STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195272	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Healthcare Center	2200 Jefferson Hwy Jefferson, LA 70121

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 30587 47081 Based on interviews and record reviews, the facility failed to ensure residents were able to access and manage their funds at all times for 3 (Resident #17, Resident #56, Resident #67) of 3 (Resident #17, Resident #56, and Resident #67) sampled residents reviewed for personal funds. Findings: Review of the facility's Resident Trust Fund policy and procedure, undated, revealed, in part, residents or family members may deposit funds into the resident trust fund account for resident's personal spending. Further review revealed just like a bank the facility had banking hours, and to please see the facility business office specialist for a listing of the resident's banking hours. Review of the facility's Resident Trust Fund Policy and Procedure, effective date of 01/23/2023, revealed, in part, residents who have authorized the facility to manage their personal funds must have reasonable access to those funds. Further review revealed the facility was expected to maintain amounts of petty cash on hand that may be required by the residents, and a request for fifty dollars or less would be honored the same day. Resident #17 Review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/2025 revealed a Brief Interview for Mental Status (BIMS) score of 14 (score of 13-15 indicated Resident #17 was cognitively intact). In an interview on 04/28/2025 at 10:21AM, Resident #17 indicated he could not access his funds on the weekends. Resident #56 Review of Resident #56's MDS with an ARD of 03/21/2025 revealed a BIMS score of 12 (score of 08-12 indicated Resident #56 had a moderate cognitive impairment). In an interview on 04/28/2025 at 10:46AM, Resident #56 indicated he could not access his funds on the weekends. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #67 Review of Resident #67's MDS with an ARD of 01/29/2025 revealed a BIMS score of 14 (score of 13-15 indicated Resident #67 was cognitively intact). In an interview on 04/28/2025 at 11:39AM, Resident #67 indicated she could not access her funds on the weekends. Resident #67 further indicated she was informed the money dispersal was closed on Saturdays and Sundays. In an interview on 04/29/2025 at 11:30AM, S26Business Office Specialist (BOS) indicated Resident #17, Resident #56, and Resident #67 had personal funds accounts with the facility. S26BOS further indicated the process for the residents to access their funds was the facility's bank was open from 1:00PM through 3:00PM Monday through Friday. S26BOS further indicated she only opened Monday through Friday, and on the weekends she would leave a petty cash box with the weekend registered nurse, usually S2Director of Nursing (DON). In an interview on 04/29/2025 at 11:47AM, S2DON indicated she was given a petty cash box on the weekends for residents with personal funds accounts. S2DON further indicated she can dispense funds, but she never publicized this information. S2DON further indicated the funds would only be available for the 8 hours she was working at the facility. In an interview on 05/01/2025 at 12:20PM, S26BOS indicated the facility did not have anything documented which identified the facility's banking hours. S26BOS further indicated the facility did not have documented evidence that residents were provided with banking hours or it was discussed with residents during care plan meetings and/or resident council meets as to how to access funds on the weekends. S26BOS further indicated the facility did not have any documented evidence that any resident had accessed their funds on the weekends. There was no documented evidence, and the facility presented no documented evidence, the facility had resident's personal funds available on the weekends and that residents were made aware that their personal funds could be accessed on weekends. In an interview on 05/01/2025 at 1:19PM, S1Administrator indicated personal funds were available to residents on the weekends; however, the facility had no documented evidence personal funds were available on weekends, that the facility had notified residents on how to access their funds on the weekends, and/or that residents were accessing funds on the weekends.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47487 Based on interviews and record reviews, the facility failed to ensure a resident's physician was notified of a resident's elevated blood glucose level for 1 (Resident #114) of 5 (Resident #36, Resident #67, Resident #104, Resident #105, Resident #114) sampled residents investigated for unnecessary medications. Findings: Review of Resident #114's April 2025 physician's orders revealed, in part, an order to administer Resident #114's Humalog Insulin Pen (a medication used to help control blood glucose levels) 100 units/milliliters as per a sliding scale before meals and at bedtime. Further review revealed, if Resident #114's blood glucose level was between [PHONE NUMBER] mg/dL (milligrams per deciliter), Resident #114's physician should be called. Review of Resident #114's April 2025 electronic Medication Administration Record (eMAR) revealed, in part: On 04/07/2025 at 4:00PM, Resident #114's blood glucose level was 433 mg/dL; On 04/11/2025 at 4:00PM, Resident #114's blood glucose level was 360 mg/dL; On 04/17/2025 at 4:00PM, Resident #114's blood glucose level was 389 mg/dL; On 04/22/2025 at 4:00PM, Resident #114's blood glucose level was 384 mg/dL; On 04/25/2025 at 4:00PM, Resident #114's blood glucose level was 394 mg/dL; On 04/30/2025 at 4:00PM, Resident #114's blood glucose level was 389 mg/dL; On 04/11/2025 at 8:00PM, Resident #114's blood glucose level was 398 mg/dL; On 04/13/2025 at 8:00PM, Resident #114's blood glucose level was 385 mg/dL; On 04/22/2025 at 8:00PM, Resident #114's blood glucose level was 361 mg/dL; On 04/24/2025 at 8:00PM, Resident #114's blood glucose level was 369 mg/dL; On 04/26/2025 at 8:00PM, Resident #114's blood glucose level was 394 mg/dL; On 04/28/2025 at 8:00PM, Resident #114's blood glucose level was 365 mg/dL; and, On 04/29/2025 at 8:00PM, Resident #114's blood glucose level was 389 mg/dL. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence, and the facility did not present any documented evidence Resident #114's physician was notified of the above mentioned blood glucose levels as ordered. In an interview on 05/01/2025 at 12:10PM, S2Director of Nursing (DON) indicated the nurses should have been notifying Resident #114's physician for any blood glucose level above 352. In an interview on 05/01/2025 at 1:15PM, S2DON indicated the facility had no documented evidence Resident #114's physician was notified of the above elevated blood glucose levels as ordered.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 30587 Based on interviews and record reviews, the facility failed to ensure a resident with a facility initiated discharge with Medicare Part A skilled services days remaining was provided with a Notice of Medicare Non-Coverage (NOMNC) for 1 (Resident #227) of 3 (Resident #34, Resident #68, Resident #227) sampled residents reviewed for Beneficiary Notification requirements. Findings: Review of Resident #227's Skilled Nursing Facility (SNF) Beneficiary Notification Review revealed, in part, Resident #227 started Medicare Part A skilled services on 09/23/024 with the last covered day of Part A services on 11/03/2024. Further review revealed the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. Review of Resident #227's Social Service note dated 11/04/2024 revealed, in part, social services issued a local coverage of determination (LCD) for skilled services on 11/03/2024 with discharge home on 11/04/2024. Further review revealed no documented evidence a Notice of Medicare Non-Coverage (NOMNC) was provided to Resident #227 or Resident #227's responsible party prior to discharge and prior to non-covered days. There was no documented evidence, and the facility presented no documented evidence, Resident #227 was provided with a NOMNC notice prior to Medicare Part A services being discontinued. In an interview on 04/30/2025 at 10:09AM, S19Social Services Director indicated the facility had not been able to locate Resident #227's NOMNC that should have been completed by S21Prior Social Worker. In an interview on 05/01/2025 at 12:57PM, S1Administrator indicated the facility had identified a problem with beneficiary notices, but had not implemented a Quality Assurance and Perform Improvement (QAPI) at this time. S1Administrator further indicated the facility should have a NOMNC for the facility initiated discharge with skilled days remaining; however, the facility was unable to provide documented evidence Resident #227 or Resident #227's family was provided with a NOMNC prior to Medicare Part A services discontinuing.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34060 Based on observations, interviews, and record review, the facility failed to maintain a sanitary environment in a resident's room for 1 (Resident #36) of 1 (Resident #36) sampled residents investigated for environment. Findings: Review of Housekeeper Aide Job Description, dated 04/15/2015, revealed, in part, the primary purpose of the Housekeeper Aide was to perform the day-to day activities of the housekeeping department in accordance with current federal, state, and local standards. Further review revealed the housekeeper aide was responsible for cleaning walls by washing, wiping, dusting, spot cleaning, disinfecting, and deodorizing. Observation on 04/28/2025 at 10:25AM of Resident #36's room, revealed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. Observation on 04/29/2025 at 10:31AM of Resident #36's room, revealed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. Observation on 04/30/2035 at 10:42AM of Resident #36's room, revealed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. Observation on 05/01/2025 at 11:53AM of Resident #36's room, revealed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. In an interview on 05/01/2025 at 11:57AM, S8Housekeeper indicated she was responsible for ensuring she cleaned each resident's room. S8Housekeeper further indicated she had cleaned and wiped all unclean areas on Resident #36's wall. Observation with S8Houskeeper on 05/01/2025 at 12:02PM, revealed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. In an interview on 05/01/2025 at 12:02PM, S8Housekeeper indicated she noticed there was an unknown dried brown substance on two areas of the wall next to Resident #36's bed. In an interview on 05/01/2025 at 12:05PM, S5Business Office Specialist confirmed Resident #36's wall was not maintained in a sanitary manner at this time, and should have been maintained in a sanitary manner. In an interview on 05/01/2025 at 1:43PM, S1Administrator acknowledged she was aware of the above findings and had nothing to present to dispute the above mentioned deficient practice.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30587 Based on interviews and record reviews, the facility failed to ensure: 1. An injury of unknown origin was reported to the State Survey Agency as required after discovery of a bruise to a resident's right eye (Resident #146); and, 2. An allegation of resident to resident physical abuse was reported to the State Survey Agency as required (Resident #154). This deficient practice was identified for 2 (Resident #146, Resident #154) of 3 (Resident #56, Resident #146, Resident #154) sampled residents reviewed for abuse. Findings: Review of the facility's Abuse Prevention and Prohibition policy and procedure, dated 09/30/2019, revealed, in part, the facility must ensure all alleged violations involving injuries of unknown origin and abuse were reported immediately, but no later than 2 hours after the allegation was made to the administrator of the facility and to other officials (including the State Survey Agency) in accordance with state law through established procedures. 