

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Southern Pines Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6140 Congress St New Port Richey, FL 34653	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to promptly notify the resident representative of a room change for one resident (#4) of three sampled residents.</p> <p>Findings included:</p> <p>Resident #4 was admitted on [DATE] and discharged on 04/16/2025. Review of the admission Record showed diagnoses included but not limited to fracture of the left femur, history of falling, hypertension, anemia, urine retention, and weakness. Review of the admission Minimum Data Set (MDS) dated [DATE] showed in Section C, Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 09 or moderately impaired.</p> <p>Review Resident #4's progress notes lacked any documentation regarding the room change that occurred on 04/09/2025 from room A2A to A5A.</p> <p>Review of a Social Services Director's (SSD) progress note read: On 04/11/2025 at 10:12 a.m. Resident #4 will be moving from A5A to A3A due to family request. Resident was notified of the room change on 04/11/2025. The resident representative was notified, the family member requested the move in person. Resident was agreeable to a room change. Resident's representative was agreeable to a room change at this time.</p> <p>Review of Resident #4's medical record revealed a Room Change Notification for the room change on 04/09/2025 was not documented.</p> <p>Review of Room Change Notification dated 04/11/2025 showed appropriate documentation:</p> <p>Date of room change: 04/11/2025;</p> <p>Moving from A5A to room A3A</p> <p>Reason for room change: family request</p> <p>Was resident notified of room change: yes on 4/11/2025</p> <p>Resident representative (family member) was notified of room change</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Interdisciplinary Plan of Care Plan Meeting (IPOC) dated 04/08/2025 showed Resident #4 attended, family member attended via phone. New resident at facility. Active family involvement, family representative actively involved. Family member felt resident was not compatible with current roommate. Possible placement at another facility close to caregiver. Discussion with room change per family member.</p> <p>During an interview on 6/11/25 at 3:18 p.m. with the Social Service Director (SSD) and the Director of Nursing (DON) the SSD stated if a resident requested a room change we look for an empty room of their liking. SSD stated we show it (the room) and proceed. The SSD stated they document the room change on the Room Change Notification form in the assessment section. The SSD verified the 04/09/2025 room change was not documented on a Room Change Notification form nor in the progress notes. SSD stated If she did not change the room, someone else may have and not performed the notification. SSD stated we have to make sure both SSD and admissions know of the bed changes. SSD verified there was no documentation regarding the room change for 04/09/2025. SSD stated she moved Resident #4 due to the family member requested Resident #4 to be moved. SSD stated she could not remember why the family member wanted the resident moved.</p> <p>Review of the facility's policy, Standards and Guidelines: Room Changes, revised 1/2024 showed changes in room or roommate assignment are made when the facility deems it necessary to meet the needs of current residents or when the resident requests a change. Policy Interpretation and Implementation 1. Resident room or roommate assignments may change if the facility deems it necessary. Resident preferences are taken into account when such changes are considered. 2. Residents have the right to share a room with their roommate of choice, including a spouse, domestic partner, or friend, as long as both parties live in the same facility, and consent to the arrangement. 3. Prior to changing a room or roommate assignment parties involved in the change / assignment (for example residents and their representatives) are given advance notice of such change. 4. Documentation of a room change is recorded in the residence medical record.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations and interviews, the facility failed to provide a clean, comfortable, sanitary, and homelike environment in four halls (A, B, C, D) of four hallways and one of one dining room.