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	345537	A. BUILDING _____ B. WING _____	C 03/07/2025

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PEAK RESOURCES-WILMINGTON, INC	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 3/3/2025 to 3/7/2025. The facility was found in compliance with requirement CFR.483.73 Emergency Preparedness. Event ID #9QT911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/3/2025 through 3/7/2025. The following intakes were investigated: NC00227956, NC00227958, NC00227315, NC00226737, NC00226314, NC00226255, NC00226292, NC00226125, NC00226017, NC00224142, and NC00224137. 9 of the 20 complaint allegations resulted in deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		4/3/25

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

Electronically Signed | 03/28/2025

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to treat residents in a dignified manner as evidenced by staff interactions with residents that included cursing, slamming doors and arguing with residents for 3 of 5 residents reviewed for dignity (Resident #26, Resident #54, and Resident #85). Findings included: 1. Resident #26 was admitted on 10/12/18. A review of Resident #26's annual Minimum Data Set (MDS) assessment dated 10/11/24 revealed resident was cognitively intact, had no behaviors, required assistance with bed mobility, transfers	F 550	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Resident Resident #26 remains in the facility and has not voiced any further concerns regarding any violation of resident rights. Certified Nursing Assistant (CNA) #5 received disciplinary action which included a documented initial verbal warning	

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F 550	Continued From page 2 and toileting and was non-ambulatory. a. Review of a grievance form dated 11/11/24 indicated a grievance was completed by the Director of Nursing (DON) on behalf of Resident #26. The form indicated an incident occurred on 11/11/24 during the 7:00 AM to 3:00 PM shift between Nursing Assistant (NA) #5, Resident #26 and her family member. The incident was witnessed by the DON. The form indicated that the DON was called to Resident #26's room by the family member. A typed statement attached to the form signed by the DON dated 11/11/24 indicated: the nurse alerted the DON that the family member wished to speak with a manager. The DON went to Resident #26's room and observed NA #5 was removing dirty linens from the room and the family member was removing gloves from her hands. The family member started to explain that upon her arrival to visit she walked into the room and noticed it smelled of urine. The family member expressed concern about Resident #26's care and asked NA #5 when Resident #26 last received incontinence care. The statement indicated that as the DON, the family member and Resident #26 were talking, NA #5 came back into the room and started arguing with the family member and Resident #26. The DON informed NA #5 that she was being rude and asked her to leave the room. The family member said something, NA #5 responded using curse words and left the room. The family member stated she did not want NA #5 to provide care to Resident #26 again. The investigation concluded that NA #5 was disrespectful to the family member and the resident. Corrective action was taken and indicated that NA #5 was not to provide care for Resident #26 again. Education was provided to	F 550	regarding acceptable standards of respect. She was educated by the Director of Nursing (DON) on customer service on 11/12/2024. CNA #5 does not provide care to Resident #26. The resident did not suffer any adverse effects from the alleged deficient practice. Resident #54 and Resident # 85 remain in the facility and have not voiced any further concerns regarding any violation of resident rights. CNA #1 received disciplinary action on 1/15/2025, which included suspension for two days. She was educated by DON on customer service on 1/23/2025. CNA #1 does not provide care to Resident #54 or Resident #85. Resident #54 and Resident # 85 did not suffer any adverse effects from the alleged deficient practice. Other Residents with potential to be affected The Administrator/designee reviewed grievances from November 2024 to March 26, 2025, to ensure that any concern voiced regarding resident rights violations were thoroughly investigated and corrected immediately. This was completed on 3/26/2025. There were no additional negative findings. No other resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes The Director of Nursing (DON), or designee will educate all staff on resident rights and customer service. This will be completed by 04/03/2025. Any staff out on leave or PRN status will be educated on this prior to returning to duty by the	

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F 550	Continued From page 3 NA #5 regarding customer service verbally on 11/11/24 and in writing on 11/12/24. Attempts to interview NA #5 on 3/6/25 and 3/7/25 at 9:00 AM were unsuccessful. Voice messages were left and text messages sent with no return call. An interview was conducted on 3/7/25 at 11:50 AM with Nurse #4 who was assigned to Resident #26 on 11/11/24. Nurse #4 indicated he was working on 11/11/24 from 7:00 AM to 3:00 PM when Resident #26's family member came to him (Nurse #4) and had care concerns for the resident. Nurse #4 stated the family member requested to talk to the DON. Nurse #4 stated he informed the DON, and she went to Resident #26's room to talk to the family member. Nurse #4 indicated he was not involved in the discussion that ensued. Nurse #4 stated he worked with NA #5 a few times and was not aware of any problems. An interview with the DON on 3/7/25 at 12:37 PM revealed she was informed on 11/11/24 by Nurse #4 that Resident #26's family member had concerns regarding the resident's care and requested to speak with her. The DON stated she went to Resident #26's room and observed NA #5 and the family member were completing the resident's care. The DON stated she observed NA #5 arguing with the family member and Resident #26. The DON indicated NA #5 cursed in front of Resident #26. The DON asked NA #5 to leave the room. The DON stated she did not think Resident #26 was affected by the altercation at the time, but she did not recall. The DON indicated NA #5 received a written warning regarding cursing and arguing with the family	F 550	DON/designee. This training is provided to all newly hired employees during orientation by the Staff Development Coordinator (SDC). This is also required education for all staff annually. Monitoring An audit tool was developed that includes the following: • Do you have any concerns about any violation of resident rights, including concerns with poor customer service? The Administrator or designee will interview 5 random residents or family members weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Any negative findings will be corrected immediately with identified staff. The results of these audits will determine the need for further monitoring. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement committee meeting by the Administrator for review and further recommendations. Date of completion: April 3, 2025	

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member and the resident. The DON stated she started in the position at the facility in late August of 2024 and she did not know NA #5 at the time of the incident. The DON stated she was not aware of any reports of other issues involving NA #5. The DON stated she was not sure why there were customer service issues with staff members and there seemed to be a pattern of issues. The DON indicated arguing with a resident and family member and cursing were not appropriate behaviors and did not demonstrate treating a resident with dignity and respect.

b. A review of a grievance reporting form dated 1/10/25 completed by Resident #26's family member stated an incident happened on the 11:00 PM to 7:00 AM shift on 1/9/25 involving Nursing Assistant (NA) #1. A description of the grievance indicated that the family member witnessed NA #1 being rude and arguing with the resident, the resident was not provided with good customer service and the NA was slamming doors. NA #1 had an attitude with the resident when asked to pick something from the floor, cursed at her, refused to pick up the item and left the room. The grievance was referred to the DON to investigate. The conclusion of the investigation was that NA #1 did not provide good customer service. The corrective action taken was that the NA was not to be assigned to the hallway that Resident #26 resided or in her room. The grievance reporting form indicated NA #1 received education regarding customer service and treatment of residents with dignity and respect. The form included no indication that other residents were interviewed to determine if they had experienced similar behaviors when NA #1 provided care.

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An interview was conducted with Resident #26 on 3/7/25 at 2:00 PM. Resident #26 stated she recalled the incident with NA #1 in January. Resident #26 stated that night, NA #1 came in and she was really mad. Resident #26 indicated she could tell NA #1 was mad because she kept slamming the door, she was rude and abrupt and refused to pick something up for her from on the floor. Resident #26 stated it upset her how NA #1 treated her.

An interview with the Administrator on 3/7/25 at 8:30 AM revealed that NA #1 received a verbal warning and education regarding customer service and was not to be assigned to Resident #26's room. The Administrator stated the facility was going through the process with NA #1 according to the facility human resources policy. The Administrator stated NA #1 did not treat Resident #26 with dignity and respect. The Administrator indicated that she expected that all residents would be treated with dignity and respect.

