| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195365 | A. Building<br>B. Wing | 08/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Maison DE Lafayette | 2707 Kaliste Saloom Road<br>Lafayette, LA 70508 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement the plan of care and follow physician orders for 6 (#13, #52, #65, #69, and #120) of 56 sampled residents. This was evidenced by failing to:1. provide Resident #13 with Nepro (dialysis supplement) as ordered;2. apply a carrot stretcher (used for hand contractures) to Resident #52's right hand as ordered; 3. supervise Resident #65 for all meals4. administer medication for Resident #69; and5. provide Resident #120 with two person assistance for toileting.Findings:Resident #13<br><br>Review of Resident #13’s EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] and had diagnoses including end stage renal disease and diabetes type 2.<br><br>Review of Resident #13’s quarterly MDS (Minimum Data Set Assessment) dated 07/11/2025 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12, indicating her cognition was intact.<br><br>Review of Resident #13’s August 2025 physician’s orders revealed an order dated 07/18/2025 that read: Nepro , two times a day related to end stage renal disease, give 1 carton twice daily.<br><br>Review of Resident #13’s plan of care initiated on 03/14/2025 revealed in part: I have altered diet needs r/t (related to) diverticulosis, HTN (hypertension), HLD (hyperlipidemia), GERD (gastro-esophageal reflux disease), DM2 (diabetes mellitus type 2), ESRD (end stage renal disease). I am at risk for malnutrition, dehydration and weight fluctuations r/t vitamin deficiency, obesity vertigo, depression, hemodialysis… Interventions in part: Serve my diet and supplements as ordered.<br><br>On 08/12/2025 at 9:35 a.m., an interview was conducted with Resident #13. Resident #13 was asked if she drank her Nepro twice daily. She stated that she drank her Nepro when the facility provided it to her, but she had not received it in a while. She stated she has not had it this week at all (08/11/2025, 08/12/2025) and did not think she got it at the end of last week either. She stated the nurse told her that it was on back order.<br><br>On 08/12/2025 at 9:42 a.m., an interview was conducted with S23LPN (Licensed Practical Nurse) who stated the resident did not receive her Nepro because it is was on back order and could not say the last time she received the Nepro. S23LPN then stated that Nepro was stored in the nutrition room, and there was none in the nutrition room. An observation of the nutrition room was made with S23LPN. There was no Nepro in the nutrition room.<br><br>On 08/12/2025 at 10:05 a.m., an interview was conducted with S6QA (Quality Assurance Nurse) who<br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated that she was responsible for ensuring nutritional supplements were ordered and available for residents who required them. She stated that she, along with her central supply assistant, ensured that supplements were in stock, and ordered when the supply got low. S6QA was asked when the last time an order was placed for Nepro. S6QA could not provide evidence of when Nepro was last ordered. S6QA stated that if a supplement was on back order, they would contact the ordering physician and get a backup supplement to give until the other one came in. S6QA stated that because there was a physician’s order for Nepro, the facility was responsible for ensuring that the resident received Nepro and should have had it available.<br><br>Resident #52<br><br>Resident #52 was admitted to the facility on [DATE], with diagnoses which included, but were not limited to, cerebral infarction, syncope and collapse, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.<br><br>Review of Resident #52’s quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 14, indicating the resident’s cognition was intact.<br><br>Review of August 2025 physician’s orders, revealed an order written on 05/05/2025 which read, “Carrot stretcher for R (right) hand contracture. Apply daily & (and) remove once per day to clean hand.”<br><br>Review of the resident’s July 2025 and August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no evidence the carrot stretcher was placed in Resident # 52’s hand daily as ordered.<br><br>On 08/11/2025 at 1:00 p.m., an observation and interview was conducted of Resident #52. The resident’s right hand was contracted with her fingers turned into her palm. The resident was unable to open her right hand. Resident #52 did not have a carrot stretcher or hand roll in her hand. The resident was unable to remember the last time she had a hand roll placed in her hand and stated it had been “a while.”