STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185461	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Ridge Health Campus	6415 Calm River Way Louisville, KY 40299

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46659 Based on observation, interview, record review, and facility policy review, it was determined, the facility failed to ensure personal privacy for one (1) of six (6) sampled residents reviewed for dignity (Resident #32). Observation revealed staff obtained Resident #32's blood glucose level and administered insulin in the resident's abdomen while he/she was seated at a table in a common area with five (5) other residents. The findings include: Review of the facility policy titled, Resident Rights Guidelines, revised 05/11/2017, revealed the purpose of the policy was To ensure resident rights are respected and provide an environment in which they can be exercised. Further policy review revealed facility residents had the right to be treated with dignity and respect and privacy. Review of Resident #32's Resident Face Sheet revealed the facility admitted the resident on 10/03/2022 with diagnoses which included type 2 diabetes. Review of Resident #32's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3), indicating the resident had severe cognitive impairment. Per MDS review, the facility assessed Resident #32 to have medically complex conditions and diabetes. Further review of the MDS revealed the facility assessed Resident #32 to have received insulin injections in the last seven (7) days of the assessment period. Review of Resident #32's Care Plan, dated 10/10/2022, revealed the facility care planned the resident as at risk for hypo/hyperglycemia related to diabetes mellitus. Further review revealed the facility developed interventions that included staff to administer medication per physician orders. During an observation on 03/12/2024 at 8:33 AM, Resident #32 was seated at a table in a common area with five (5) other residents. Continued observation revealed Licensed Practical Nurse (LPN) #4 checked Resident #32's blood glucose level and administered the resident's insulin in his/her abdomen. Further observation revealed Resident #32 was not able to answer any questions related to privacy or dignity. (continued on next page)

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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2024 at 8:53 AM and 2:51 PM, LPN #4 stated she should not have obtained Resident #32's blood glucose level and administered his/her insulin in the resident's abdomen at a table where other residents were present. She stated she should have taken Resident #32 to his/her room to perform those procedures in privacy for the resident. In interview on 03/14/2024 at 3:53 PM, the Director of Health Services (DHS) stated she expected staff to treat all the residents with respect. The DHS stated the nurse should have taken Resident #32 to his/her room before checking the resident's blood glucose level or administering an insulin injection. In interview on 03/15/2024 at 1:36 PM, the Executive Director stated he expected staff to provide treatments, such as an insulin injection, in a private area. He further stated he expected staff to provide privacy during medication administration.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 22445 Based on interview, record review, and review of facility documents and policy, it was determined the facility failed to ensure resolution of a grievance for one (1) of twenty (20) sampled residents, (Resident #9). Interview with staff revealed they were aware Resident #9 did not sleep well at night due to his/her roommate's yelling/screaming out, and reported everyone knew about that information. However, the facility failed to make prompt efforts to resolve the resident's complaint/grievance and ensure he/she received the care and treatment necessary to achieve adequate rest/sleep at night. The findings include: Review of the facility policy titled, Resident Concern Process, effective 11/13/2019, revealed, the purpose of the policy was To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service. Continued review revealed the facility was to provide an open and customer friendly atmosphere for residents and their families/representatives to voice concerns and problems to ensure their concerns were heard and acted upon. Per review, the facility was committed to the on-going education of their employees on immediately responding to and resolving customer concerns. Further review revealed the facility was to follow its Resident Concern Process flow chart when any concern or complaint was voiced. Additionally, policy review revealed the facility staff were to take steps to correct the problem, ensure the problem was resolved, and the Executive Director was to review and manage the follow up of the concerns. Review of Resident #9's Resident Face Sheet revealed the facility admitted the resident on 07/05/2022, with diagnoses that included atrial fibrillation, chronic pain syndrome, fatigue, muscle weakness, and a history of falling. Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated he/she had moderate cognitive impairment. Review of Resident #9's Care Plan revealed a Problem statement, last edited on 02/26/2024, that indicated the resident had the potential for experiencing symptoms of fatigue, weakness, and confusion related to anemia. Further review revealed the Care Plan interventions directed staff to encourage Resident #9 to take rest periods during episodes of fatigue. During an interview on 03/11/2024 at 10:52 AM, Resident #9 stated his/her roommate kept him/her up at night screaming and yelling. Resident #9 stated he/she had discussed the problem with the Executive Director (ED), who stated he would fix the problem; however, the problem had not been resolved. Review of the facility's resident complaint log for the timeframe of 03/02/2023 through 02/19/2024, revealed no documentation noting Resident #9's issues of not being able to sleep at night due to his/her roommate's screaming/yelling. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2024 at 10:12 AM, the Director of Social Services (DSS) described Resident #9 as able to make his/her needs known however, at times, did not accurately recall events. The DSS stated she did not know Resident #9 as well as other residents, and had not received any concerns from staff, or the resident regarding his/her relationship with his/her roommate. The DSS further stated if Resident #9 was having difficulty with his/her roommate, she expected staff to have notified her of that information. During an interview on 03/13/2024 at 10:53 AM, Registered Nurse (RN) #10 stated Resident #9 had told her and everyone else that his/her roommate screamed and yelled at night which kept the resident awake and was unable to sleep. RN #10 stated she had not notified anyone of Resident #9's concern because everyone knew about it. She further stated she was not aware of whether a room change had ever been offered to Resident #9, or whether the facility's grievance process had been completed as required. During an interview on 03/13/2024 at 12:09 PM, Licensed Practical Nurse (LPN) #5 stated Resident #9 had reported his/her inability to sleep at night due to his/her roommate's yelling and screaming. LPN #5 stated she had documented that information in Resident #9's medical record and had reported the resident's concerns to the Director of Health Services (DHS). The LPN stated the DHS told her she would report the resident's concerns to the ED. She further stated she had not completed a written grievance regarding Resident #9's concerns, but felt she had done her part by reporting the resident's concerns to the DHS. During a telephone interview on 03/14/2024 at 1:10 PM, Certified Resident Care Associate (CRCA) #17 stated she worked at the facility on the 6:00 PM to 6:00 AM shift or on the 10:30 PM to 6:30 AM shift. She stated she knew Resident #9 well and confirmed the resident had reported his/her roommate keeping him/her awake at night. The CRCA stated Resident #9's roommate yelled and screamed at night, keeping Resident #9 awake. She stated when staff from the night shift went into Resident #9's room, the resident begged the staff to do something about his/her roommate's behaviors. CRCA #17 stated she had not reported that information however, because everyone knew about it, including the ED, who was also well aware of the issue. She stated the ED changed Resident #9's shower time from 5:00 AM to 7:00 AM, due to the resident not being able to sleep at night. CRCA further stated however, the DHS and the ED changed Resident #9's shower time back to 5:00 AM because the first shift did not consistently assist the resident as he/she needed. During an interview on 03/14/2024 at 3:13 PM, RN #19 stated Resident #9 complained about his/her roommate yelling and screaming at night, keeping Resident #9 awake. RN #19 stated Resident #9's complaints regarding his/her roommate keeping him/her awake at night had been occurring since she was hired in May 2023. She stated she reported Resident #9's concerns to the DHS and knew several other staff members had also reported the resident's concerns to the DHS. RN #19 further stated however, she had not completed a grievance form. During an interview on 03/15/2024 at 9:13 AM, the DHS stated sometimes Resident #9 and his/her roommate got along fine, and sometimes they argued about the heat, and Resident #9's roommate yelled. She stated no one had reported any recent problems occurring between the roommates. The DHS stated staff had offered Resident #9 earplugs. She stated if there was not a record of a written grievance regarding Resident #9's concerns, then a grievance had not been filed. The DHS further stated she had not completed the grievance process because they handled the resident's concerns at the time of occurrence. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/15/2024 at 1:37 PM, the ED stated a couple of months ago, he had given Resident #9 earplugs to use (when the roommate was yelling). He stated he had followed up with Resident #9 about a month later and found out the earplugs were not working. The ED stated he offered Resident #9 a larger set of earplugs, and the resident declined. He further stated no other interventions were attempted. According to the ED, staff had not notified him of the lack of sleep for Resident #9 being an on-going problem.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22445 Based on interview, record review, and facility policy review, it was determined the facility failed to implement the bowel protocol in accordance with physician's orders for one (1) of one (1) sampled resident for bowel management (Resident #213) out of the total sample of twenty (20) residents. The facility failed to implement the bowel protocol for Resident #213, when the resident exceeded 72 hours with no bowel movement (BM). The findings include: Review of the facility policy titled, Bowel Protocol Guidelines, reviewed on 12/31/2023, revealed its purpose was to provide guidance for the use of bowel stimulants for residents with constipation. Per policy review, the procedures included upon admission, an order might be obtained to 'Utilize Bowel Protocol as needed for the newly admitted resident. Continued review revealed if the resident needed to utilize the bowel protocol, the 'Bowel Protocol' order set might be opened and orders entered from the order set for the affected resident. Review of the policy revealed the Ineffective Bowel Pattern Event should be initiated for any resident not having a BM within 72 hours (unless that had been determined to be a usual bowel pattern for the individual). Policy review revealed a progress note associated to the initiation of the Ineffective Bowel Event, was to be completed until the resident had a BM or the bowel pattern returned to normal for that resident. Further review revealed the progress note was to include (assessment for) abdominal distention, pain, and bowel sounds, and nursing staff to assess for effectiveness. Additional policy review revealed orders might be written to administer a Natural Laxative if a resident had no BM within 72 hours; if no results within twenty-four (24) hours after the natural laxative, give Milk of Magnesia (MOM) q [every] day and PRN (as necessary) for constipation. Review of the policy further revealed if no BM resulted within approximately twelve (12) hours after the MOM, administer a Dulcolax suppository, and if no satisfactory BM resulted after the suppository within two (2) hours give a Fleets enema. In addition, the policy further noted nursing staff were to enter residents' bowel movements, in the resident's electronic medical record [EMR] each shift. Review of the Resident Face Sheet for Resident #213 revealed the facility admitted the resident on 01/04/2024, with diagnoses that included unspecified constipation, chronic pancreatitis, unspecified severe dementia, and gastroesophageal reflux disease (GERD) without esophagitis. Further review of the Resident Face Sheet, revealed Resident #213 was discharged from the facility on 02/14/2024. Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/05/2024, revealed the facility assessed Resident #213 to have a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident had severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #213 as dependent upon staff for toilet use and was always incontinent of bowel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #213's Care Plan revealed the facility developed a Problem area, with a start date of 01/12/2024, that noted the resident had inflammatory bowel disease and colon polyps. In addition, review of the Care Plan revealed the facility developed another Problem area, with a start date of 01/12/2024, regarding Resident #213 having a diagnosis of hypothyroidism and was at risk for complications. Continued review of the care plan revealed interventions which included staff to observe the resident for signs of hypothyroidism, including constipation, and to notify the physician as needed. Further review of the Care Plan revealed the facility also developed a Problem area, with a start date of 01/18/2024, regarding Resident #213 to receive high risk medications, including a diuretic, with an intervention for staff to observe and report signs of