</p> <p>Findings included:</p> <p>The following observations were made on 6/11/25:</p> <ul style="list-style-type: none"> - At 9:20 a.m. a treatment cart parked in the dining room beside the exit door to the courtyard. The cart was empty and unlocked, on top of the cart were crumbs of an unknown substance, a piece of black fabric, and the front of the cart was stained with brown and black substances, the cart appeared to be unclean and unsanitary. On the floor next to the cart was a piece of white paper and a plastic domed lid with a brown liquid attached to it. The floor surrounding the cart was unclean and scuffed. The observation revealed a white piece of paper and a clear piece of plastic against the wall opposite of where the cart was parked in the dining room. The floor was unclean. At the time of the observation no residents were eating a meal in the dining room. Staff B, Certified Nursing Assistant (CNA) reported being unsure how long the cart had been parked there. - At approximately 9:23 a.m. an observation was conducted of room D4. The closet doors to be not hanging correctly, not perpendicular to the floor, on the top right hand outside corner of the closet was an unfinished patch, the wall beside the in-room sink was multiple small patches unpainted, the room was painted a bright green however an area behind a box of gloves (above the sink) was a cream color. The ceiling tile was white except for the tile above the sink was outlined with a dark tan color while the inner area of the tile was a cream color. The wall behind the first bed was gouged revealing an unpainted, uncleanable surface. - At approximately 9:46 a.m. the bathroom was shared between rooms D6 and D7 where 6 residents resided, a strong pungent urine smell was emitting from the room, prior to opening the door from room D7. The observation showed the flooring did not meet up with the toilet and the approximate 1.5-to-2-inch gap was filled with cracked white silicone-looking substance and tapered along the side of toilet. A green microfiber-looking cloth was observed on the sink, and a white towel with a brown substance was observed lying across the only toilet paper dispenser. The floor was stained and unclean. - At 9:32 a.m. an observation revealed on the floor of room C16, to the side of the bathroom door was half a circular item attached to the floor, next to the item was an unmovable upside-down bolt. Resident #8 stated the circular item was a door stop. The floor next to the doorstop and bolt was stained black. - At 9:32 a.m. an observation was made of the floor under the window of room C1. The window sill held multiple potted plants and on the floor was 3 small piles of black dirt. - At 9:35 an observation showed an unfinished patch approximately two feet by three feet section of wall behind and beside the entry door of room C7. <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- At 9:36 a.m. an observation of room C8 revealed an air conditioning unit was observed with a disconnected accordion-style hose lying on the floor at the end of the resident's bed. One of two closet doors was not on its track. The bathroom shared by room C7 and C8 was odorous of bowel. A gray wash basin, unlabeled, was sitting on the floor beside the back of the toilet, the trash can contained an incontinent brief with a brown substance attached to it, and a piece of paper littered the floor. Resident #8 reported using the bathroom with staff assistance.</p> <p>- At 9:40 a.m. an observation was made of room C13. The bathroom was odorous of urine. A toilet plunger was observed sitting on top of an opaque plastic bag on the floor and an upside down gradient clear plastic container was observed sitting on a brown paper towel on the back of toilet.</p> <p>On 6/11/25 at approximately 9:45 a.m., an observation showed two housekeepers were in the dining room, each with a housekeeping cart.</p> <p>- At 9:51 a.m. an observation of the bathroom of room A8 revealed the room was very odorous of urine and a liquid was on the floor surrounding the toilet. The toilet bowl was filled with a yellow liquid and liquid splattered the toilet seat. The flooring was scuffed and dirty looking.</p> <p>- At 9:55 a.m. an observation of room A1 revealed one of two closet doors was off its track and leaning into the closet and an unfinished and uncleanable surface was noted behind and to the right side of the second beds. The bathroom revealed the floor grout was stained, the caulking around toilet and back wall were missing and the tiles on the wall behind the toilet were stained brown.</p> <p>- At 10:08 a.m. an observation was conducted of the treatment cart parked next to the courtyard door in the dining room. The observation showed the domed plastic lid continued to lie next to the cart and the cart continued with splatters of unknown substances. The floor was scuffed and stained. In the lobby area, in front of the half wall looking into the dining room was an area stained with an unknown black substance.</p> <p>- At 10:12 a.m. an observation of room B8 revealed an overturned medication cup was on the floor in front of a trash can which contained unwanted items, a black stain was observed on the floor in front of room's vanity area, and the privacy curtain of B-bed was askew and not fully hooked. The toilet contained a brown-colored substance with crumb-looking material and feces. The bathroom was very odorous. On top of the dresser were piles of different items, specifically an unprotected toothbrush lying on items, and an emesis basin containing an unprotected toothbrush. A bottle of antiseptic oral rinse was observed on top of the dresser.