<br><br>On 08/13/2025 at 10:35 a.m., an interview and review of Resident #52’s electronic health record was conducted with S2DON (Director of Nursing), S6QA (Quality Assurance Nurse), and S5ADON (Assistant Director of Nursing). They all confirmed the physician’s order for the carrot stretcher to be applied to the resident’s right hand daily. They also confirmed there was no evidence on the MAR or TAR to prove the carrot stretcher was placed in the resident’s right hand daily, and stated that it should have been documented to prove it was done.<br><br>On 08/13/2025 at 1:19 p.m., an interview was conducted with S20CNA (Certified nursing Assistant). S20CNA stated she had been working with Resident #52 since June 2025 and had never seen a carrot stretcher in her right hand, and didn’t know she needed one.<br><br>Resident #69<br><br>Review of Resident #69’s electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, osteomyelitis of vertebra, lumbar region.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #69’s July 2025 physician’s orders revealed an order dated 07/03/2025 Cefazolin Sodium Injection Solution reconstituted 2 gm (gram). Use 2 gram intravenously every 8 hours related to infection and inflammatory reaction due to internal fixation device of spine.<br><br>Review of Resident #69’s July 2025 MAR (medication administration record) revealed no evidence Cefazolin Sodium 2gm Injection Solution was administered intravenously for the resident on the dates of 07/05/2024 at 0400 and 07/26/2025 at 0400.<br><br>On 08/13/2025 at 11:54 a.m., an interview and record review was conducted with S2DON (Director of Nursing). She reviewed Resident #30’s MAR and confirmed the resident’s medication was not administered as ordered on 07/05/2025 at 0400 and 07/26/2025 at 0400.<br><br>Resident #120<br><br>Review of the Resident’s electronic medical record revealed Resident #120 was admitted to the facility on [DATE] with diagnoses including, but not limited to: hemiplegia and hemiparesis following cerebrovascular disease affecting left dominant side, difficulty in walking, generalized muscle weakness, peripheral vascular disease, major depressive disorder, generalized anxiety disorder, stiffness of left knee, lack of coordination and degenerative disease of nervous system.<br><br>Review of Resident #120’s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment. Resident #120’s bowel and bladder status was assessed as the resident always having bowel and bladder incontinence.<br><br>Review of Resident #120’s care plan revealed the resident required ADL (Activities of Daily Living) assistance r/t (related to) lack of coordination, difficulty walking, muscle weakness, left hemiplegia with an intervention to assist with ADL's as needed including mobility and toileting hygiene; may require more assistance as condition warrants.<br><br>Review of Resident #120’s POC (Plan of Care) revealed a task for toileting/urinary continence require two (2) person assistance provided by CNAs (Certified Nursing Assistants) every shift.<br><br>On 08/13/2025 at 10:45 a.m., an observation was made of Resident #120 lying in bed, awake and alert. S13CNA knocked on the resident’s room door and stated she was coming to change the resident’s soiled adult brief. S13CNA verified S14CNA was the other CNA working with her. S13CNA stated she was able to change the resident’s soiled brief herself. S13CNA proceeded to turn and clean the resident by herself. S13CNA never attempted to call for assistance to help with changing and cleaning the resident.<br><br>On 08/13/2025 at 2:01 p.m., an interview was conducted with S24LPN. S24LPN reported Resident #120 was bedbound and dependent on staff. S24LPN would neither confirm nor deny that Resident #120 required two person assistance for brief change.<br><br>Resident #65<br><br>Review of Resident #65’s electronic medical record (EMR) revealed she admitted on [DATE] with diagnoses including but limited to cognitive communication deficit, gastrostomy, type 2 diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction, dysphagia oropharyngeal, and adult (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | failure to thrive.<br><br>Review of Resident #65’s admission MDS (Minimum Data Set Assessment) dated 05/29/2025 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 11, indicating severely impaired cognition.<br><br>Review of Resident #65’s August 2025 physician’s orders revealed an order dated 07/30/2025 that read: Speech therapy recommends Resident #65 return to oral intake, mechanical soft with thin liquids by straw, resident to be placed in dining room/supervised for all meals.<br><br>Review of Resident #65’s care plan initiated on 05/24/2025 read in part: “I have altered diet needs related to diabetes, hypertension, dysphagia, and chronic kidney disease.” Interventions – serve my diet and supplements as ordered, provide verbal encouragement, cues, reinforcement if need, refer to therapy services s ordered.