An interview conducted with the Director of Nursing on 3/7/25 at 9:00 AM indicated Resident #26's responsible party voiced a grievance that NA #1 was rude and disrespectful on the 11:00 PM to 7:00 AM shift on 1/9/25. The DON stated she interviewed NA #1 as part of the investigation and NA #1 stated she did not think she (NA #1) was rude. The DON stated NA #1 can be abrasive and can come across as not very nice. The DON stated she did not want to say it was just the NA's personality to not be nice, but maybe that was the problem. The DON indicated she (the DON) started in the position in August 2024, she had not gotten to know NA #1 and was not familiar with the care she provided. The DON

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stated that a few days after this incident there was an incident with another resident (Resident #54) and NA #1, and this indicated there was a pattern of concerns with this NA. The DON stated NA #1 was not written up for this incident on 1/9/25 and was not suspended for this incident. The DON indicated she addressed the issue as a customer service issue not an abuse issue. The DON indicated she interviewed some of the nurses that work the 11:00 PM to 7:00 AM shift and they did not report a concern regarding NA #1. The DON stated she thought there was training on the computer regarding customer service, but she did not know how often it was required. The DON stated the facility conducted a monthly meeting that was mandatory, and customer service was discussed but staff didn't always attend. NA #1 did not attend the meeting in February. There were two halls that NA #1 was not allowed to work on. The DON stated the facility was progressing through the steps of the human resources process to address the issues with this NA. The DON indicated she interviewed some residents following the incidents with NA #1 but did not record this information. The DON stated it was not appropriate for NA #1 to curse at or in front of a resident, to be rude or refuse to provide care.

An interview was conducted with the NA #1 on 3/7/25 at 10:30 AM. NA #1 confirmed she was assigned to Resident #26 on 1/9/25 from 11:00 PM to 7:00 AM. NA #1 indicated the DON never talked to her about an incident with Resident # 26 or any other resident. NA #1 stated she did not recall any problems with Resident #26 and was assigned to her a few weeks ago. NA #1 stated she did not recall having any education in January regarding customer service. NA #1 stated she

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might have had an online in-service regarding customer service and resident rights a few months ago but she did not recall.

A telephone interview was conducted with Nurse #3 on 3/7/25 at 1:35 PM. Nurse #3 indicated he was working on the 11:00 PM to 7:00 AM shift on 1/9/25 when the incident occurred between Resident #26 and NA #1. Nurse #3 stated there were incidents with other residents and NA #1 prior to this incident. Nurse #3 stated he was aware there was another resident that requested to not have NA #1 provide her care due to her attitude. Nurse #3 stated he had witnessed episodes including the night of 1/9/25 in which NA #1 was argumentative and rude to Resident #26, but he had not reported the incidents because he did not realize it was a dignity issue.

An interview was conducted with Nurse #1 on 3/7/25 at 10:05 AM. Nurse #1 stated she worked 11:00 PM to 7:00 AM shift sometimes and worked with NA # 1. Nurse #1 indicated NA #1 was thorough with her work but was not friendly and came across as rude sometimes.

2. A grievance reporting form dated 1/15/2025 completed by Director of Nursing (DON) stated an incident happened on the 11:00 P.M. to 7 A.M. shift on 1/14/2025 involving Nurse Assistant (NA) #1 and Resident #54 and Resident #85. A description of the grievance indicated NA #1 was speaking rudely to the resident, slamming doors, and slamming water cups on the table. She didn't change the resident when she came into the room. The grievance was investigated by the DON. The conclusion of the investigation was that NA #1 didn't provide good customer service. The corrective action taken was that NA #1 was

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suspended pending an investigation, education, and she was not to take care of Residents #54 and #85. The grievance reporting form indicated NA #1 had received education regarding customer service and treatment of residents with dignity and respect. The form included no indication that other residents were interviewed to determine if they had experienced similar behaviors when NA #1 was assigned to their care.

a. Resident #54 was admitted to the facility on 8/12/2024.

The quarterly Minimum Data Set (MDS) assessment for Resident #54 dated 11/15/2024 revealed she was cognitively intact, had no behaviors, and required assistance of staff with toileting, bed mobility, and transfers. She was coded for using a walker and a wheelchair for mobility.

An interview was completed with Resident #54 on 3/7/2025 at 8:20 A.M. Resident #54 stated she recalled the incident that occurred with NA #1 on the 11:00 P.M. to 7:00 A.M shift on 1/14/2025. She further stated that NA #1 seemed mad when she came into her room to change her that night, because she turned on both bright lights, was being loud, cursing and slamming things around. Resident #54 stated she had asked NA #1 to pick something up off the floor for her and that NA #1 had started cursing and yelling at her and said she wasn't going to change her and left slamming the door. She stated that it made her feel bad and like there was something "wrong with her" for NA #1 to act that way. Resident #54 stated she couldn't understand why NA #1 would treat her like that and it made her feel sad. She indicated

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that she told the Medication Aid (MA) on the 7:00 A.M. to 3:00 P.M. shift about the incident and the DON came and filled out the grievance for her.

b. Resident #85 was admitted to the facility 8/27/2024.

The quarterly MDS assessment for Resident #85 dated 12/4/2024 revealed Resident #85 was cognitively intact.

An interview was conducted with Resident #54's roommate, Resident #85, on 3/7/2025 at 8:27 A.M. Resident #85 stated that on 1/14/2025 at 4:00 A.M when NA #1 came into the room to change Resident #54 she was being very loud and cursing. She further stated that NA #1 slammed Resident #54's bedside table against the wall and her (Resident #54) pink plastic water cup had fallen off and broke. Resident #85 indicated that NA #1 was mad and left the room without changing Resident #54. She stated when NA #1 was acting that way it made her feel like she didn't have any rights.

An interview was completed with Medication Aid (MA) #1 on 3/7/2025 at 8:35 A.M. MA #1 stated that on 1/14/2025 both Resident #54 and Resident #85 had complained to her about NA #1 being rude. She further stated that Resident #85 had shared that NA #1 was rude and slamming doors. MA #1 indicated she had informed the DON, and she said she would handle it.

A facility employee action form-performance for NA #1 indicated NA#1 was written up and suspended on 1/15/2025 for residents' complaints of poor attitude, slamming doors, slamming cups on table, and not picking up something from the

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floor when asked. It was noted on the form that NA #1 was suspended from 1/15/20205 through 1/17/2025 and that she refused to sign the form.

A telephone interview was completed with NA #1 on 3/7/2025 at 10:13 A.M. NA #1 stated that she had worked at the facility for 3 years. She further stated that when she was suspended the DON had told her she was being accused of being rude and slamming things. NA #1 indicated that she was not allowed to go in Resident #54's and Resident #85's room anymore. She further indicated she could not recall ever having an incident with Resident #54 or Resident #85. NA #1 stated she could not recall receiving any customer service education but that she had received education on dignity, respect, and abuse. She further stated most of the education provided was through online healthcare training.