</p> <p>On 6/11/25 at 5:23 p.m. observations were conducted with the Senior Administrator (SA). The SA observed the black stain on the floor next to lobby's half wall and stated he would take care of that. The following observations were made, and some were discussed with the SA:</p> <p>- Observation of the plastic domed lid lying in between the treatment cart and another similar cart in the dining room next to the courtyard exit door. The SA picked it up and threw it away, stating housekeeping should be moving the carts.</p> <p>- Observation of the D6-D7 bathroom, which the SA confirmed, the bathroom continued to be odorous. The washcloth and towel had been removed. Resident #9 was lying on bed and reported thinking there were only 2 of the 6 residents using the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide treatment and care in accordance with professional standards of practice related to performing weekly skin checks for four residents (#1, #3, #5, #6) out of five sampled residents. Findings included: 1. Review of Resident #3s admission Record showed the resident was admitted on [DATE] and discharged to the community on 3/13/25, residing at the facility for a total of 15 days. The record revealed diagnoses not limited to prediabetes, morbid (severe) obesity due to excess calories, and generalized muscle weakness. Review of Resident #3s nursing assessments showed the resident was evaluated on 2/27/25 for an admission/readmission. The clinical record did not reveal a skin evaluation/check was completed during the fifteen days the resident resided at the facility. The admission/readmission evaluation revealed the resident had redness to buttocks. The progress notes did not reveal licensed nursing had completed a weekly skin evaluation/check for the resident. An interview was conducted with the Director of Nursing (DON) on 6/11/25 at 4:19 p.m. The DON reviewed Resident #3's record confirming there were no skilled nursing notes or any nursing progress notes. 2. Review of Resident #5's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to post-laminectomy syndrome not elsewhere classified, unspecified paraplegia, and thoracic region spinal stenosis. Review of Resident #5's Order Summary Report showed the resident did not have an order for weekly skin checks by licensed nursing staff. Review of an Advanced Practitioner Registered Nurse (APRN) note dated 5/19/25 showed the resident had increased pain seeming like it was due to the location of bed pad was making contact with (pronoun) thoracic incision from surgery. Looking at the site, patient's dressing had peeled up exposing a few of (pronoun) staples which remained intact with no redness or bleeding. The practitioner noted Resident #5 was status post (s/p) T10=T11 laminectomy and was at high risk for skin breakdown that can lead to infections/sepsis that may require admission to the hospital for debridement. Review of Resident #5's assessments showed a Skin Check - Weekly or Other was completed on 5/26/25, showing no new concerns at this time. The evaluation did not reveal the resident had any previous skin conditions. Review of a Summary for Providers change in condition evaluation, dated 5/26/25 at 8:00 p.m. showed no physician recommendations after Resident #5 had fallen and a skin evaluation was not completed. Review of Resident #5's progress notes did not show nursing staff had evaluated the resident's body for any new skin impairments or the status of the post-laminectomy incision until a note on 6/4/25 at 4:42 p.m. revealed a late entry regarding notifying the physician of left lower leg swelling and redness and warmth to the surgical incision. Review of Resident #5's record showed one Skin Check Weekly or Other assessment was completed on 5/26/25 at 8:00 p.m., twelve days after the resident was admitted and eleven days before the resident was transferred to an acute care facility. 3. Review of Resident #6's admission Record revealed the resident was admitted on [DATE] with a most recent readmission on [DATE] following a 4-day (5/22/25) hospital stay. The record included diagnoses not limited to unspecified peripheral vascular disease and unspecified type 2 diabetes mellitus with diabetic neuropathy. The record showed the resident was discharged on 3/3/25 and returned on 3/24/25. On 6/11/25 at approximately 9:35 a.m. Resident #6 was observed lying in bed, face covered with a sheet, knees bent and uncovered. The observation showed multiple abrasions/ discolorations of reddish/purple coloration to the resident's right knee. An interview was conducted on 6/11/25 at 2:17 p.m. with Resident #6. The resident reported having a wound on