1. Review of Resident #146's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/16/2025 revealed, in part, Resident #146 had a Brief Interview for Mental Status (BIMS) score of 02 (00-07 indicated Resident #146 had a severe cognitive impairment). Further review revealed Resident #146 required supervision for transfers and was independent for ambulation. Review of Resident #146's progress note dated 04/20/2025 at 10:48PM revealed, in part, Resident #146 was observed with a bruise of unknown origin to the right periorbital (area around the eye) area. Further review revealed the skin to the right periorbital area was reddish-blue in color. Review further revealed Resident #146 was unable to provide a history of the bruise. In an interview on 04/29/2025 at 5:34PM, S1Administrator indicated she was aware of Resident #146's right periorbital bruising with no witnessed falls reported around 04/20/2025. S1Administrator further indicated due to Resident #146 having a habit of picking things up off the floor the facility assumed he must have hit his eye on something or had a fall. S1Administrator indicated she did not submit a SIMS report to the State Survey Agency. In an interview on 04/29/2025 at 5:34PM, S29Regional Administrator indicated a SIMS report was not completed for Resident #146's right periorbital bruising. S29Regional Administrator acknowledged origin of Resident #146's right periorbital bruising was not identified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 05/01/2025 at 1:23PM, S1Administrator indicated Resident #146 was unable to explain the reason for the bruising, and the facility had no documented evidence Resident #146 had a witnessed fall. S1Administrator further indicated the facility was unable to prove the origin of Resident #146's right periorbital injury; however she did not believe she needed to complete a SIMS report to notify the State Survey Agency of Resident #146's injury of unknown origin. S1Administrator did not offer any further explanation for the reason why the facility felt the injury of unknown origin was not reportable. 2. Review of Resident #154's medical record revealed Resident #154 was admitted to the facility on [DATE] with diagnoses, which included, vascular dementia and mood or anxiety disturbance. Review of Resident #154's MDS with an ARD of 01/22/2025 revealed, in part, Resident #154 had a BIMS of 03 (score of 00-07 indicated severe cognitive impairment). Review of the facility's Incident Log revealed, in part, on 03/24/2025 Resident #154 was listed as the recipient of physical aggression on 03/24/2025 at 12:00AM with Resident #91 listed as the aggressor. Review of Resident #154's nurse's note dated 03/24/2025 at 2:52PM revealed, in part, the staff was notified by a Certified Nursing Assistant (CNA) that Resident #91 grabbed Resident #154 out of his wheelchair. Further review revealed Resident #91 was hovering over and yelling at Resident #154. In an interview 04/30/2025 at 2:10PM, S2Director of Nursing (DON) indicated on 03/24/2025 Resident #91 pulled Resident #154 out of a wheelchair onto floor in response to Resident #154 extending his arm out to him. S2DON was unable to verify if the incident involving Resident #91 and Resident #154 on 03/24/2025 was an allegation of resident to resident abuse which required reporting to the State Survey Agency. There was no documented evidence, and the facility presented no documented evidence, of the allegation of resident to resident abuse involving Resident #91 and Resident #154's on 03/24/2025 had been reported to the State Survey Agency. In an interview on 04/30/2025 at 4:15PM, S1Administrator indicated the facility had not reported the allegation of a resident to resident altercation between Resident #91 and Resident #154 to the State Survey Agency. 40405

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 30587 40405 Based on interviews and record reviews, the facility failed to ensure an injury of unknown origin was thoroughly investigated for 1 (Resident #146) of 3 (Resident #56, Resident #146, Resident #154) sampled residents reviewed for abuse. Findings: Review of the facility's Abuse Prevention and Prohibition policy and procedure dated 09/30/2019, revealed, in part, for an allegation of abuse, the administrator was to complete a thorough investigation, including interviews of employees who were working in the resident's room during the time in question, and obtaining signed statements from these employees. Further review revealed the investigator would interview the resident if the resident was cognitively able to answer questions, and if not able to interview, the investigator would interview the resident's roommate. Review of Resident #146's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 04/16/2025 revealed, in part, Resident #146 had a Brief Interview for Mental Status (BIMS) score of 02 (00-07 indicated Resident #146 had a severe cognitive impairment). Further review revealed Resident #146 required supervision for transfers and was independent for ambulation. Review of Resident #146's progress note dated 04/20/2025 at 10:48PM revealed, in part, Resident #146 was observed with a bruise of unknown origin to the right periorbital (area around the eye) area. Further review revealed the skin to the right periorbital area was reddish-blue in color. Review further revealed Resident #146 was unable to provide a history of the bruise. In an interview on 04/29/2025 at 5:34PM, S1Administrator indicated she was aware of Resident #146's right periorbital bruising with no witnessed falls reported around 04/20/2025. S1Administrator further indicated due to Resident #146 having a habit of picking things up off the floor the facility assumed Resident #146 may have hit his eye on something or had a fall. S1Administrator further indicated she had spot checked the security footage but did not have any documented evidence of the dates and times reviewed or what was seen, and she was still waiting on the written statements from the staff S30Certified Nursing Assistant (CNA) Supervisor had interviewed. In an interview on 04/29/2025 at 5:48PM, S30CNA Supervisor indicated she only conducted verbal interviews with staff regarding Resident #146's right periorbital bruising. S30CNA Supervisor further indicated she had only interviewed S31CNA and S32CNA. S30CNA Supervisor further indicated she did not have any documented evidence of S31CNA and S32CNA's verbal statements as she failed to write down their statements. In an interview on 04/29/2025 at 5:55pm S31CNA indicated none of the staff had ever interviewed her regarding Resident #146's right periorbital bruising. In an interview on 04/29/2025 at 5:59PM, S33Licensed Practical Nurse (LPN) indicated she had not been asked about the bruising to Resident #146's right eye. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 04/29/2025 at 6:09PM, S32CNA indicated she had notified S33LPN of the bruise to Resident #146's right periorbital area on a Thursday. S32CNA indicated the area under Resident #146's eye was reddish purple, then became black and red. S32CNA further indicated neither S30CNA Supervisor nor S1Administrator had interviewed her or asked her to write a statement regarding the bruising to Resident #146's right periorbital area. In an interview on 05/01/2025 at 1:23PM, S1Administrator indicated the facility had assumed Resident #146 had a fall which caused the bruising/discoloration to the right periorbital area; however, Resident #146 did not have any documented falls. S1Administrator further indicated she did not document the video surveillance footage review, nor did she interview any other shifts or staff other than S31CNA and S32CNA. S1Administrator further indicated she had no other documented evidence to present that the facility had completed a thorough investigation into the bruising on Resident #146's right periorbital area.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 40405 Based on interviews and record reviews, the facility failed to provide a resident with a 30-day notice prior to discharge for 1(Resident #174) of 1 (Resident #174) sampled residents reviewed for discharge. Findings: Review of Resident #174's electronic medical record revealed, in part, Resident #174 was discharged from the facility on 02/05/2025 at 3:33PM. Review of Resident #174's electronic medical record revealed, in part, that Resident #174 did not receive 30-day notice prior to discharge. The facility did not present any documented evidence that Resident #174 received a 30-day written notification of discharge as required. In an interview on 05/01/2025 at 12:30PM, S19Social Service Director indicated Resident #174 did not receive a 30-day notification prior to discharge. In an interview on 05/01/2025 at 2:30PM, S1Administrator confirmed Resident #174 did not receive a 30-day written notification prior to discharge.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081 Based on interviews and record reviews, the facility failed to ensure: 1. A referral was made to the Louisiana Office of Behavioral Health's Preadmission Screening and Resident Review (PASRR) program for a resident with a onset of mental illness since admission (Resident #121); and, 2. A referral was made to the Louisiana Office of Behavioral Health's PASRR program for a resident identified with a mental illness upon admission (Resident #17). This deficient practice was identified for 2 (Resident #17, Resident #121 of 3 (Resident #17, Resident #57, Resident #121) sampled residents investigated for PASRR. Findings: 1. Review of Resident #121's Electronic Medical Record (EMR) revealed, in part, Resident #121 was admitted to the facility on [DATE]. Further review revealed Resident #121 had a diagnosis of moderate, recurrent, Major Depressive Disorder with an onset date on 09/02/2022. Further review revealed no documented evidence a PASRR Level II evaluation was completed for Resident #121 and/or a referral was made to the Louisiana Office of Behavioral Health's PASRR program for Resident #121 since admission. Review of facility's Quality Improvement Corrective Action Plan regarding the facility not appropriately submitting Level II reviews to the Louisiana Office of Behavioral Health's PASRR program revealed, in part, a Re-Admit Screening for New Psychiatric Diagnosis and/or Psychotropic Medication Changes form was completed for Resident #121 on 03/28/2025 as part of the facility's auditing for the Quality Improvement Corrective Action Plan. Review of Resident #121's Re-Admit Screening for New Psychiatric Diagnosis and/or Psychotropic Medication Changes form dated 03/28/2025 revealed, in part, no documentation staff identified a referral to the Louisiana Office of Behavioral Health's PASRR program needed to be completed due to Resident #121's diagnosis of Major Depressive Disorder since his admission. In an interview on 04/30/2025 at 1:25PM, S24Corporate Nurse acknowledged Resident #121's Major Depressive Disorder diagnosis occurred after his admission, and was a diagnosis that would have required a referral to the Louisiana Office of Behavioral Health's PASRR Program. S24Corportate Nurse further indicated the staff should have identified during the facility auditing on 03/28/2025 that Resident #121 required a referral to the Louisiana Office of Behavioral Health's PASRR program. There was no documented evidence, and the provider did not present any documented evidence, a referral was made to the Louisiana Office of Behavioral Health's PASRR program regarding Resident #121's diagnosis of Major Depressive Disorder that occurred after his admission. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/30/2025 at 1:30PM, S4Administrator Assistant indicated the facility's staff should have identified Resident #121 required a Level II PASRR evaluation during the facility's 03/28/2025 PASRR audit of Resident #121's record. 2. Review of Resident #17's EMR revealed, in part, Resident #17 was admitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder and Bipolar II Disorder. Further review revealed no documented evidence a PASRR Level II evaluation was completed for Resident #17 and/or a referral was made to the Louisiana Office of Behavioral Health's PASRR Program for Resident #17. In an interview on 04/30/2025 at 1:35PM, S4Administrator Assistant indicated Resident #17 was admitted with diagnoses of Major Depressive Disorder and Bipolar II Disorder. S4Administrator Assistant further indicated if a resident was admitted with a mental illness diagnosis, a referral for a Level II PASRR evaluation should have been submitted to the Louisiana Office of Behavioral Health's PASRR program. There was no documented evidence, and the provider did not present any documented evidence, a referral was made to the Louisiana Office of Behavioral Health's PASRR program regarding Resident #17's diagnoses of Major Depressive Disorder and Bipolar II Disorder. In an interview on 04/30/2025 at 1:39PM, S1Administrator confirmed a referral for a Level II PASRR evaluation should have been submitted to the Louisiana Office of Behavioral Health's PASRR program for a resident who was admitted with a mental illness diagnoses. 47487