dehydration, including constipation. Review of Resident #213's Order History revealed an order dated 01/04/2024 that specified, May utilize bowel protocol as needed .enter bowel protocol order set. Continued review of the Order History also revealed the following orders were started on 01/05/2024, as part of the bowel protocol order set: - If no bowel movement within 72 hours; 2 Tablespoons (30 cc) of 'Natural Laxative' Special Instructions: assign to bowel protocol flow sheet Once A Day - PRN [as needed]; - If no results within 24 hours, after 'natural laxative' give 30 cc of Milk of Magnesia Special Instructions: q [every] day/PRN for constipation; - If no results within approximately 12 hours of above MOM administration give Dulcolax suppository per rectum Special Instructions: q day/PRN if no results from MOM; and - If results of suppository are not satisfactory within 2 hours give Fleets enema per rectum once a day - PRN. Review of Resident #213's BM record, for the duration of his/her stay at the facility, revealed the resident had a medium BM on 01/05/2024 at 9:02 PM. Continued review of the BM record revealed the next BM recorded for Resident #213 was noted on 01/10/2024 at 8:08 AM. Per review of the documentation, Resident #213 exceeded 72 hours with no documented BM. Continued review of the BM record revealed BMs were then recorded every one (1) to three (3) days until 01/19/2024 at 2:03 PM, when a large BM was noted. Further review of the record revealed however, Resident #213 did not have another BM documented until 01/26/2024 at 9:54 PM, seven (7) days later. Review of Resident #213's January 2024 Medication Administration History revealed no documented evidence the bowel protocol medications were administered when the resident exceeded 72 hours with no BM, during the timeframe from 01/05/2024 to 01/10/2024 and from 01/19/2024 to 01/26/2024. Review of Resident #213's Resident Progress Notes for the timeframe of 01/05/2024 to 01/10/2024, when the resident first exceeded 72 hours with no BM, reflected no documented evidence of Ineffective Bowel Pattern Event documentation or an assessment of the resident's abdomen or bowel sounds until 01/10/2024 at 1:49 AM. Review of the 01/10/2024 at 1:49 AM documentation revealed staff noted Resident #213's abdomen was soft and non-tender and bowel sounds were active. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #213's Progress Notes for the timeframe of 01/19/2024 to 01/26/2024, when the resident again exceeded 72 hours with no BM, revealed staff documented his/her abdomen was soft and non-tender and bowel sounds were active on 01/19/2024 at 1:15 AM, 01/20/2024 at 8:47 AM, 01/21/2024 at 1:14 AM, 01/22/2024 at 8:02 PM, 01/24/2024 at 11:07 PM, 01/25/2024 at 9:37 PM, and 01/26/2024 at 8:05 PM. Further review revealed however, no documented BMs, nor documentation related to the implementation of the facility's bowel protocol. During an interview on 03/13/2024 at 12:18 PM, Licensed Practical Nurse (LPN) #5 stated the facility utilized a BM protocol that instructed staff to initiate the protocol if a resident had no BM for three (3) days. LPN #3 stated the facility's EMR was not designed to flag the nurse after a resident had no BM for three (3) days, and the nurse would have to check the vital sign section of the EMR to know when a resident had their last BM. She further stated she remembered assisting Resident #213 to the bathroom, and as far as she knew, the resident was having regular BMs. During an interview on 03/14/2024 at 11:37 AM, the Medical Director was unable to recall Resident #213. The Medical Director stated he expected staff to intervene if a resident had no BM for 72 hours unless that was the resident's normal BM routine. He stated staff should increase fluids, add fiber to the resident's diet, and implement the bowel protocol after 72 hours of no BM. He further stated if a resident had no BM for three (3) days he also expected to be notified of that information. During an interview on 03/14/2024 at 1:35 PM, LPN #3 stated if a resident had no documented BM for three days, the nurse was expected to open a bowel pattern event in the EMR; assess for hard stool in the resident's rectum; check for nausea and vomiting; and check to make sure the resident had active bowel sounds. LPN #3 reviewed Resident #213's BM record, and stated when the resident went without a BM for five (5) days and then again for seven (7) days, the Medical Director should have been notified, an ineffective bowel pattern event opened, and the bowel protocol implemented. During an interview on 03/14/2024 at 3:17 PM, Registered Nurse (RN) #19 stated the BM protocol was initiated if a resident had no BM for three (3) days. RN #19 stated the protocol started with use of MiraLAX (a laxative), and if the