An interview was completed with the DON on 3/7/2025 at 09:00 A.M. The DON stated that when the incident occurred between NA #1 and Resident #54 in the presence of Resident #85 on 1/14/2025, there had already been a prior event just a few days before involving the same allegations with another resident (Resident #26). She further stated that NA #1 was written up for the first incident but received a 2-day suspension for the incident involving Resident #54 because it was starting to be a pattern. The DON indicated that NA #1 was suspended for poor customer service, for speaking rudely and being loud, slamming doors, and not changing the resident. She further indicated that NA #1 refused to sign the employee action performance form. The DON explained NA #1 was not a friendly type person and could come across as abrasive at times. The DON stated that customer service was a topic

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F 550	Continued From page 11 they focused on at the monthly staff meetings, and that was covered in the online healthcare training provided by the facility. An interview was completed with the Administrator on 3/7/2025 at 9:45 A.M. The Administrator stated that NA #1 was suspended for her poor customer service and rude behavior. She further stated when a disciplinary issue arose with a staff member, the facility followed the procedure outlined in the employee handbook, verbal counseling, written warning, suspension, and termination. The Administrator indicated that she considered being rude, loud, and slamming doors a customer service issue. She further indicated that she expected the residents to be treated with dignity and respect.	F 550		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/30/25

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PEAK RESOURCES-WILMINGTON, INC	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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F 584	Continued From page 12 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and residents, the facility failed to provide a clean, homelike environment for 4 resident rooms on 2 of 5 halls reviewed for the environment (200 hall and 300 hall). Findings: Review of the resident council meeting minutes revealed the minutes dated 12/10/24 indicated a concern of resident rooms were not clean. a. The following observations were made of Room 316: On 3/3/25 at 12:00 PM Observation of Bed 2	F 584	F 584 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Resident Room 316: The nightstand for Bed 1 was replaced and both dressers in the room were replaced on 3/27/2025 by the Maintenance Director. The debris under	

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F 584	Continued From page 13 revealed the top of the nightstand was cluttered and dirty with a sticky substance and an unwrapped cough drop was stuck to the top. Scratches were observed on the front of the nightstand. The floor under Bed 2 and around the bed was observed with cough drop wrappers, food and other debris. The dressers for both residents in the room had scratches and the drawers did not fully close. The privacy curtain was observed with scattered orange food stains. Observation of Bed 1 revealed the nightstand was scratched and cluttered, and a recliner chair was piled with pillows and linens. A bag of incontinence pads was observed on the floor. On 3/4/25 at 2:15 PM. Room 316 Beds 1 and 2. The dressers in the room had scratches and the drawers did not fully close. A recliner chair piled with pillows and linens was observed beside the resident in Bed 1. The floor underneath and around Bed 2 was observed with cough drop wrappers, food and other debris. The nightstand was cluttered with multiple tubes and bottles of creams and lotions, the drawers of the nightstand would not close The privacy curtain was observed with stains. A bag of incontinence pads was observed on the floor. On 3/5/25 at 1:30 PM Room 316. Beds 1 and 2. The dressers in the room had scratches and the drawers did not fully close. A recliner chair piled with pillows and linens was observed beside the resident in Bed 1. The floor underneath and around Bed 2 was observed with cough drop wrappers, food and other debris. The nightstand was cluttered with multiple tubes and bottles of creams and lotions, the drawers of the nightstand would not close The privacy curtain was observed with stains. A bag of incontinence pads was	F 584	bed 2 was swept, the linen was removed from the recliner chair and the bag of incontinence pads were removed from the room by the housekeeping staff on 3/7/2025. The privacy curtain was changed by housekeeping staff on 3/7/2025. Room 316-2 has a care plan in place as of 12/11/2024 that she has a behavior of throwing items on the floor instead of the trash can. This resident also has a behavior care planned as of 3/3/2025 of having an excessive number of personal items in the room. Room 307: Soiled linen was removed from the bathroom by facility staff on 3/7/2025. The debris under bed was swept, the floor and bedrails cleaned by the housekeeping staff on 3/7/2025. All the clutter was removed from the nightstand and the bedside table by facility staff on 3/28/2025. The dressers were replaced by the Maintenance Director on 3/28/2025. The rolling walker and recliner were removed from the room with the resident's permission on 3/24/2025 by the Administrator and Director of Nursing. Room 314: The black marks on the wall beside the bed were removed by the Administrator. The overbed table was cleaned by housekeeping staff on 3/7/2025. Room 208: The floor was cleaned by housekeeping staff on 3/7/2025, and the black marks were removed from the wall beside the bed by the maintenance director on 3/28/2025. Other Residents with potential to be affected	

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F 584	Continued From page 14 observed on the floor. On 3/6/25 at 1:45 PM Room 316. Beds 1 and 2. The dressers in the room had scratches and the drawers did not fully close. A recliner chair piled with pillows and linens was observed beside the resident in Bed 1. The floor underneath and around Bed 2 was observed with cough drop wrappers, food and other debris. The nightstand was cluttered with multiple tubes and bottles of creams and lotions, the drawers of the nightstand would not close The privacy curtain was observed with stains. A bag of incontinence pads was observed on the floor. b. The following observations were made of Room 307: On 3/3/25 at 12:15 PM. Soiled towels were observed on the floor in the bathroom. A soiled brief was noted on top of the plastic cabinet in the bathroom. A green plastic soda cap was observed under the bed by the wall. The bed rails were visibly dirty and sticky. The bedside table was cluttered with bottles of lotion and tubes of cream. There were scratches on the dressers. A recliner chair was piled with bed linens, pillows and personal items. A rollator (a rolling walker with a seat) was piled with personal items in the corner of the room by the window. The resident in the window bed was not ambulatory. On 3/4/25 at 2:45 PM. The bedside table was observed to be cluttered with bottles of lotion and tubes of cream. The front of the dressers were scratched. The floor in the room was dirty with a white substance observed and various food debris and trash. A soda bottle cap was observed on the floor under the bed by the wall,	F 584	On 3/28/2025, the Maintenance Director completed an observational inspection of resident rooms to identify cabinetry that required repair or replacement and inspected the walls to identify any black marks that require cleaning or the wall repainted. Repairs or replacements will occur on a schedule until all cabinetry is replaced or repaired and the walls cleaned or painted. The Housekeeping Supervisor completed observational rounds to ensure floors in resident rooms were clean and free of spills and there was no soiled linen and briefs in the room. No additional concerns observed. This was completed on 3/28/2025. Systemic Changes The Administrator will educate the Maintenance Director that all rooms will be observed on a schedule to observe for any furniture that needs repair or replacement. This will be completed by 3/27/2025. The Staff Development Coordinator (SDC)/designee will provide education to nursing staff on how to properly dispose of soiled briefs as well as how to properly remove soiled linen after use. This will be completed by 3/28/2025. The Housekeeping Manager will provide education to housekeeping staff on the following topics: • Changing privacy curtains/privacy curtain cleaning schedule • Bed rail cleaning procedure • Tray table cleaning procedure	

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F 584	Continued From page 15 an empty plastic medication cup and a plastic drinking cup were observed. An empty soda bottle was on the floor next to the bed. A recliner chair was piled with bed linens, pillows and personal items. A rollator piled with personal items was observed in the corner by the window bed. The resident in the window bed is not ambulatory. On 3/5/25 at 1:30 PM: The bedside table was observed to be cluttered with bottles of lotion and tubes of cream and the front of the dressers were scratched. The green soda cap was by the wall, an empty plastic medication cup and a plastic drinking cup were observed. An empty soda bottle was on the floor next to the bed. Items were piled in the recliner chair including bed linens, pillows and personal items. The unused rollator was in the corner piled with items. On 3/6/25 at 1:45 PM. The bedside table was observed to be cluttered with bottles of lotions and tubes of cream and the front of the dressers were scratched. The same green bottle cap was in the same place under the bed as it had been the past 3 days. The plastic cup and plastic medicine cup were observed in the same place under the resident's bed. The over bed table was covered in sticky substance. c. The following observations were made of Room 314: On 3/3/25 at 12:20 PM. Black marks were observed on the wall beside the bed and the overbed table was observed with a sticky substance. On 3/4/25 at 2:20 PM. Black marks were	F 584	• Floor cleaning procedure This will be completed by 3/28/2025 Monitoring An audit tool will be completed by 3/28/2025 and includes the following: • 5% of facility privacy curtains will be examined by management to ensure cleanliness weekly x4, biweekly x4, monthly x1. • 5% of facility bed rails will be examined by management to ensure cleanliness weekly x4, biweekly x4, monthly x1. • 5% of facility tray tables will be examined by management to ensure cleanliness weekly x4, biweekly x4, monthly x1. • 5% of resident room floors will be examined by management to ensure they are not sticky weekly x4, biweekly x4, monthly x1. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement committee meeting by the Administrator for review and further recommendations. Date of completion: March 30, 2025	

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observed on the wall beside the bed and the overbed table was covered with a sticky substance.