the right heel which is dressed daily. Review of Resident #6's care plan revealed the following focuses and related interventions:- At risk for adverse effects of hyper/hypo glycemia related to (r/t) diagnosis of diabetes. The interventions instructed nursing to monitor feet for open areas, sores, pressure areas, blisters, edema, or redness and to report to medical doctor (MD) as indicated. - On anticoagulant/antiplatelet therapy r/t cardiac prophylaxis (ppx). The interventions instructed nursing and Certified Nursing Assistant (CNA) staff to monitor skin for abnormalities and report to nurse/Medical Doctor (MD) as indicated. - Has impaired skin: right (R) heel wound, R great toe wound, (and) R dorsal 3rd toe wound (revised on 1/28/25). The interventions instructed nursing staff to Complete weekly skin checks. Measure length, width, and depth, if possible. Document status of wound and healing progress. Monitor for signs/symptoms (s/s) of infection. Report changes to MD as indicated. Review of Resident #6's clinical record revealed an Unavoidable Skin Condition evaluation was signed by the physician on 4/15/25. The evaluation showed the resident had conditions of peripheral vascular disease (PVD)/peripheral arterial disease, continuous urinary incontinence</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident #1 was admitted on [DATE] and discharged on 12/24/2024. Review of the admission Record showed diagnoses included but were not limited to metabolic encephalopathy, contusion of scalp, history of falling, necrotizing enterocolitis, dementia with mood disturbance, disorder of brain, orthostatic hypotension, Hypertension, muscle weakness, and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) dated [DATE] showed in Section C, Brief Interview for Mental Status (BIMS) score of 03 or severe impairment. Review of the admission / readmission Nursing Evaluation dated 12/11/2024 showed Skin Evaluation: top of his scalp was left parietal area secondary to ground level fall, scabbing 4 cm [centimeters] x 3 cm both right and left antecubital areas with multiple bruises from hospital IV/blood draws Review of the Skilled Documentation dated 12/12/2024 showed resident had hematoma to head, bilateral upper extremity bruises present on admission. Review of the Skilled Documentation dated 12/13/2024 showed resident had hematoma to head, bilateral upper extremity bruises present on admission. Review of the Skilled Documentation dated 12/14/2024 showed resident had hematoma to head, bilateral upper extremity bruises present on admission. Review of the Skilled Documentation dated 12/15/2024 showed resident had hematoma to head, bilateral upper extremity bruises present on admission. Review of the progress notes showed no skilled notes after 12/15/2024. Progress notes lacked any documentation regarding his skin. Review of the medical record showed no weekly skin checks performed after 12/15/2024. Review of the care plans showed: Resident #1 was at risk for skin impairment related to weakness/decreased mobility as of 12/12/2-24. Interventions included but not limited to monitor/observe skin while providing routine care. Notify nurse for any concern as indicated. During an interview on 06/11/2025 at 3:18 p.m. the Director of Nursing (DON) stated Resident #1 had a couple of skilled documentation notes but not the whole time. DON stated they were now reviewing for Skilled Service Notes during the morning meetings. The DON stated Resident #1 had a scab on top of his scalp per the admission assessment. The DON stated they did not do a further assessment / skin check on the resident. The DON stated they should have been doing skin checks on Resident #1. 5. Review of the facility's policy, Standards and Guidelines: Prevention of Skin Impairments/Pressure Injury, revised 01/2024 showed the purpose of this policy is to provide information regarding identification of skin wound risk factors and interventions for specific risk factors. Risk Assessment: 1. Assess the resident on admission for existing wounds risk factors. 2. Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity-any evidence of existing or developing pressure ulcers or injuries; b. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Inspect the skin when performing or assisting with personal care or activities of daily living (ADL's). a. Identify any signs of developing skin wound. B. Inspect pressure points c. Wash the skin after episodes of incontinence d. repositioned resident as indicated on the care plan. Monitoring / Documenting 1. Evaluate, report, and document potential changes in the skin. 2. Notify the physician and the resident / resident representative of changes in the skin. 3. Review the interventions and strategies for effectiveness on an ongoing basis. 