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081 Based on record reviews and interviews, the facility failed to ensure a Level I Pre-Admission Screening and Resident Review (PASRR) was accurately completed to reflect a resident's mental illness for 1 (Resident #17) of 3 (Resident #17, Resident #57, Resident #121) sampled residents investigated for PASRR requirements. Findings: Review of Resident #17's medical record revealed, in part, Resident #17 was admitted to the facility on [DATE] with diagnoses, which included, major depressive disorder and bipolar II disorder. Review of Resident #17's incomplete and undated Level I PASRR revealed, in part, Resident #17 was documented to not have been diagnosed with a mental illness. Further review revealed no psychiatric diagnosis was selected/identified on the above mentioned assessment. In an interview on 04/30/2025 at 1:35PM, S4Administrator Assistant (AA) indicated Resident #17 was admitted with diagnoses of major depressive disorder and bipolar II disorder. S4AA further indicated Resident #17's undated preadmission Level I PASRR indicated Resident #17 did not have a mental illness diagnosis, and was inaccurate and incomplete. There was no documented evidence, and the provider did not present any documented evidence a complete Level I PASRR was completed for Resident #17. In an interview on 04/30/2025 at 1:39PM, S1Administrator confirmed Resident #17's Level I PASRR was not verified for accuracy and completeness and should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47487 Based on observations, interviews, and record review, the facility failed to ensure a dependent resident received nail care for 1 (Resident #22) of 2 (Resident #21, Resident #22) sampled residents investigated for activities of daily living (ADLs). Findings: Review of Resident #22's April 2025 Care Task log revealed, in part, Resident #114's nail care task was documented as not applicable on 05/01/2025 at 5:59AM. Observation on 05/01/2025 at 8:28AM revealed all 10 of Resident #22's fingernails were yellowed and extended one-fourth to one-half of an inch above the tips of Resident #22's fingers. Further observation revealed an unknown gray substance was visible underneath Resident #22's nails where they extended above Resident #22's fingertips. In an interview on 05/01/2025 at 8:28AM, Resident #22 indicated that he would like his fingernails cut. In an interview on 05/01/2025 at 8:39AM, S25CNA indicated Resident #22 required total assistance with ADLs. Observation on 05/01/2025 at 10:40AM revealed all 10 of Resident #22's fingernails were yellowed and extended one-fourth to one-half of an inch above the tips of Resident #22's fingers. Further observation revealed an unknown gray substance was visible underneath Resident #22's nails where they extended above Resident #22's fingertips. Observation on 05/01/2025 at 12:47PM, revealed all 10 of Resident #22's fingernails were yellowed and extended one-fourth to one-half of an inch above the tips of Resident #22's fingers. Further observation revealed an unknown gray substance was visible underneath Resident #22's nails where they extended above Resident #22 finger tips. Further observation revealed, when Resident #22 turned his hands over to present his palms, the nails on the middle three fingers of Resident #22's left hand had an unknown gray substance packed beneath the nail area that extended above Resident #22's fingertips. In an interview on 05/01/2025 at 12:47PM, S9Assistant Director of Nursing (ADON) acknowledged Resident #22's nails needed to be cut, and staff should have cleaned the unknown gray substance from beneath Resident #22's fingernails.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081 Based on interviews and record reviews, the facility failed to follow a physician's order to ensure daily wound care was provided for a resident with unhealed pressure ulcers for 1 (Resident #14) of 1 (Resident #14) sampled residents reviewed for pressure ulcers. Findings: Review of the May 2023 Louisiana Administrative Code, Title 46, Part XLVII revealed, in part: the registered nurse retained the accountability for the total nursing care of the individual and was responsible for and accountable to each consumer of nursing care for the quality of nursing care he or she received, regardless of whether the care was provided solely by the registered nurse or by the registered nurse in conjunction with other licensed or unlicensed assistive personnel. Further review revealed, in part, the plan for nursing care was implemented according to the following criteria: nursing actions were consistent with the plan for nursing care and nursing actions were documented by written records. Review of the facility's Wound Care policy and procedure, dated 11/26/2014, revealed, in part, nursing interventions for the treatment of wounds included the cleansing and dressing of wounds as ordered. Review of Resident #14's medical record revealed, in part, Resident #14 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (a disease that causes the heart to inefficiently pump blood), peripheral vascular disease, and unhealed pressure ulcers. Review of Resident #14's Braden Scale assessment dated [DATE] revealed, in part, a total score of 15.0, which indicated Resident #14 was at a risk for skin breakdown and/or developing a pressure ulcer. Review of Resident #14's March through April 2025 electronic Medication Administration Record (eMAR) revealed, in part, the following physician's orders were documented as not performed: - Clean Resident #14's left heel with normal saline, pat dry, apply santyl (a medication used to remove damaged skin tissue from wounds) to the wound bed, apply a moisture barrier to the peri wound, and cover with a dressing once a day by an unnamed agency nurse on 03/21/2025 and 04/16/2025, S16LPN/TN on 04/17/2025 and 04/21/2025, and no eMAR entry on 04/05/2025; - Paint distal aspect of left great toe with betadine and leave open to air once a day by an unnamed agency nurse on 03/21/2025, S16Licensed Practical Nurse (LPN)/Treatment Nurse (TN) on 04/17/2025 and 04/21/2025, and no eMAR entry on 04/05/2025; - Cleanse Resident #14's left hip Stage 3 (a wound that has broken through the top two layers of skin and into the fatty tissue below) pressure ulcer wound with wound cleanser, pat dry, apply santyl, and cover with a clean dry dressing by an unnamed agency nurse on 04/16/2025, S16LPN/TN on 04/17/2025 and 04/21/2025; and, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Clean Resident #14's Unstageable (a full-thickness tissue injury where the depth is obscured by eschar and/or slough) sacrum pressure ulcer wound with wound cleanser, apply santyl to wound bed and surrounding area, apply barrier of choice to the surrounding wound area, and cover with a dry dressing daily and as needed until healed once a day by S16LPN/TN on 04/23/2025. Review of Resident #14's progress notes from March 2025 through April 2025 revealed, in part, no documented evidence Resident #14 was provided wound care as ordered on the above mentioned dates. In an