On 3/5/25 at 1:45 PM. Black marks were observed on the wall beside the bed and the overbed table was covered with a sticky substance.

d. An observation of Room 208 and interview with the resident representative was conducted on 3/3/25 at 11:45 AM and revealed the floor was dirty and sticky. The resident representative stated the room did not get cleaned regularly and the floor needed to be swept and mopped more frequently.

An interview on 3/03/25 at 2:41 PM with Resident #28 in Room 314 revealed there were black marks on the wall beside the bed. Resident #28 stated her room was cleaned every 3 days. Resident #28 stated she tried to not get her room too dirty since it doesn't get cleaned that often and she tries to clean up for herself as much as she can.

Interviews were conducted with Housekeepers #1 and #2 on 3/4/25 at 9:30 AM. Housekeepers #1 and #2 stated all rooms were supposed to be cleaned daily but sometimes when there are call outs or someone was scheduled to be off, they were not able to clean all the rooms. Housekeepers #1 and #2 stated the facility was usually staffed with 3 housekeepers and a floor technician. Housekeeper #1 and #2 stated even when they were fully staffed, it was hard to get everything done as they were assigned 20 or more resident rooms plus the common areas and offices. Housekeepers #1 and #2 stated they

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completed the 5 steps of cleaning resident rooms which consisted of empty trash, clean the horizontal surfaces, spot clean the vertical surfaces, dust mop and damp mop the room.

An interview was conducted with the Housekeeping Account Manager on 3/5/25 at 10:00 AM. The Account Manager stated she was the manager of the housekeeping department. The Account Manager stated the housekeeping department was fully staffed with 10 employees. The Account Manager indicated the facility was staffed with 3 housekeepers and a floor technician daily. The Account Manager indicated all resident rooms were to be cleaned daily as well as the common areas. The Account Manager indicated she was in the position with the contracted company in the facility for the past 8 months. The Account Manager indicated she completed daily rounds to spot check random rooms for cleanliness and she had found that rooms were not always done per standard. The Account Manager stated she brought it to the assigned staff member's attention when she found rooms not meeting the standard. The Account Manager stated she had new staff members and had call outs which impacted on the cleaning of the rooms. The Account Manager indicated she received some grievances recently regarding the cleanliness of the facility and was trying to address them. The Account Manager stated she expected the following to be completed in each room: empty the trash, clean the trash can, put in extra bags, disinfect the horizontal surfaces including door knobs, air conditioner, light fixtures, disinfect the vertical surfaces including the walls, dust and damp mop the floors. Each housekeeper was assigned approximately 20 rooms per day plus cleaning of

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F 584	Continued From page 18	F 584		

the common areas and the offices.

An interview was conducted with the Unit Manager on 3/5/25 at 11:45 AM. The Unit Manager stated he assumed that the rooms were cleaned daily or at least every other day. The Unit Manager indicated it was a team effort to keep rooms clean and clutter free, but he did not know who should clean the rooms of spills or trash when housekeeping was not available or who removed no longer used medical equipment from rooms. The Unit Manager stated the managers were assigned rooms to complete concierge rounds daily which consisted of observing the cleanliness of the rooms.

A resident council meeting was held on 3/5/25 at 1:30 PM as part of the recertification survey process. The resident council meeting included a sample of cognitively intact residents. The residents in attendance at the meeting stated the cleanliness of the rooms was improving but the floors in their rooms were often sticky.

A follow-up interview and observation of Room 307 was completed with the Housekeeping Account Manager on 3/6/25 at 2:20 PM. The Housekeeping Account Manager stated there was an issue with clutter in the rooms and the facility planned on working on this. The Housekeeping Account Manager indicated the privacy curtains were supposed to be cleaned monthly and as needed. The Housekeepers were expected to check the privacy curtains daily and if soiled replace it. The Housekeeping Account Manager stated the housekeepers can't clean the surfaces in the rooms due to the clutter and they don't think they can move anything in the rooms.

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F 584	Continued From page 19 An interview with the Administrator on 3/7/25 at 2:30 PM revealed that she expected that resident rooms would be clean, homelike and clutter free. The Administrator stated that the scratched furniture should be addressed.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and Physician Assistant (PA), the facility failed to protect the resident's right to be free from physical abuse when the resident reported pain during care and the Nurse Aide (NA) willfully disregarded the resident's complaint and continued to provide care to the resident despite the NA's knowledge that she was hurting the resident. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #25). The findings included:	F 600	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected resident NA #6 that provided care to resident #25 was terminated on 11/13/2024 after	3/30/25

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F 600	Continued From page 20 Resident # 25 was admitted to the facility on 08/31/21 with diagnoses including [a condition where there is partial paralysis of all four limbs], chronic pain, anxiety, and neuromuscular dysfunction (a problem with the nerves that control muscles and communication between them, resulting in muscle weakness, fatigue, and loss of function). Resident #25's care plan included a problem area (initiated on 09/09/21) of an activities of daily living (ADL) deficit related to [a condition where there is partial paralysis of all four limbs]. The interventions included to ensure effective pain management prior to ADL activity (initiated on 09/09/21). The care plan also included the problem area (initiated on 09/09/21) of potential pain related to chronic pain. The interventions included handle the resident gently (initiated 09/09/2021) and position resident for comfort (initiated 09/09/21). Resident #25's quarterly Minimum Data Set (MDS) assessment dated 10/31/24 indicated her cognition was fully intact. She had no behaviors and no rejection of care. She had functional limitations with range of motion on both sides of her upper and lower extremities and required assistance with toileting hygiene, personal hygiene, bathing and bed mobility. Resident #25 received routine and as needed pain medication and experienced moderate pain frequently. She was administered opioid medication. The facility's 5-day investigation report completed by the Administrator and submitted to the state on 11/13/24 indicated the facility was made aware of an abuse allegation on 11/08/24 at 11:00 AM for an incident that occurred on 11/03/24 involving	F 600	disregarding the resident's complaint while providing care. The resident did not suffer any adverse effects related to the alleged deficient practice. Other Residents with potential to be affected The Administrator will interview all alert and oriented residents regarding any concerns with resident care and/or customer service. Any negative findings will be investigated immediately and appropriate actions completed. This will be completed by 3/28/2025. Skin assessments will be conducted by the Director of Nursing/designee on non-interviewable residents' facility wide to observe any signs of resident abuse. Any negative findings will be investigated immediately and appropriate actions completed. This will be completed by 3/28/2025. Systemic Changes The Staff Development Coordinator (SDC) /designee will provide education to all facility staff on abuse, neglect, and exploitation. This will be completed by 3/30/2025. Any staff out on leave or PRN status will be educated on this prior to returning to duty by the SDC/designee. This education is completed upon hire by the SDC, annually using online education system and when necessary, by the SDC. Monitoring	