resident had no BM within four (4) hours, the resident was to be given MOM. She stated if the resident still had no BM within twelve (12) hours of the MOM; a suppository was to be given; and if the resident continued to have no BM within two (2) hours of the suppository; an enema was administered. RN #19 stated if the resident still had no BM the physician was called. She stated prior to starting the bowel protocol for a resident, an abdominal assessment was needed to listen for bowel sounds and to determine if the resident's abdomen was hard or distended. She stated if a resident had no BM for a period of five (5) days or seven (7) days, she would ask the physician for an X-ray to rule out a bowel obstruction or ileus (inability of the intestines to contract normally). RN #19 reviewed Resident #213's BM record and then further stated the resident should have been assessed and the bowel protocol should have been implemented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/15/2024 at 8:25 AM, LPN #2 stated the bowel protocol was to be initiated when a resident had no BM for 72 hours. LPN #2 said the facility's bowel protocol had been approved by the Medical Director and was included in the orders for a newly admitted resident. She stated that before she would initiate the bowel protocol, she assessed the resident and listened for bowel sounds and notified the Medical Director. LPN #2 reviewed Resident #213's BM documentation and stated based on the documentation, the bowel protocol should have been initiated for the resident. LPN #2 acknowledged she had cared for Resident #213 and had no reason or explanation for why she had not started the bowel protocol for him/her. She further stated the Director of Health Services (DHS), who used to run the BM report and post it for staff to review, had stopped posting the BM report about a year ago. During an interview on 03/15/2024 at 9:53 AM, the DHS stated if a resident had not had a BM for three (3) days nurses were expected to follow the facility's bowel protocol. The DHS said that prior to the initiation of the bowel protocol, she expected nurses to assess the resident and document their findings in the nurse's notes of the resident's medical record. She stated the Certified Registered Care Associates (CRCAs) were responsible for documenting BMs and informing the nurses if a resident had no BM for three (3) days. The DHS stated however, the CRCAs were unable to review BM documentation and would be unable to determine how long it had been since a resident had a BM. She stated nurses were also expected to communicate from shift to shift if a resident had not had a BM during their shift. The DHS stated she was responsible for generating residents' BM reports and notifying the nurses if a resident had not had a BM for three (3) days. The DHS reviewed Resident #213's BM record, and stated the bowel protocol should have been implemented when the resident had no BM for five (5) days and longer. During an interview on 03/15/2024 at 1:50 PM. The ED stated he expected nurses to follow the facility's bowel protocol for any resident when the resident had no BM for three (3) days.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 22445 Based on observation, interview, and record review, the facility failed to provide necessary foot care for one (1) of seven (7) residents sampled for activities of daily living (ADLs), (Resident #3). Observation revealed Resident #3's toenails extended half an inch to one (1) inch beyond the tips of his/her toes. The findings include: A policy was requested regarding nail care on 03/15/2024 at 4:45 PM; however, the Assistant [NAME] President of Clinical Operations stated the facility did not have a policy that addressed toenail care. Review of Resident #3's Resident Face Sheet revealed the facility admitted the resident on 03/25/2022, and most recently readmitted the resident on 12/24/2022, with diagnoses that included unspecified dementia, chronic respiratory failure with hypoxia (low oxygen level in the blood), chronic kidney disease with heart failure, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/21/2023, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #3 had short- and long-term memory problems and was moderately impaired cognitively. Further review of the MDS revealed Resident #3 had expressed no rejection of care during the assessment period. In addition, MDS review revealed Resident #3 was dependent on staff to put on or take off footwear and to shower/bathe and required substantial/maximal assistance from staff with personal hygiene. Review of Resident #3's Care Plan, revealed the facility identified a Problem area, started on 12/10/2021 and revised on 02/26/2024, that indicated the resident had impairment in his/her ADLs in regard to bed