interview on 04/29/2025 at 3:40PM, Resident #14 indicated there were multiple days he did not receive wound care for his unhealed pressure ulcers when he left the facility for dialysis treatment. In an interview on 05/01/2025 at 11:45AM, S18Registered Nurse/Treatment Nurse (RN/TN) indicated Resident #14 should have received daily wound care for his unhealed pressure injuries as ordered. S18RN/TN further indicated she was unaware of any orders to hold Resident #14's wound care on the above mentioned dates related to Resident #14 attending dialysis appointments There was no documented evidence and the facility could not provide any documented evidence, Resident #14 refused or received wound care for his unhealed pressure injuries on the above mentioned dates. In an interview on 05/01/2025 at 12:20PM, S2Director of Nursing (DON) indicated Resident #14 should have received daily wound care as ordered. S2DON further indicated Resident #14 should have received wound care before or after his scheduled dialysis appointments.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47081 Based on interviews and record reviews, the facility failed to maintain a system to accurately reconcile controlled substances for 5 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d, Medication Cart e) of 5 (Medication Cart a, Medication Cart b, Medication Cart c, Medication Cart d, Medication Cart e) medication carts reviewed for the reconciliation documentation of controlled substances. Findings: Review of the facility's Medication Administration policy and procedure dated 10/04/2024 revealed, in part, at change of shift, the off going and oncoming nurses shall count the medications in the narcotic cabinet for any discrepancies utilizing the controlled drug package inventory form. Review of the facility's undated Controlled Drug Count Record and Package Inventory form revealed, in part, a signature acknowledged the nurse had counted the controlled drugs and had found the quantity of each medication was in agreement with the quantity stated on the Controlled Dug Administration Record. Further review revealed the nurse should have signed and had another nurse witness. Review of the facility's April 2025 Medication Cart a Controlled Drug Count Record and Package Inventory revealed, in part, there was no signature that indicated the oncoming nurse had reconciled Medication Cart a's controlled substances with the off going nurse on 04/06/2025 for the 11:00PM to 7:00AM shift. There was no documented evidence and the facility did not present any documented evidence the facility's nurses reconciled the controlled substances on Medication Cart a as required for the above mentioned date and times. Review of the facility's April 2025 Medication Cart b Controlled Drug Count Record and Package Inventory revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart b's controlled substances with the oncoming nurse on: - 04/03/2025 for the 11:00PM to 7:00AM shift; - 04/04/2025 for the 11:00PM to 7:00AM shift; - 04/07/2025 for the 11:00PM to 7:00AM shift; - 04/08/2025 for the 11:00PM to 7:00AM shift; - 04/13/2025 for the 11:00PM to 7:00AM shift; and, - 04/14/2025 for the 11:00PM to 7:00AM shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart b's controlled substances with the off going nurse on: - 04/08/2025 for the 11:00PM to 7:00AM shift; - 04/13/2025 for the 11:00PM to 7:00AM shift; - 04/14/2025 for the 11:00PM to 7:00AM shift; and - 04/28/2025 for the 7:00AM to 3:00PM shift. There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart b for the above mentioned dates and/or times. Review of the facility's April 2025 Medication Cart c Controlled Drug Count Record and Package Inventory revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart c's controlled substances with the oncoming nurse on: - 04/22/2025 for the 11:00PM to 7:00AM shift; and, - 04/29/2025 for the 7:00AM to 3:00PM shift. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart c's controlled substances with the off going nurse on: - 04/22/2025 for the 3:00PM to 11:00PM shift; and, - 04/23/2025 for the 11:00PM to 7:00AM shift. There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart c for the above mentioned dates and/or times. Review of the facility's April 2025 Medication Cart d Controlled Drug Count Record and Package Inventory revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart d's controlled substances with the oncoming nurse on: - 04/05/2025 for the 11:00PM to 7:00AM shift; and, - 04/28/2025 for the 11:00PM to 7:00AM shift. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart d's controlled substances with the off going nurse on: - 04/23/2025 for the 3:00PM to 11:00PM shift; and, - 04/29/2025 for the 7:00AM to 3:00PM shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review revealed the oncoming nurse and off going nurse did not document the total number of controlled medication packages reconciled on the following dates: - 04/01/2025; - 04/12/2025; - 04/13/2025; - 04/14/2025; and, - 04/15/2025. There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart d for the above mentioned dates and/or times. Review of the facility's April 2025 Medication Cart e Controlled Drug Count Record and Package Inventory revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart e's controlled substances with the oncoming nurse on: - 04/01/2025 for the 3:00PM to 11:00PM shift; - 04/15/2025 for the 7:00AM to 3:00PM shift; - 04/16/2025 for the 7:00AM to 3:00PM shift; - 04/21/2025 for the 7:00AM to 3:00PM shift; - 04/22/2025 for the 7:00AM to 3:00PM shift; and, - 04/28/2025 for the 7:00AM to 3:00PM shift. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart e's controlled substances with the off going nurse on: - 04/01/2025 for the 3:00PM to 11:00PM shift; - 04/16/2025 for the 3:00PM to 11:00PM shift; and, - 04/29/2025 for the 7:00AM to 3:00PM shift. Further review revealed the oncoming nurse and off going nurse did not document the total number of controlled medication packages reconciled on 04/29/2025. There was no documented evidence and the facility did not present any documented evidence of having a record of receipt and disposition of all controlled drugs in Medication Cart e for the above mentioned dates and/or times. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2025 at 9:15AM, S12Licensed Practical Nurse (LPN) indicated nurses were required to reconcile controlled substances with the off going nurse at the beginning of their shift and reconcile controlled substances with the oncoming nurse at the end of their shift. S12LPN further indicated the nurses should document that the controlled substance reconciliation was completed on the facility's Controlled Drug Count Record and Package Inventory form. S12LPN further indicated she did not sign the Medication Cart c Controlled Drug Count Record and Package Inventory with the off going nurse at the beginning of her above mentioned shift on 04/29/2025 and should have. In an interview on 04/29/2025 at 10:10AM, S17LPN indicated nurses were required to reconcile controlled substances with the off going nurse at the beginning of their shift and reconcile controlled substances with the oncoming nurse at the end of their shift. S17LPN further indicated the nurses should have documented that the controlled substance reconciliation was completed on the facility's Controlled Drug Count Record and Package Inventory form. S17LPN further indicated she did not sign the Medication Cart e Controlled Drug Count Record and Package Inventory with the off going nurse at the beginning of her above mentioned shift on 04/29/2025 and should have. There was no documented evidence and the facility did not present any documented evidence to dispute the above mentioned deficient practice. In an interview on 05/01/2025 at 12:20PM, S2Director of Nursing confirmed the above mentioned Controlled Drug Count Record and Package Inventory sheets were not completed with a nurse's signature at the beginning and/or at the end of the nurse's shift as required and should have been.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47081 Based on observation, interviews, and record review, the facility failed to ensure a carton of nutritional supplement was stored per a manufacturer's guideline and was not available for resident consumption. Findings: Review of Med Plus 2.0 nutritional supplement's directions revealed, in part, the product should be used within 4 hours of opening if not refrigerated. Observation on 05/01/2025 at 8:30AM revealed an opened unrefrigerated carton of Med Plus 2.0 nutritional supplement on Medication Cart d. Further observation revealed the above mentioned carton had an opened date of 04/30/2025. In an interview on 05/01/2025 at 8:45AM, S13Licensed Practical Nurse (LPN) confirmed the above mentioned supplement was opened on 04/30/2025, not refrigerated, and available for resident consumption. S13LPN further indicated he did not know the supplement should have been used within 4 hours of opening if not refrigerated. In an interview on 05/01/2025 at 11:00AM, S2Director of Nursing (DON) confirmed nursing staff should have ensured the carton of Med Plus 2.0 nutritional supplement was discarded 4 hours after being opened if not refrigerated. S2DON confirmed an opened and unrefrigerated Med Pass 2.0 nutritional supplement dated 04/30/2025 should not have been on Medication Cart d and available for use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47081 Based on interviews and record reviews, the facility failed to ensure a resident's electronic Medication Administration Record (eMAR) was accurately documented for 2 (Resident #14, Resident #99) of 4 (Resident #14, Resident #17, Resident #67, Resident #99) sampled residents reviewed for accurate medical record documentation. Findings: Review of the facility's Employee Handbook Code of Conduct dated 10/01/2024 revealed, in part, all employees were required to be truthful in all communication and written records to ensure resident records were accurate. Review of the facility's Licensed Practical Nurse (LPN) job description dated 10/2024 revealed, in part, it was the responsibility of the LPN to have knowledge of federal and state laws and regulations related to resident care and to carry out the assigned duties and responsibilities in accordance with current existing federal and state regulations. Resident #14 Review of Resident #14's electronic medical record revealed, in part, Resident #14 was admitted to the facility on [DATE] with a diagnoses which included unhealed pressure ulcers (wounds on the body created by prolonged pressure). Review of Resident #14's Minimum Data Set with an Assessment Reference Date of 04/10/2025 revealed, in part, a Brief Interview for Mental Status summary score of 14, which indicated Resident #14 was cognitively intact. In an interview on 04/29/2025 at 3:40PM, Resident #14 indicated he was not seen by a wound care nurse on 04/28/2025. Review of Resident #14's Wound Care assessment dated [DATE] revealed, in part, the following wounds were documented as evaluated by S18Registered Nurse/Treatment Nurse (RN/TN) on 04/28/2025: - Unstageable (a full-thickness tissue injury where the depth is obscured by eschar and/or slough) left heel pressure injury; -Rear left malleolus deep tissue pressure injury (damage under the skin's surface that usually appears as a bruise); and, - Stage 2 (a shallow open wound) sacral pressure injury. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/2025 at 11:45AM, S18RN/TN indicated she did not treat and/or evaluate Resident #14's pressure ulcer wounds on 04/28/2025. S18RN/TN could offer no further explanation as to why the above mentioned documented assessments were dated 04/28/2025. In an interview on 05/01/2025 at 10:20AM, S2Director of Nursing (DON) was presented the above findings and could offer no further explanation as to why the above mentioned documentation was inaccurate. In an interview on 05/01/2025 at 12:25PM, S24Corporate Nurse confirmed the above mentioned assessments for Resident #14's pressure ulcers were inaccurate and should not have been. Resident #99 Review of Resident #99's medical record revealed, in part, Resident #99 was admitted to a local hospital on 02/16/2025 and returned back to the facility on [DATE]. Review of Resident #99's progress note by S27Licensed Practical Nurse (LPN) dated 02/16/2025 at 8:31PM revealed, in part, Resident #99 was found unresponsive and transferred by Emergency Medical Services to a local Emergency Department. Review of Resident #99's progress note by S28LPN dated 02/19/2025 at 9:31PM revealed, in part, resident arrived back to the facility. Review of Resident #99's February 2025 electronic Medication Administration Record (eMAR) revealed, in part, the following orders were documented as having been completed and/or administered: - Latanoprost Ophthalmic Solution (a medication used to treat glaucoma) 0.005% 1 drop instilled in both