4. Evaluate open areas per physician orders. Review of the facility's policy, Standards and Guidelines: Documentation, revised 01/2024 showed services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Procedure: 1. Documentation in the medical record may be electronic, manual, or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Treatments or services performed; d. Changes in the resident's condition. 3. Documentation in the medical record is required as updates / changes in the resident's plan of care are made. 4. Documentation in the medical record will be objective, complete, and accurate. 8. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure / treatment was provided; b. The name and title of the individual (s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. Whether the resident refused the procedure / treatment; e. Notification of family, physician or other staff, if indicated; and f. The signature and title of the individual documenting.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Southern Pines Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6140 Congress St New Port Richey, FL 34653	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of Resident #3's admission Record revealed the resident was admitted on [DATE] from an acute care hospital. The record included diagnoses not limited to other idiopathic peripheral autonomic neuropathy, unspecified chronic obstructive pulmonary disease, unspecified cord compression, and generalized muscle weakness. The resident discharged to a private home on 3/13/25. An interview was conducted on 6/11/25 at 1:57 p.m. with the Director of Rehab (DOR). The DOR stated all new admissions are evaluated or screened by therapy. The DOR reported remembering Resident #3 did participate in physical and occupational therapies. A review of the therapy notes for both disciplines revealed the resident did not miss any scheduled visits. Review of Resident #3's assessments did not reveal any Daily Skilled Nursing notes were completed for the resident. Review of Resident #3's progress notes showed no nursing notes had been completed after the residents' admission. The progress notes showed Physician/Practitioner notes were written on 3/8/25, 3/7/25, and 3/5/25, a pharmacy note was written by pharmacy on 3/3/25, a nutritional evaluation was conducted on 2/27/25, and the Admission/readmission Nursing Evaluation on 2/27/25. Review of Resident #3's bowel management tasks showed from 3/2/25 to 3/13/25 staff had documented 2 no bowel movement, NA no applicable, RR resident refused, or did not document the task. The documentation showed the resident had no bowel movement for 10 days between 3/2/25 to 3/13/25. An interview was conducted on 6/11/25 at 4:19 p.m. with the DON. The DON reviewed Resident #3's insurance and stated she thought it was skilled nursing. She reviewed the resident's record and confirmed not seeing any skilled nursing or nursing progress notes. The DON reviewed the bowel management task documentation and confirmed the facility had a Certified Nursing Assistant (CNA) documentation issue. 4. Review of Resident #5's admission Record showed the resident was admitted on [DATE] from an acute care hospital. The record included diagnoses not limited to, thoracic region spinal stenosis, unspecified paraplegia, and not elsewhere classified post-laminectomy syndrome. Review of Resident #5's progress notes showed on 5/19/25 the Physical Medicine and Rehabilitation Practitioner noted the resident was admitted to the facility to receive subacute rehabilitation with the goal to maximize functional level/independence. The note revealed the resident was seen at bedside and had increased pain upon being moved related to the bed pad was making contact with her thoracic incision from surgery. Looking at the site, patient's dressing had peeled up exposing a few of (pronoun) staples .Review of Resident #5's progress notes revealed from the day of the resident's admission on [DATE] to 5/21/25 staff had not completed a progress note or Skilled Nursing note for this resident. The note on 5/21/25 revealed the resident complied with treatment orders, an indwelling catheter was removed and on 5/22/25 staff noted the resident was voiding sufficient quantity. The resident had an episode of a behavior as noted on 5/24/25 and a fall on 5/26/25. The record did not include any nursing documentation related to the resident's condition from 5/26/25 to 5/29/25 when a Summary of Skilled Service note was completed showing the resident continued on oral antibiotic for an infectious process to surgical incision. The next nursing note was a late entry note dated 6/4/25 regarding redness and warmth to the resident's surgical incision and left lower leg swelling. The last Summary of Skilled Service progress note from nursing staff was completed on 6/5/25. Review of the facility census dated 6/11/25 at 8:48 a.m. revealed Resident #5 was on therapeutic unpaid leave. Review of a Change in Condition evaluation, dated 6/4/25 showed