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F 600	Continued From page 21 NA #6 and Resident #25. The abuse allegation summary indicated Resident #25 requested a grievance after receiving care from NA #6 that she described as rough. The resident reported that she complained of pain and discomfort during the care and NA #6 ignored her requests to stop and kept providing care. NA #6 stated that she heard the resident tell her that she was being rough and was in pain but continued to provide the care anyway. NA #6 did not provide any reason for continuing to provide care to Resident #25 despite being asked to stop. NA #6 was placed on leave on 11/08/24 for the facility to complete an investigation of the incident and was terminated on 11/13/24. A typed statement completed by the Director of Nursing (DON) dated 11/08/24 indicated she (the DON) spoke with NA #6 regarding Resident #25's statement. The NA stated she did provide care for the resident in question on the weekend. When asked if the resident told her that she was hurting her while providing care, NA #6 replied, "Yes, I did hear her say that." When asked what she did after hearing the resident say that, NA #6 replied, "I continued to finish performing care." NA #6 stated she did not respond to the resident after hearing her say she (NA #6) hurt her. The DON explained to NA #6 that if a resident says that she is hurting during care, then she needs to stop doing what she is doing and re-evaluate how to do the care." An interview was conducted on 03/07/25 at 12:45 PM with Resident #25. She said on 11/03/24 around 10:30 AM NA #6 gave her a bath and provided incontinence care and was rough while providing the care. Resident #25 said NA #6 pushed on her back and side while turning and	F 600	The DON/SDC/designee will conduct interviews with residents using Resident Questionnaire tool for allegations of abuse. 5% of resident population will be audited weekly x4, biweekly x4, monthly x1. Any negative findings will be investigated immediately. Weekly skin assessments will continue to be completed by nursing staff for any signs of abuse. Any negative findings will be investigated immediately. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement committee meeting by the DON for review and further recommendations. Date of completion: March 30, 2025	

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cleaning her, and it hurt. Resident #25 said she told NA #6 to stop, that it was hurting, but NA #6 did not stop. Resident #25 said her pain was mostly on her backside. She said she had chronic pain in her back, but after the bath and incontinence care, she had increased pain but had no bruise or injury. She said she was not scared or tearful and had no physical or emotional injuries. She indicated she was just concerned that the NA did not stop when she was asked to stop multiple times.

An interview was attempted with Nurse Aide #6, but she was not available for interview.

An interview was conducted on 03/07/25 at 10:00 AM with the Physician Assistant (PA) and Administrator. Both stated on 11/3/24 NA #6 should have stopped Resident #25's ADL care when the resident complained of pain and told the nursing aide to stop. The Administrator said NA #6 did not stop ADL care when the resident asked her to stop. The Administrator indicated she asked NA #6 why she did not stop, she gave no answer.

An interview was conducted on 03/07/25 at 1:00 PM with the DON. She stated on 11/03/24, NA #6 should have stopped incontinence care immediately when asked to stop and she did not.

The facility provided a corrective action plan that was not acceptable to the State Agency. When identifying other residents who had the potential to be affected by the deficient practice, the facility completed resident interviews only with alert and oriented residents on NA #6's assignment. The facility did not consider that all residents had the potential to be affected by abuse and did not

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F 600	Continued From page 23 interview all alert and oriented residents in the facility to ensure no other residents had been affected by the same deficient practice. The facility provided education on abuse and behaviors only to nursing staff. Other facility staff, to include therapy staff who provided hands on resident care and had the potential to encounter residents who refused care, were not provided with education. Additionally, the facility's monitoring audits did not include any observations of care.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		4/3/25

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F 656	Continued From page 24 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 interviews with staff and Physician Assistant, the facility failed to follow the plan of care for 2 staff members to assist with activities for daily living (ADL) for 1 of 4 residents (Resident #25) whose care plans were reviewed. The findings included: Resident # 25 was admitted to the facility on 08/31/21 with diagnoses including [a condition where there is partial paralysis of all four limbs], chronic pain, anxiety, and neuromuscular dysfunction (a problem with the nerves that control muscles and communication between them, resulting in muscle weakness, fatigue, and loss of function).	F 656	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected resident NA #6 was terminated after this event took place and resident did not suffer any adverse effects. Other Residents with potential to be affected The Director of Nursing (DON) will review	

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F 656	Continued From page 25 Resident #25's care plan initiated on 12/12/23 included a focus area of activities of daily living (ADL) deficit related to [a condition where there is partial paralysis of all four limbs]. A care plan intervention included Resident #25 required 2 or more staff members for care at all times. Resident #25's Minimum Data Set (MDS) assessment dated 10/31/24 revealed she had no cognitive impairments and needed substantial to maximum assistance for personal hygiene. An interview was conducted on 03/07/25 at 12:45 PM with Resident #25. She said on 11/03/24 NA #6 was alone when she performed resident's ADL care and repositioning, and that there should have been two NAs who changed her and turned her. A brief description of Resident #25's grievance interview dated 11/08/24 from the Director of Nursing (DON) revealed she spoke with Nurse Aide (NA) #6 regarding Resident #25's statement about being treated roughly by NA #6 during her personal care on 11/03/24. NA #6 stated she did provide care for the resident in question on the weekend. I asked her how many people were in the room providing care during this time. She stated, "it was just me." I explained to NA #6 that the resident had a care plan for 2-people to provide care and that she needed to have a second person with her. NA #6 responded with an okay. An interview was conducted on 03/06/25 at 3:15 PM. with Nurse #5 during which she stated on 11/03/24, NA #6 who provided the bath and ADL care for Resident #25 should not have done it	F 656	all residents profiles to ensure that the profile contains the care needs required of the resident based on the comprehensive care plan. Any discrepancies will be corrected immediately by the DON/designee. This will be completed by 3/28/2025. Systemic Changes All Certified Nursing Assistants will be educated by the Staff Development Coordinator (SDC) or designee on how to review the resident's profile to review the care needs required by the resident. This will be completed by 4/03/2025. Any staff out on leave or PRN status will be educated on this prior to returning to duty by the SDC/designee. Education is provided to all newly hired Certified Nursing Assistants by the SDC during the orientation process Monitoring An audit tool was developed to monitor compliance with comprehensive care plan. The DON/SDC/designee will complete these audits. The audit tool contains the following: • Whether staff are following the resident profile and are providing care as directed by the comprehensive care plan This will be completed on 5 employees weekly x4, biweekly x4, monthly x1. The results of these audits will be brought to the monthly Quality Assurance	

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F 656	Continued From page 26 alone. Nurse #5 added per the resident's care plan stated Resident #25 required 2 staff for all care. Nurse #5 also stated, whenever care was provided to Resident #25, there should always be 2 staff present, and there wasn't. An interview was not conducted with NA#6 due to being unavailable to interview. An interview was conducted on 03/07/25 at 1:00 PM. with the DON. She stated on 11/03/24 there should not have been only one NA giving Resident #25 ADL care, and that there should have been 2 NAs per resident's care plan. An interview was conducted on 03/07/25 at 10:00 AM with the Physician Assistant (PA) and Administrator. They stated per Resident #25's care plan there should have been two nursing aides assisting with her care, not just NA #6.	F 656	Performance Improvement committee meeting by the DON x 3 months for review and further recommendations. Date of completion: April 3, 2025	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide supervision to Resident #44, a severely cognitively impaired resident, who was inadvertently let out of the facility by some visiting	F 689	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was	4/3/25