eyes on the evening shift on 02/17/2025 at 6:08PM by S15LPN; - Turn/repositioned every 2 hours and monitored for incontinence and skin breakdown on 02/17/2025 on the evening shift by S15LPN and on the night shift by S11LPN; - Flushed percutaneous endoscopic gastrostomy (PEG) tube (a tube that goes directly into the stomach to receive nutrition) with 250 milliliters (mL) of water every 6 hours on 02/17/2025 at 6:00PM by S15LPN and on 02/18/2025 at 12:00AM by S11LPN; - Non pharmalogical interventions implemented during shift: resident checked for incontinence on 02/17/2025 during the evening shift by S15LPN and on the night shift by S11LPN; - Enhanced barrier precautions were utilized for high contact activities with resident on 02/17/2025 during the evening shift by S15LPN and on the night shift by S11LPN; - PEG tube placement was checked on 02/17/2025 during the evening shift by S15LPN and on the night shift by S11LPN; - Observed resident for signs of dehydration, distention, and breath sounds on 02/17/2025 during the evening shift by S15LPN and on the night shift by S11LPN; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195272	A. Building B. Wing	05/01/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Isosource 1.5 enteral feed (a nutritional formula given directly into the stomach) ran at 65 mL/hour continuously through PEG tube on 02/17/2025 during the evening shift by S15LPN and on the night shift by S11LPN; - Amount of formula and water provided to Resident #99 during the evening shift on 02/17/2025 was 400 mL on 02/17/2025 by S15LPN; and, - Elevated Resident #99's head of the bed while receiving tube feeding during the evening shift by S15LPN and on the night shift by S11LPN. In an interview on 05/01/2025 at 10:01AM, S14LPN indicated a nurse should not have documented medications were given or tasks were completed on the resident's eMAR unless they were actually performed. S14LPN further indicated a checkmark on the resident's eMAR indicated a medication was given and/or a task was performed. In an interview on 05/01/2025 at 10:20AM, S2DON confirmed all resident's eMARs should have been accurate. S2DON further confirmed nurses should not have documented medications were administered and/or tasks were completed if they were not actually completed and/or performed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 51373 Based on interviews and record review, the facility failed to ensure the Quality Assurance Committee implemented a developed plan of action to correct identified quality deficiencies in monitoring their system for accurate narcotic count documentation. Findings: Cross Reference F755. Review of facility's Quality Assurance (QA) program revealed, in part, a Quality Assurance Performance Improvement (QAPI) plan created on 03/25/2025 which identified a problem with medication cart audit reports. Further review revealed a corrective action plan that included an initial audit would be performed on all medication carts by administrative nurses and weekly audits would be performed to ensure all required nurse signatures were documented. Further review revealed documentation on 04/01/2025, the narcotic book weekly audit was documented as a recurring problem with an intervention to discipline staff for noncompliance. In an interview on 05/01/2025 at 11:08AM, S2Director of Nursing (DON) confirmed the facility opened the QAPI for medication cart audits which included the narcotic book audits on 03/25/2025. S2DON further confirmed during the current survey, the survey team identified the narcotic reconciliation documentation which was missing nurse signatures and they were inaccurate. S2DON indicated that no disciplinary actions of nursing staff were performed regarding the recurring problems identified in the narcotic book audits. S2DON further indicated continued problems in the above area would indicate the facility's QA/QAPI process had been ineffective and had not been revised.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 51373 Based on interview and record review, the facility failed to ensure the required members of the Quality Assessment and Assurance committee met at least quarterly. Findings: Review of the facility's Quality Assurance Policy and Procedure revealed, in part, the facility's Quality Assurance committee would meet at least quarterly to identify issues and develop, implement, and/or oversee implementation of appropriate plans of correction for identified quality deficiencies. Further review revealed the Quality Assurance committee would consist of the Medical Director (MD), the Administrator, the Director of Nursing (DON) and 3 other staff members designated by the facility. Review of the facility's Quarterly Quality Assurance (QQA) meeting minutes on 07/26/2024 revealed the sign-in sheet documented the staff that participated in the QQA meeting, validated by signatures, included the DON, the Administrator, Dietary Manager, and MD. Further review revealed no documented evidence, and the facility was unable to present any documented evidence, additional staff were present for the 07/26/2024 QQA meeting Review of the facility's QQA meeting minutes on 10/30/2024 revealed the sign-in sheet documented the staff that participated in the QQA meeting, validated by signatures, included the included the DON, the Assistant Director of Nursing, 3 Minimum Data Set Nurses, 2 Social Workers, the Dietary Manager, and the Nurse Educator. Further review revealed there was no documented evidence, and the facility was unable to present any documented evidence the MD and the Administrator were present for the 10/30/2024 QQA meeting. Review of the facility's QQA meeting minutes on 01/30/2025 revealed the sign-in sheet documented the staff that participated in the QA meeting, validated by signatures, included the DON, the Administrator, and the MD. Further review revealed no documented evidence, and the facility was unable to present any documented evidence additional staff were present for the QQA meeting on 01/30/2025. There was no documented evidence, and the facility was unable to present any documented evidence the facility's Quality Assessment and Assurance committee was composed of all required members on 07/26/2024, 10/30/2024, and 01/30/2025. In an interview on 05/01/2025 at 11:08AM, S2DON indicated she had no additional documented evidence to present to show the QQA meetings on 07/26/2024, 10/30/2024, and 01/30/2025 had the required members in attendance.