on 6/11/25 at 5:07 p.m. the document was In Progress. The record did not reveal a transfer form, or a Change of Condition evaluation was completed for the resident's transfer. The progress notes did not reveal information regarding the resident's transfer. Review of Resident #5's assessments showed nursing had completed skilled documentation on 5/21/25, 5/29/25, and 6/5/25. Review of the Daily Skilled Documentation list, updated 5/20/25 revealed the 7:00 a.m. - 7:00 p.m. shift was responsible for the Daily Skilled documentation of Resident #5. Review of the clinical policy - Medical Records, revised 1/2024 revealed Services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the residence condition and response to care. The procedure outlined:1. Documentation in the medical record may be electronic, manual, or a combination. 2. The following information is to be documented in the resident medical record:- a) Objective observation;- b) Medications administered;- c) Treatments or services performed; stop- d) Changes in the residence condition;3. Documentation in the medical record is required as updates/ changes in the residents plan of care are made 4. Documentation in the medical record will be objective (not opinionated or speculative)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review the facility failed to maintain medical records according to standards of practices related to skilled nursing notes, change in condition notes, transfer notes, activities of daily living notes, for residents receiving skilled services were documented for four residents (#1, #3, #4, and #5) of four sampled residents. Finding included: 1. Resident #4 was admitted on [DATE] and discharged on 04/16/2025. Review of the admission Record showed diagnoses included but not limited to fracture of the left femur, history of falling, hypertension, anemia, urine retention, and weakness. Review of the admission Minimum Data Set (MDS) dated [DATE] showed in Section C, Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 09 or moderately impaired. Review of the physician orders showed to admit the resident to the facility for skilled services. Occupational Therapy services five times a week times 30 days as of 04/04/2025. Physical Therapy services five times a week times 30 days as of 04/07/2025. Review of the progress notes showed no Skilled Notes documentation. Review of the medical record showed no Skilled Nurses notes in the assessment section of the chart. During an interview on 06/11/2025 at 3:18 p.m. the Director of Nursing (DON) stated skilled services entails, nursing services are needed in a facility and not at home. These services can include IV (intravenous) therapy, wound care, vital signs monitoring, physical therapy, nurses need to oversee the resident. The DON stated there should either be a Skilled Nurses Note, or a Skilled Progress Note in the progress notes every day the resident was on Skilled Services. The DON verified there were no Skilled Nursing Notes in the assessment section. The DON reviewed the progress notes and found no Skilled Notes from the nurse in the progress notes either. The DON stated she would expect to see the Skilled Notes. 2. Resident #1 was admitted on [DATE] and discharged on 12/24/2024. Review of the admission Record showed diagnoses included but were not limited to metabolic encephalopathy, contusion of scalp, history of falling, necrotizing enterocolitis, dementia with mood disturbance, disorder of brain, orthostatic hypotension, hypertension, muscle weakness, and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) dated [DATE] showed in Section C, Brief Interview for Mental Status (BIMS) score of 03 or severe impairment. Review of the physician orders showed admit the resident to the facility for skilled services as of 12/11/2024. Occupational Therapy services four times a week times 30 days as of 12/12/2024. Physical Therapy services four times a week times 30 days as of 12/12/2024 and increased to five times a week for 30 days as of 12/17/2024. Speech Therapy services three times a week for 30 days as of 12/12/2024. Review of the Skilled Documentation showed notes dated 12/12/2024, 12/13/2024, 12/14/2024, 12/15/2024 only. Review of the progress notes showed no Skilled Notes after 12/15/2024. Progress notes lacked any documentation regarding his skin. During an interview on 06/11/2025 at 3:18 p.m. the DON stated Resident #1 had a couple of Skilled Documentation notes but not the whole time. The DON stated they were now reviewing for Skilled Service Notes during the morning meetings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review the facility failed to follow standard infection control practices related to hand hygiene and cleaning of resident care multi-use equipment.