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F 689	Continued From page 27 children, who held the front door open preventing the wander guard system from locking the door, and she exited the building. The resident was outside without staff knowledge for approximately 5 minutes, where she self-propelled her wheelchair to the curb cut for wheelchairs leading to the parking lot, and overturned hitting her head, resulting in her having to be transported by emergency medical services (EMS) to the emergency department for evaluation and treatment. This deficient practice was identified for 1 of 4 residents reviewed for supervision to prevent accidents. The findings included: Resident #44 was admitted to the facility on 1/5/2023 with diagnoses to include cognitive communication deficit and unspecified dementia with agitation. A physician's order dated 10/2/2024 for Resident #44 was to check for wander guard placement on resident and to test the battery every shift and to check wander guard expiration date and replace prior to expiration date. The quarterly Minimum Data Set (MDS) dated 1/20/2025 indicated Resident #44 was severely cognitively impaired. She was coded for using a wheelchair for mobility and being dependent on staff for transfers to wheelchair. Resident #44 was not coded for wandering behavior or for wearing a wander guard. The care plan for Resident #44 initiated on 1/5/2023 and reviewed on 1/19/2025 revealed a plan of care for cognitive loss/ dementia-resident has a history of alteration in cognitive	F 689	cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected resident Resident #44 remains in the facility and did not suffer any sustained adverse effects related to the alleged deficient practice. Resident is care planned for wandering behaviors. Other Residents with potential to be affected All residents with wandering potential in the facility have the potential to be affected. The Director of Nursing reviewed all residents with wandering potential to ensure that that no other resident was identified as having left the facility without staff knowledge. This was completed on 3/26/2025 and no other residents were affected by the alleged deficient practice. Systemic Changes All facility staff will be educated on the facility wandering and elopement policy to ensure residents who have wandering/elopement potential are safe. The licensed nursing staff will be educated on the facility protocol of completing a wandering/elopement assessment on all residents quarterly and as needed to determine wandering/elopement status. This will be completed by the Administrator, Staff Development Coordinator and/or	

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F 689	Continued From page 28 function/dementia or impaired thought processes related to dementia with a goal of being able to communicate basic needs on a daily basis for the next 90 days. Interventions included to ask yes/no questions in order to determine the resident's needs and cue, reorient, and supervise as needed. The care plan included resident experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety, resident is difficult to redirect) with a goal for her to not injure/harm- self secondary to wandering for next 90 days. Interventions included to assure resident has proper fitting and appropriate foot attire; to equip resident with a device that alarms when she wanders close to exit doors; check for proper functioning of device daily; and check placement every shift. Review of the February Medication Administration Record (MAR) for Resident #44 revealed on 2/14/2025 on the 3:00 PM-11:00 PM shift Nurse #14 documented the wander guard was on Resident #44's right ankle and the battery was working. A nurses' progress note written by Nurse #14 on 2/14/2025 at 8:59 P.M. read in part, "Resident observed on ground after attempting to exit facility in wheelchair without assistance. Had previously propelled self in wheelchair from door to door in facility on multiple occasions this shift; stating she was "leaving and going back to Glenn Falls." Redirection by this writer and other staff of multiple attempts without success; resident setting off multiple facility door alarms from wader guard. Children exiting facility during her many attempts to leave inadvertently assisted resident out front door by mistake, which resulted in resident sustaining a fall out of her wheelchair	F 689	designee by 3/30/2025. Any facility staff out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and any contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee. All alert and oriented residents will be notified orally and by posting and all resident contacts will be informed via letter of facility elopement policy and ask them not to open doors for any resident allowing for an exit without verifying with facility staff that resident is permitted to exit. This will be completed by 4/3/2025. A sign was posted by all exits reminding visitors not to let residents exit the facility without staff awareness. This was completed on 4/3/2025. Monitoring An audit tool was developed to monitor wandering/elopement to ensure that all residents who have wandering/elopement potential are safe. Audit tool consists of the following: • Resident wandering/elopement assessment was completed on admission, quarterly and prn • Resident wanderguard is working properly • Facility recommendations from IDT with wandering/elopement are being followed • Elopement book is updated to include	

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F 689	Continued From page 29 onto the ground; resulting in laceration to right scalp just above ear. Neuro checks within normal limits, 911 activated. Healthcare Provider notified via on call as well as resident's Responsible Party (RP) and also the Director of Nursing. Transferred to the emergency department for further evaluation and treatment. No acute distress upon departure from this facility. Respirations even and unlabored. Moves all extremities without complaints of pain. Remains at baseline. Scalp wound covered with compression bandage to control bleeding. Hemostasis achieved by the time of paramedics' arrival. Resident was alert and talking. Denied pain or discomfort at that time. Report to oncoming as well." A Fall Report completed by Nurse #14 dated 2/14/2025 at 8:44 P.M. revealed Resident #44 was found outside on facility grounds lying on the pavement. She was noted to have a laceration to the right side of her scalp, just above the ear. Resident #44 was alert, and she was not complaining of pain. A possible contributing factor was listed as dementia/progressive cognitive decline. The interventions for Resident #44 listed direct pressure to wound and transferred to the hospital emergency department. A telephone interview was completed with Nurse #14 on 3/6/20205 at 4:17 P.M. Nurse #14 stated that on 2/14/2025 she was working the 3:00 P.M. to 11:00 PM shift. She further stated Resident #44 was very active in her wheelchair that night and was going from door to door in the facility trying to exit and was setting off the wander guard door alarms. She further stated that she was chasing Resident #44 all evening trying to redirect her away from the doors. Nurse #14 indicated	F 689	resident information d/t high risk for wandering/elopement The audit was initiated on 3/28/2025. The Director of Nursing, and/or designee will audit 100% of all high risk wandering/elopement residents weekly x 4 weeks, then 50% biweekly x 4 weeks, then monthly x 1 month. The need for further monitoring will be determined by the prior month of auditing. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement committee meeting monthly by the DON x 3 months for review and further recommendations. Date of completion: April 3, 2025	

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that she had retrieved Resident #44 each time she had set off the door alarms that evening. She further indicated that at around 7:30 P.M. as she was starting her medication pass, she had noticed 2 young girls approximately 10 years old to 12 years old exiting the facility. Nurse #14 stated that about 5 minutes after she noticed the girls leaving, they had come running back into the facility stating a resident was outside on the ground. She stated the young girls must have held the door open for Resident #44, because otherwise the doors would have locked when she got too close, and the alarms would have continued to go off. Nurse #14 indicated the alarms were not going off when Resident #44 was found outside in front of the facility at the end of the sidewalk in the yellow area for wheelchair access to the parking lot. She stated that Resident #44 was lying on her right side and there was blood coming from a laceration on her scalp. Nurse #14 stated it was dark outside but there were lights in the parking lot, so she was able to assess the resident. She stated she left Resident #44 outside with Nursing Assistant (NA) #9, and she ran to call 911, and notify the provider and the Responsible Party (RP). Nurse #14 indicated the Nursing Supervisor was outside administering first aid to Resident #44 while she was notifying everyone.

The emergency department encounter note written by the Emergency Department Physician on 2/14/2025 read in part that Resident #44 was brought to the hospital by ambulance for an unwitnessed fall. She was found in the parking lot of the nursing facility, and it was unknown if she had a loss of consciousness, no blood thinners, and she was not in any acute pain. The report further read that Resident #44 sustained a 1

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centimeter (cm) jagged abrasion to forehead and it was repaired with 4 steri strips. Computed tomography (CT) scans of the head and neck were completed for Resident #44 with no evidence of intracranial pathology, fracture, or malalignment. Resident #44 was diagnosed with a urinary tract infection and discharged back to the facility on 2/15/2025.

A telephone interview was completed with Nursing Assistant (NA) #9 on 3/7/2025 at 10:07 AM. NA #9 stated that Resident #44 managed to get outside on 2/14/2025 because some young girls held the door open for her. She further stated that she ran outside with Nurse #14 when the children came running back into the facility and stated a resident was outside lying on the ground. NA #9 indicated Resident #44 was found outside at the end of the sidewalk that leads to the parking lot. She further indicated that Resident #44 was bleeding from her head and that the Unit Supervisor came outside and was applying pressure and a dressing to the wound. NA #9 stated that she and the Unit Supervisor waited with Resident #44 until EMS arrived and took her to the emergency department.