<br><br>On 08/11/2025 at 12:01 p.m., observation of Resident #65 in the dining room was conducted. The resident was observed sitting at a table with two other residents. The resident was not being monitored by staff, or being cued by staff. The resident was observed trying to get the attention of the staff, because she did not want the carrots, rice, white beans, and corn bread.<br><br>On 08/13/2025 at 8:05 a.m., another dining room observation was conducted. Resident #65 was observed during breakfast meal. The resident was not being supervised. She sat at a table with two other residents. The resident’s nurse was observed outside of the dining room, preparing medications at her medication cart.<br><br>On 08/13/2025 at 8:10 a.m., an observation and subsequent interview was conducted with S16LPN (Licensed Practical Nurse). S16LPN confirmed that she was the nurse for Resident #65. She stated she was not aware the resident had an order to be monitored for all meals. S16LPN reviewed Resident #65’s physician orders and confirmed that the resident was supposed to be supervised for all meals. S16LPN also confirmed that she had not been monitoring the resident during her meals as per the physician’s orders. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observations, interview, and record review, the facility failed to ensure menus were followed for 7 (#1, #3, #71, #89, #121 #145, #148) residents who required mechanical soft diets out of a final sample of 56 residents. Findings: Review of the facility's policy titled, Menus, with a last revision date of October 2017, read in part: 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board. Review of the diet spread sheet for residents prescribed mechanical soft diets revealed the following meal was to be served on 08/11/2025: Beans [NAME] Northern f (featured)/Dry Ham buffet, [NAME] Steamed, Carrot Sliced Parslied, Cornbread, Crisp Pear. On 08/11/2025 at 11:30 a.m., an observation was made during lunch in Dining Hall B. Residents #1, #3, #71, #89, #121 #145, and #148 were all prescribed Mechanical Soft diets and had whole Brussel sprouts on their plates. Residents #1 and #145 had eaten all of the Brussel sprouts that were served on their plates. Resident #89 attempted to eat the Brussel sprouts but stated that she could not chew them. On 08/11/2025 at 11:55 a.m., dietary staff was observed bringing a covered pan to the serving kitchen for Dining Hall B. An interview was conducted with S25Dietary who confirmed the pan contained sliced carrots. S25Dietary stated that the dietary staff from the main kitchen was responsible for bringing the carrots to the Dining Hall B serving kitchen. She stated that she saw that the meal tickets read that the residents who received mechanical soft diets were to have sliced carrots with their meals and not Brussel sprouts. She stated that she still served them Brussel sprouts because she did not want them to start their meal without a vegetable. On 08/11/2025 at 12:09 p.m., an interview was conducted with S7DD (Dietary Director) who confirmed residents on mechanical soft diets were to have sliced carrots with their meals. She stated that the dietary staff responsible for serving the lunch meal from Dining Hall B's kitchen should have followed the menu and meal tickets, which included sliced carrots. S7DD further stated the dietary staff should not have served residents, who were prescribed mechanical soft diets, Brussel sprouts instead of carrots. She explained that the dietary staff member should have notified the main kitchen that they did not receive carrots for the mechanical soft diets prior to serving any resident meals. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure the resident's right to make choices about aspects of her life that were significant to the resident for 1 (#49) resident out of a final sample of 56 residents. Findings: Review of the facility's policy titled Resident Rights, with a last revised date of February 2021, read in part: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: e. self-determination.v. have the facility respond to his or her grievance. Review of Resident #49's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] and had diagnoses including spastic diplegic cerebral palsy, major depressive disorder, and anxiety disorder.Review of Resident #49's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating that her cognition was intact.On 08/11/2025 at 10:01 a.m., an interview was conducted with Resident #49. She stated that she had an issue with S15CNA (Certified Nursing Assistant) that began last year. She stated there were instances where she asked for assistance