</p> <p>Findings included:</p> <p>On 06/11/2025 at 9:55 a.m. Staff A, Licensed Practical Nurse (LPN) was observed entering room A-3 which had Contact Precaution signage on the outside of the door. Staff A placed a blood pressure cuff on Bed A's, Resident #8's lower right arm. While waiting for the blood pressure to be performed Staff A placed her right hand on the footboard of the bed. Staff A removed the blood pressure cuff, exited the room and placed it on the medication cart. Staff A did not hand hygiene nor clean the blood pressure cuff. Staff A documented the blood pressure on her paperwork. Staff A moved the medication cart across the hall to room A-11. Staff A was approached by another staff member, and she went down the hall with the staff member. Staff A opened the wound care cart and removed items and returned to the medication cart without performing hand hygiene. Staff A started performing medication administration for Resident #9 in room A-11 without hand hygiene. Staff A moved the blood pressure cuff which was on top of the medication cart to another spot. Staff A applied gloves without hand hygiene. Staff A opened the medication cart and removed a glucometer machine, a strip, and an alcohol wipe. Staff A entered A-11 and went to the other side of the bed to get a cup of water. Staff A performed the blood glucose monitoring and then returned to the medication cart. Staff A removed her gloves and did not perform hand hygiene. Staff A replaced her gloves and opened the medication cart. She removed Resident #9's insulin pen and drew up the insulin. Staff A reentered room A-11 and administered the insulin. Staff A removed her gloves and returned to the medication cart. Staff A did not perform hand hygiene. Staff A placed the blood pressure cuff inside a bag which was on the medication cart. Staff A moved the medication cart to room A-2 and began medication administration.</p> <p>During an interview on 06/11/2025 at 3:47 p.m. the Director of Nursing (DON) stated hand hygiene was to be performed upon removal of gloves, before going into a resident room, when exiting a resident room, between passing of meal trays, before and after resident care. The DON stated items like blood pressure cuffs should be cleaned after use with wipes. The DON stated Resident #8 was on enhanced barriers for c-aureus (candida- aureus). The DON stated she would have to check regarding Resident #8's roommate as to why the contact isolation signage was on the door. The DON stated the roommate was on contact isolation due to an infection in her urine.</p> <p>Review of the facility's policy, Hand Hygiene Infection Control, revised 6.2023 showed hand hygiene is the single most important measure for preventing the spread of infection. The facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated. Procedure: the facility acknowledges the CDC guidelines to improve adherence to hand hygiene in health care settings. The hand hygiene guidelines are part of an overall CDC (Centers for Disease Control and Prevention) strategy to reduce infections in health care settings to promote resident safety. When the hands are not visibly soiled, the CDC recommends the use of alcohol-based hand rubs by healthcare personnel for resident care to address the obstacles that health care professionals face when taking care of residents.</p> <p>Situations that require hand hygiene include, but are not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>before and after direct contact (for which hand hygiene is indicated by acceptable professional practice)</p> <p>before and after performing any invasive procedure (for example finger stick blood sampling)</p> <p>before and after entering isolation precaution settings</p> <p>upon and after coming in contact with the resident's intact skin (for example when taking a pulse your blood pressure)</p> <p>after removing gloves or aprons</p> <p>Review of the facility's policy, Infection Control-Infection Prevention and Control Program, dated 1/2024 showed an infection prevention and control program are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Prevention of Infection 1. Important facets of infection prevention include: C. Educating staff and ensuring that they adhere to proper techniques and procedures; G. Implementing appropriate isolation precautions when necessary; and H. Following established general and disease specific guidelines such as those of the Centers for Disease control (CDC).</p> <p>Review of the facility's policy, Standards and Guidelines: Maintenance of Resident Care Items and Equipment, revised 3/2024 showed resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogen standard. 2. Non-critical items are those that come in contact with intact skin but not mucous membranes. A. non-critical resident care items include bed pans, blood pressure cuffs, crutches and computers. B. Most non-critical reusable items can be decontaminated where they are used. 3. reusable items are cleaned and disinfected or sterilized between residents.</p>		