An interview was conducted with the Nursing Supervisor on 3/5/2025 at 3:50 P.M. The Unit Supervisor explained that on 2/14/2025 at around 7:30 P.M. someone came and told her Nurse #14 needed assistance outside with a resident. She stated when she ran outside, she found Resident #44 at the end of the sidewalk where the curb is lower for the wheelchairs to exit to the parking lot. The Unit Supervisor further stated that it was dark outside but there were security lights in the parking lot so she could see the resident. She indicated that Resident #44's wheelchair was

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overturned, and she was lying on her right side on the sidewalk and Nurse #14 was already assisting the resident. The Unit Supervisor further indicated she and NA #9 had stayed with the resident until EMS arrived, and Nurse #14 went and called the provider and EMS. She stated Resident #14 had a laceration to her head and that she had applied a pressure dressing to get it to stop bleeding. The Nursing Supervisor further stated that she was told some young girls about 10 years old or 11 years old had held the door open for Resident #44 and that was how she was able to get outside with a wander guard on.

An observation and interview with the Unit Supervisor of Resident #44's wander guard was completed on 3/5/2025 at 4:25 P.M. The Unit Supervisor stated there was a machine on each hall that was for testing the wander guards to make sure the batteries were functioning properly. The wander guard was intact to Resident #44's right ankle and when the Unit Supervisor scanned it with the machine a light came on indicating the wander guard was functioning properly.

An interview and observation of the facility wander guard system was completed with the Maintenance Director on 3/6/2025 at 9:35 A.M. The Maintenance Director stated the front lobby door was locked automatically every day from 8:00 P.M. to 7:00 A.M. He further stated that after 8:00 P.M. a code was needed to unlock the keypad and open the door. The Maintenance Director indicated that during the day there was a receptionist that monitored the door and at night the door was locked to keep the residents from wandering outside. He demonstrated that when a person wearing a wander guard got within

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approximately 5 feet of the exit doors the wander guard would begin to chirp. The Maintenance Director stated that as the resident approached closer the alarm would chirp louder and faster, and if the resident was within a few inches of the door, it would automatically lock. He further stated that if the door was being held open and was unable to reset then once the person with wander guard got over 5 feet away from the door outside the alarm would stop. The Maintenance Director measured the distance from the front door to the edge of the sidewalk and the parking lot as 60.8 feet. The facility and the parking lot is located off of a cul-de-sac on a dead-end street with not a lot of traffic except visitors to the facility.

An interview was completed with Receptionist #1 on 3/7/20205 at 11:55 A.M. Receptionist #1 stated that she had worked at the facility for 2 years. She further stated that part of her responsibilities included preventing residents with wander guards from exiting the building. Receptionist #1 stated she worked Monday through Friday and from 8:00 A.M. to 4:30 P.M. and that Receptionist #2 worked from 4:30 P.M. to 8:00 P.M. Receptionist #1 Monday through Friday and 8:00 A.M to 4:30 P.M. on the weekend. She indicated that someone was responsible for monitoring the door when she was at lunch. Receptionist #1 stated she checked the elopement book several times a week to make sure nobody had left or had been added to the list. She further stated the book contained current pictures of the residents that wore wander guards and were not allowed outside without supervision. She stated that she usually tried to distract residents from setting off the alarm and get them away from the door. Receptionist #1 further

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F 689	Continued From page 34	F 689		

stated if she was unable to distract the residents or they became agitated she would call the nurse for help. She further stated that she recalled that Receptionist #1 called in on 2/14/2025, so there was no one assigned to watch the front door from 4:30 P.M. to 8:00 P.M
.
An interview was completed with the Director of Nursing (DON) on 3/7/2025 at 10:55 A.M. The DON stated that she heard Resident #44 got outside because some children had held the front door open for her. She further stated that the doors were unable to lock when Resident #44 got too close to the door because they were holding the door open. The DON stated that Resident #44 was only outside for about 5 minutes, and it was unfortunate that her wheelchair had turned over at the end of the sidewalk and she was injured. She stated that she did not expect someone wearing a wander guard to be found outside and injured.

An interview was completed with the Administrator on 3/7/2025 at 9:45 A.M. The Administrator stated that the facility employed a receptionist that worked from 8:00 A.M. to 4:30 P.M. Monday through Friday and another one that usually works 4: 30 P.M to 8:00 P.M. She stated that the receptionist for the 4:30 P.M. to 8:00 P.M. shift had called in sick on 2/14/2025. The Administrator further stated that it was everyone's responsibility to respond if a wander guard alarm was going off. She indicated she didn't believe the incident involving Resident #44 that occurred on 2/14/2025 was the facility's fault, because some children had held the door open for her. The Administrator stated that Resident #44 was only outside for a few minutes, but unfortunately, she had already fallen out of her wheelchair when

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F 689	Continued From page 35 she was found. She further stated there was sign in the lobby by the front door that says, "Please check with Nurse before assisting residents outside".	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to provide nutritional supplements to 1 of 11 residents reviewed for nutrition (Resident #89). Findings included: Resident #89 was admitted on 10/20/24 with	F 692	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law.	4/3/25

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F 692	Continued From page 36 diagnosis of protein calorie malnutrition, Alzheimer's, and dysphagia (swallowing difficulty). Review of Resident #89's quarterly Minimum Data Set (MDS) assessment dated 1/21/25 revealed resident had cognitive impairment, severe cognitive impairment, and hold food in mouth or cheeks after meals, coughing or choking during meals or when swallowing and weight loss. Review of Resident #89's electronic health record revealed the following weights were recorded: 10/20/2024 130.4 Pounds (Lbs.) 10/27/2024 132.8 Lbs. 11/03/2024 133.2 Lbs. 11/10/2024133.1 Lbs. 11/17/2024 133 Lbs. 12/17/2024 132.8 Lbs. 1/08/2025 118.2 Lbs. 2/05/2025 116.2 Lbs. 2/24/2025 103 Lbs. 3/01/2025 106.3 Lbs. 3/03/2025 104.9 Lbs. A review of Resident #89's care plan revealed a problem initiated on 10/23/24 and last revised on 2/20/25 of nutrition impairment related to multiple chronic diseases, cognitive impairment, Alzheimer's, protein calorie malnutrition, underweight status, increased nutrient needs with a pressure ulcer, mechanically altered diet, and honey thick liquids. Interventions indicated to provide and serve supplements as indicated. Review of Resident #89's physician orders revealed an order dated 2/19/25 for frozen nutritional cup with meals.	F 692	Affected resident Resident #89 did not receive frozen nutritional cup as reflected on meal tray ticket. Unable to correct for this resident. Resident did not suffer any adverse effects related to the alleged deficient practice. Other residents with potential to be affected The Kitchen Manager reviewed the meal trays for all residents who are ordered a nutritional supplement to ensure that the supplement was on the meal tray. This was completed on 4/3/2025. No other resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes The kitchen manager to provide education to kitchen staff to ensure that residents ordered nutritional supplements have the supplement on their meal tray. Any newly hired kitchen staff is educated on this process during orientation by the kitchen manager/designee. This will be completed by 4/3/2025 Monitoring An audit tool was developed to ensure the following: • Residents ordered to receive a nutritional supplement on meal tray will	