and S15CNA would not help her. She further stated S15CNA did not respect her wishes as far as assisting her with ADLs (Activities of Daily Living) in the way that she liked or in a way that would not increase her pain due to her diagnoses (spastic diplegic cerebral palsy) of which she experiences pain all of the time. Resident #49 went on to say that S15CNA was fired, but recently got rehired. She had spoken with the previous administrator, S5ADON (Assistant Director of Nursing), and S2DON (Director of Nursing) about her issue with S15CNA, and stated she did not want her as her CNA because the CNA made her uncomfortable, and she did not like the way the CNA cared for her. Resident #49 stated S2DON told her that she just had to get used to S15CNA. The former administrator, S5ADON and S2DON also told her that they didn't move resident rooms or CNA assignments. The resident stated she felt she should not have to be cared for by someone who made her uncomfortable. On 08/12/2025 at 1:43 p.m., an interview was conducted with S2DON and S5ADON. Both confirmed that approximately three to four weeks ago, a conversation was had with Resident #49 regarding S15CNA. S2DON stated that Resident #49 reported to both of them that she did not want S15CNA to be her CNA, but when asked if S15CNA had done something, Resident # 49 could not give an answer, only that she just did not like the CNA. S2DON further stated that she told Resident #49 during that meeting that she could not simply move CNAs around because she did not like someone. There had to have a legitimate reason to move the CNA or not allow the CNA to work with her. She stated that if she removed the resident from the CNA's assignment, it would not be fair to the CNA. As a solution, to protect S15CNA, she told S15CNA to have another CNA go in the room with her so that the resident could not say anything occurred that did not occur. S2DON did not remove S15CNA from Resident #49's room assignment as the resident requested. |

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| F 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure individual financial records were provided to the resident through quarterly statements for 1 (Resident #35) out of 56 residents included in the sample.Findings:On 08/11/2025 at 3:54 p.m., an interview was conducted with Resident #35. Resident #35 stated she had not received quarterly statements for her personal funds account.On 08/12/2025, a review of Resident #35's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition.On 08/12/2025, a review of Resident #35's admission Record revealed resident was admitted to the facility on [DATE] with diagnoses which included in part, unspecified dementia, Parkinson's disease, and Alzheimer's disease. Further review under the Contacts section revealed Resident #35's Responsible Party (RP) was a family member.On 08/13/2025 at 10:39 a.m., an interview was conducted with S9OD (Office Director). She stated if a resident was his or her own RP, then the quarterly statements were given to the resident, if not, the statements were mailed to the resident's RP.On 08/13/2025 at 10:50 a.m., a telephone interview was conducted with Resident #35's RP. Resident #35's RP confirmed the resident did have a personal funds account at the facility. Resident #35's RP stated she had not received quarterly statements from the facility.On 08/13/2025 at 11:00 a.m., an interview was conducted with S9OD. She confirmed that a resident with an admission date in April of 2025 should have received a quarterly statement in June of 2025.On 08/13/2025 at 1:43 p.m., an interview was conducted with S9OD. S9OD confirmed that Resident #35 had a trust account at the facility. S9OD could not provide evidence that Resident #35 received a quarterly statement or that a quarterly statement was mailed to Resident #35's RP.On 08/13/2025, a review of the facility's policy titled, Resident Trust Fund Policy, indicated the following: Accounting and Recordkeeping.The individual financial record shall be available through quarterly statements. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to address and act upon grievances for 1 (#49) resident out of 56 sampled residents. Findings:Review of the facility's policy titled, Grievances/Complaints, Filing, with a last revised date of April 2017, read in part: 3. All grievances, complaints, or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including rationale for the response.7. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and report the findings to the administrator.13. The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.Review of Resident #49's EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] and had diagnoses including spastic diplegic cerebral palsy, major depressive disorder, and anxiety disorder.Review of Resident #49's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating that her cognition was intact.On 08/11/2025 at 10:01 a.m., an interview was conducted with Resident #49. She stated that she had an issue with S15CNA (Certified Nursing Assistant) that began last year. She stated there were instances where she asked for assistance and S15CNA would not help her. She further stated S15CNA did not respect her wishes as far as assisting her with ADLs (Activities of Daily Living) in the way that she liked or in a way that would not increase her pain due to her diagnoses (spastic diplegic cerebral palsy) of which she experiences pain all of the time. Resident #49 went on to say that S15CNA was fired, but recently got rehired. She had spoken with the previous administrator, S5ADON (Assistant Director of Nursing), and S2DON (Director of Nursing) about her issue with S15CNA, and stated she did not want her as her CNA because the CNA made her uncomfortable, and she did not like the way the CNA cared for her. Resident #49 stated S2DON told her that she just had to get used to S15CNA. The former administrator, S5ADON and S2DON also told her that they didn't move resident rooms or CNA assignments. The resident stated she felt she should not have to be cared for by someone who made her uncomfortable.Review of the facility's grievance log from April 2025 to August 2025 did not reveal a grievance was filed for Resident #49.On 08/12/2025 at 1:43 p.m., an interview was conducted with S2DON and S5ADON. Both confirmed that approximately three to four weeks ago, they had a conversation with Resident #49 regarding S15CNA. S2DON stated that Resident #49 reported to both of them that she did not want S15CNA to be her CNA, but when asked if S15CNA had done something, the resident did not give an answer. When asked why there was no grievance form or investigation for the resident regarding her complaint, S2DON stated that she did not complete a grievance form or investigation because the resident could not explain what she actually complained about. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>Based on record review and interview, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was completed timely for 1 (#111) out of 56 total sampled residents. Findings:Review of the CMS (Center for Medicare and/or Medicaid Services) RAI (Resident Assessment Instrument) Manual Version 3.0 provided by the facility as their policy titled, Chapter 5: Submission and Correction of MDS Assessments read in part .5.2 Timeliness Criteria: In accordance with the requirements at 42 CR 483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: Completion Time: For all non-admission OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) assessments, the MDS completion date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD)(A2300). Review of Resident #111's electronic health record (EHR) revealed an initial admission date of 03/24/2025 and a discharge date of 06/13/2025. Further review of Resident #111's EHR failed to reveal that a Discharge MDS assessment was completed and transmitted within 14 days after the resident was discharged from the facility. On 08/12/2025 at 3:37 p.m., an interview and record review of Resident #111's EHR was conducted with S4MDS. After review of the resident's EHR, she confirmed that Resident #111 did not have a discharge MDS assessment. She confirmed Resident #111's discharge MDS should have been completed and transmitted within 14 days after the resident discharged from the facility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 195365 | A. Building<br>B. Wing | 08/13/2025 |

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| Maison DE Lafayette | 2707 Kaliste Saloom Road<br>Lafayette, LA 70508 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the minimum data set (MDS) assessment accurately reflected the status of 2 (Resident #69 and #179) of 56 sampled residents. The facility failed to: 1.Accurately code medication on the MDS for Resident #69; and 2.Accurately code the discharge type on the MDS for Resident #179.Findings:<br><br>Resident #69<br><br>Review of Resident #69’s (EHR) electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included but were not limited to paroxysmal atrial fibrillation.<br><br>Review of Resident #69’s physician’s orders revealed an order dated 07/04/2025 that read in part, Aspirin 81mg (milligrams) 1 tablet by mouth daily related to paroxysmal atrial fibrillation.<br><br>Review of Resident #69’s MAR (Medication Administration Record) for July 2025 revealed she had been administered Aspirin daily from 07/04/2025 to 07/31/2025.<br><br>Review of Resident #69’s Annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/09/2025 revealed in Section N (Medications) she was coded for taking anticoagulant and blank for antiplatelet use.