business Office Manager picked up the urinal and moved it to the bedside table. Afterwards, the Business Office Manager asked the resident if he could help him with anything else and the resident requested the Business Office Manager remove the lid from his lunch plate and open his carton of milk. The Business Office Manager proceeded to take the lid off of the lunch plate and open the carton of milk without performing hand hygiene first. The resident then asked the Business Office	F0880	Continued from page 31 monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality audits will be updated as indicated.	

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F0880 SS = D	Continued from page 32 Manager to place a straw in the milk carton, and the Business Office Manager proceeded to do so. In an interview with the Business Office Manager on 9/29/25 at 11:56 PM he stated he hadn't thought touching the urinal then opening the milk and the straw was an infection control issue as he touched the body of the urinal, not the handle of the urinal that the resident would have touched. The Business Office Manager further stated he was unaware that putting the lunch tray on the overbed table with the urinal was an infection control issue. In an interview with the Infection Preventionist (IP) on 9/29/25 at 12:16 PM, she stated the Business Office Manager should have set the lunch tray in a different location, donned clean gloves, moved the urinal, removed the gloves, performed hand hygiene and then proceeded to help the resident with his tray. The IP indicated by touching the urinal, then opening the milk and the straw, the Business Office Manager could have transferred disease causing bacteria from the urinal to the milk carton and/or straw. In a follow-up interview with the Business Office Manager on 9/29/25 at 12:23 PM he stated he was a new employee of less than 4 weeks. He further stated he had training on hand hygiene and infection control upon hire. On 9/29/25 at 12:41 PM, the IP provided documentation that the Business Office Manager had been training on infection control and hand hygiene upon hire on 9/8/25. In an interview with the Director of Nursing (DON) on 9/29/25 at 12:35 PM she stated the Business Office Manager should have set the lunch tray in a different location before donning gloves, moving the urinal, removing the gloves and performing hand hygiene before moving the tray to the overbed table and assisting with opening the milk carton and placing a straw in it. In an interview with the Administrator on 9/29/25 at 3:23 PM, she stated the business office manager should have set the lunch tray on a clean surface away from the urinal. She further stated he should have donned clean gloves, moved the urinal off of the overbed table, removed the gloves and performed hand hygiene	F0880		

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F0880 SS = D	Continued from page 33 before continuing to assist the resident with his lunch tray. The Administrator indicated cross-contamination could have occurred between the urinal and the milk carton and straw.	F0880		