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F 692	Continued From page 37 A review of Resident #89's electronic health record revealed an interdisciplinary team note dated 2/27/25 which indicated in part resident with noted weight loss and nutritional decline the past few months, worsening dysphagia and dislikes pureed foods. Resident #89 had significant weight loss this month and was primarily only consuming frozen nutritional magic cups, yogurts, and pureed desserts with meals. Observation of resident on 3/3/25 at 12:50 PM revealed resident in bed with his meal tray in front of him. The meal tray ticket on the tray indicated Resident #89 was to receive a regular pureed diet with honey thickened liquids. The meal tray ticket indicated Resident #89 was to receive a frozen nutritional treat. The meal tray ticket indicated to send frozen nutritional cup. No frozen nutritional treat was noted on the meal tray. An interview with the Registered Dietitian (RD) on 3/5/25 at 4:00 PM revealed Resident #89 had weight loss and was to receive a nutritional supplement. The RD indicated he was not aware of Resident #89 receiving the frozen nutrtional treat as ordered. The RD stated he was not informed of a problem with the supplier of the supplement and that the resident should receive the nutritional supplement as ordered. An observation of Resident #89's lunch meal on 3/6/25 at 12:50 PM revealed resident was sitting up at his bedside with his meal tray in front of him. Resident #89 had a pureed meal with honey thick lemonade. No frozen nutritional treat was observed on the meal tray. Resident #89's meal tray had a small dish of pudding on the tray that was unopened.	F 692	receive it. • The Kitchen manager/Designee will audit 5 random meal trays weekly X 4 weeks, biweekly X 4 weeks, and monthly X 1 to ensure compliance. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement Committee meeting by the Kitchen Manager x 3 months for review and further recommendations. Date of completion: April 3, 2025	

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F 692	Continued From page 38 An interview with the Dietary Manager on 03/06/25 at 2:00 PM revealed the facility was out of several items including the frozen nutritional treat that week and were waiting for a food vendor shipment at the end of the week. The Dietary Manager stated that they should have frozen nutritional treats and other needed items on hand per the physician orders and they did not. She said she was new to the position and was still learning about the facility and the ordering process. The Dietary Manager stated that today the kitchen sent pudding instead of the frozen nutritional treat.	F 692		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to honor food preferences for 1 of 12 residents reviewed for nutrition (Resident # 76) reviewed for meal preferences. Findings included: Resident #76 was admitted on 4/17/23 with	F 806	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law.	4/3/25

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F 806	Continued From page 39 diagnoses which included dysphagia and gastroesophageal reflux. Resident #76's care plan dated 4/30/23 revealed a nutritional status problem that was last revised on 2/26/25. The nutritional status problem indicated Resident #76 had potential for nutritional and hydration impairment and the approaches indicated to determine resident's food likes and dislikes. Resident #76's quarterly Minimum Data Set (MDS) dated 12/11/24 revealed resident was cognitively intact, had no weight recorded and weight loss or weight gain was coded as no or unknown. Resident #76's electronic health record revealed a dietary progress note written by the Registered Dietitian (RD) dated 12/23/24 which indicated the resident received a regular diet with thin liquids and received vanilla ice cream and extra sandwiches with lunch and dinner. A grievance filed on behalf of Resident #76 dated 2/3/25 indicated the resident was not supposed to receive rice but she received rice on two occasions in the last week. The steps taken to investigate revealed the Dietary Manager was interviewed and she stated that the meal tickets were misread by the staff preparing the meal tray. The corrective action revealed that the kitchen staff was instructed to thoroughly read the meal tickets and the diet order was updated on 2/3/25 for no rice. Resident #76's electronic health record revealed a physician order dated 2/3/25 for a regular diet with no rice.	F 806	Affected resident Registered Dietician updated resident preferences to reflect dislike of fish and peanut butter on 3/27/2025. The resident did not suffer any adverse effects related to the alleged deficient practice. Other Residents with potential to be affected The Registered Dietician reviewed all residents' profiles to ensure that resident preferences/dislikes were on the profile. This was completed on 4/3/2025. No other residents were affected by the alleged deficient practice. Systemic Changes Kitchen manager to educate kitchen staff on ensuring that a disliked item is not on the meal tray and the resident preferences/dislikes are on the resident profile. This will be completed by 4/3/2025. This process will be completed upon orientation for any newly hired kitchen staff during orientation by the kitchen manager. Monitoring An audit tool was developed to ensure that meal preferences are obtained, listed on the meal tickets and meals are served according to resident preferences. The Kitchen Manager/designee will audit 5 random meal trays weekly X 4 weeks, biweekly X 4 weeks, and monthly X 1 to	

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F 806	Continued From page 40 A list of alternate entrees indicated the following items were always available: hamburger, cheeseburger, deli sandwich, chef salad, grilled cheese and the sides were French fries, potato chips, tossed salad, cream of tomato soup, and chicken noodle soup. An interview and meal observation of Resident #76 were conducted on 3/03/25 at 12:50 PM. Resident #76 was in bed with a meal tray on the overbed table in front of her. The meal ticket indicated Resident #76 was to receive a regular diet with extra items, a peanut butter sandwich and vanilla ice cream. No vanilla ice cream was observed on the meal tray. Resident #76 stated she does not like peanut butter sandwiches, and she was not able to eat the fish that was served. Resident #76 stated she tried to eat the fish twice before and it made her sick. Resident #76 stated she asked for a salad yesterday and today for lunch and was told the facility did not have any dressing so she could not get a salad as requested. She stated she just ate her cake for lunch. Resident #76 stated she frequently received foods that she did not like or could not eat so she just ate snacks her family provided, or she did not eat. An interview was conducted with the corporate Dietary Consultant on 3/3/25 at 2:45 PM. The Dietary Consultant stated the Dietary Manager was only in the position for a few weeks and she (the Consultant) assisted at the facility a few days per week. The Dietary Consultant stated resident preferences are updated as needed. The Dietary Consultant indicated that residents could request a salad anytime per their preference as part of the always available options. The Dietary	F 806	ensure compliance. The results of these audits will be brought to the monthly Quality Assurance Performance Improvement Committee meeting by the Kitchen Manager monthly x 3 months for review and further recommendations. Date of completion: April 3, 2025	

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F 806	Continued From page 41	F 806		

Consultant stated she expected the facility would have salad dressing available. If pre-made salad dressing was not available, the facility could have made salad dressing from scratch. The Dietary Consultant indicated a resident should receive items as requested per their preference and the items should be available.

An interview and observation of Resident #76's dinner tray on 3/4/25 at 6:00 PM revealed she was served greens, mashed potatoes, barbecue chicken, fruit cocktail and a grilled cheese sandwich. Resident #76 stated she does not eat greens, and the potatoes did not taste good. Resident #76's meal tray ticket indicated the resident was to receive vanilla ice cream and a grilled cheese sandwich in addition to the regular diet.

An interview was conducted with the Registered Dietitian (RD) on 3/5/25 at 4:00 PM. The RD stated items should be available to meet residents' preferences. The RD stated he visited Resident #76 at times when he was in the facility. The RD reviewed Resident #76's record and stated it looked like neither he nor the Dietary Manager had updated the resident's profile of preferences since last year. The RD stated that the Dietary Manager was supposed to update resident preferences quarterly and as needed. The RD stated the Dietary Manager was new to the position and was still learning. The RD stated he was not aware that Resident #76 did not eat fish or collards and did not like peanut butter sandwiches.

A meal observation and interview with Resident #76 on 3/6/25 at 12:50 PM revealed the resident was in bed with the head of bed elevated and the

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F 806	Continued From page 42 meal tray was in front of resident on the overbed table. The meal tray consisted of a chef salad with ranch dressing, peanut butter sandwich, water and iced tea. The meal ticket indicated resident was to receive a salad with French dressing. Resident #76 stated she does not eat the peanut butter sandwiches they keep sending on her meal trays. Resident #76 stated she liked the salad and was eating it with ranch dressing even though she had requested French dressing. An interview with the Administrator on 3/7/25 at 4:30 PM revealed she expected that resident preferences would be honored and that food items would be available to meet resident preferences.	F 806		