mobility, transfers, toileting, and eating. Further review revealed an intervention dated 12/10/2021, which directed staff to encourage Resident #3 to be as independent as safely possible. Review further revealed there were no documented interventions that addressed toenail care. Review of an untitled document dated 12/06/2021 and signed by Resident #3 revealed the resident declined a variety of outside resources, including dental, vision, and auditory services. However, further review of the document revealed it did not address podiatry services. During an observation on 03/13/2024 at 11:00 AM, Resident #3 was observed lying on his/her bed with Certified Resident Care Assistant (CRCA) #14 and CRCA #16 present in the room to provide care for the resident. Continued observation revealed Resident #3's toenails were observed to extend a half an inch to one (1) inch beyond the tips of his/her toes. During an interview on 03/13/2024 at 11:20 AM, CRCA #12 stated she was assigned to care for Resident #3, and confirmed the resident's toenails needed to be cut. CRCA #12 stated she reported the need for toenail care for Resident #3 a few months ago; however, was unable to recall who she reported the information to. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185461	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Ridge Health Campus	6415 Calm River Way Louisville, KY 40299

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)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 03/13/2024 at 11:25 AM, Registered Nurse (RN) #10 observed Resident #3's toenails and stated the resident's toenails needed to be trimmed. During a follow-up interview on 03/13/2024 at 12:38 PM, RN #10 stated podiatry services was last in the facility either in January 2024 or February 2024. RN #10 stated Director of Social Services (DSS) #38 was responsible for arranging podiatry services for residents. She further stated she was responsible for Resident #3's care on 03/13/2024; however, additionally stated no one had reported Resident #3's long toenails to her. During a concurrent observation and interview on 03/14/2024 at 10:23 AM, CRCA #13 and CRCA #14 were observed providing Resident #3 a shower. Per observation, Resident #3's toenails had not been trimmed, and his/her right great toenail extended approximately one (1) inch beyond the tip of the toe and curved under the right second toe. Continued observation revealed Resident #3's third toenail on his/her right foot extended approximately a quarter inch to a half inch beyond the tip of the toe, and the left great toenail extended approximately one (1) inch beyond the tip of the toe and curved left, resting under the left second toe. CRCA #13 stated the CRCAs were not allowed to cut residents' toenails, further stated a podiatrist visited the facility every three (3) months. CRCA #13 stated if a resident required podiatry services, the facility placed the resident's name on a list, and the resident was seen when the podiatrist came to the facility. During an interview on 03/15/2024 at 9:24 AM, the Director of Health Services (DHS) stated the podiatrist visited the facility every three (3) months, but added that recently the podiatrist had canceled a few visits. The DHS stated DSS #38 was the person who coordinated all ancillary services, including podiatry services. She stated she had observed Resident #3's toenails and stated the toenails should not have been that long. The DHS further stated no one had reported the condition of Resident #3's toenails. She additionally stated she expected Resident #3's toenails to be cut to the proper length. During an interview on 03/15/2024 at 10:50 AM, DSS #38 stated the podiatrist came to the facility every two (2) to three (3) months and the podiatry service was who sent her the list of residents to be seen. She further stated she was unsure when Resident #3 had last been seen. During a follow-up interview on 03/15/2024 at 11:24 AM, DSS #38 said Resident #3 had not received podiatry services since his/her admission to the facility and agreed podiatry care should have been provided for the resident. DSS #38 also stated she had reviewed Resident #3's admission paperwork, and the resident had declined some outside resources but she confirmed podiatry services had not been discussed with the resident. During an additional interview on 03/15/2024 at 3:46 PM, DSS #38 stated she called the facility's podiatry provider, and they confirmed Resident #3 was not receiving their services and they had never seen the resident. During an interview on 03/14/2024 at 11:53 AM, the Medical Director stated if a resident's toenails extended half an inch to one (1) inch beyond the tips of their toes, he expected the facility to arrange with an outside source to have the resident's nails trimmed.