<br><br>On 08/12/2025 at 3:45 p.m., an interview and record review was conducted with S4MDS. She confirmed Resident #69 was coded as taking anticoagulants and blank for use of an antiplatelet. She then confirmed the resident was not prescribed an anticoagulant and was prescribed Aspirin which was an antiplatelet. She confirmed the MDS was coded incorrectly.<br><br>Resident #179<br><br>Review of the resident’s care plan revealed in part: date initiated 06/23/2025 “I wish to return to the community after completion of skilled therapy services.” Goal: I will be able to return to the community with the assistance of community resources of my choice after completion of skilled therapy services…Interventions: assist me with discharge planning.<br><br>Review of Resident #179’s admission /Medicare - 5 Day /DRNA (Discharge Return Not Anticipated) /End of PPS (Prospective Payment System) Part A Stay MDS assessment dated [DATE] by S3MDS revealed the resident was admitted to the facility on [DATE] and discharged on 06/28/2025.<br><br>Section Q of the MDS assessment revealed the resident’s overall goal was to discharge to the community…discharge plan “yes”… the source of this information was from the resident’s family…a referral been made to the Local Contact Agency.<br><br>Review of the following information in Section A of the assessment revealed:<br><br>Discharge status “Home/Community”<br><br>F. entry/discharge reporting “Discharge return not anticipated”<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | G. type of discharge “unplanned”<br><br>Further review of the resident’s record did not reveal any evidence indicating the resident had an unplanned or emergent discharge.<br><br>On 08/12/2025 at 3:32 p.m., a review of Resident #179’s electronic health record, care plan and the resident’s admission /Medicare - 5 Day /DRNA /End of PPS Part A Stay dated 06/28/2025 was conducted with S3MDS who confirmed she was responsible for Resident #179’s MDS and care plan assessments. She explained the resident was admitted to the facility on [DATE] for skilled services and discharged to home on [DATE] after her skilled service days ended on 06/27/2025. S3MDS confirmed the resident’s MDS assessment was coded as an unplanned discharge, but recalled the resident’s spouse discussed upon admission that the resident’s discharge would be a planned discharge. She then stated she would review the record further to see if there was evidence indicating an unplanned discharge. Upon further review of the resident’s and facility records, S3MDS confirmed there was no evidence the resident’s discharge was unplanned therefore the resident’s MDS assessment was inaccurate.<br><br>On 08/13/2025 at 11:15 a.m., a phone interview was conducted with Resident #179’s spouse who stated the resident’s discharge had been planned with the facility upon her admission. The resident’s spouse stated the resident was discharged after her therapy days ended, confirming the resident was an anticipated planned discharge. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was stored appropriately when not in use for 3 (Resident #30, Resident #89, Resident #116) out of 5 (Resident #30, Resident #84, Resident #89, Resident #94, Resident #116) sampled residents reviewed for respiratory care.<br><br>Findings:<br><br>On 08/13/2025, a review of the facility’s policy titled, “Oxygen Administration”, with a last revision date of October 2010, failed to address the procedure for oxygen equipment storage.<br><br>On 08/13/2025, a review of the facility’s policy titled, “Administering Medications through a Small Volume (Handheld) Nebulizer”, with a last revision date of October 2010, failed to address the procedure for oxygen equipment storage.<br><br>On 08/13/2025, a review of the facility’s policy titled, “CPAP(Continuous Positive Airway Pressure)/BiPap (Bilevel Positive Airway Pressure) Support” with a last revision date of March 2015, indicated “Masks, nasal pillows and tubing…Once dry place in zip lock bag until used by resident…”<br><br>Resident #116<br><br>Review of Resident #116’s “admission Record” revealed resident was admitted to the facility on [DATE] with diagnoses which included in part, obstructive sleep apnea, pulmonary hypertension, and pleural effusion.<br><br>Review of Resident #116’s Physician’s orders revealed an order dated 09/25/2024, which stated, “CPAP—wear at night during hours of sleep. Remove in morning. Directions: at bedtime related to morbid (severe) obesity due to excess calories.”<br><br>On 08/11/2025 at 11:01 a.m., an observation was made of Resident #116’s CPAP mask stored in the top drawer of her bedside dresser. Resident #116’s CPAP mask was not stored in a plastic bag.<br><br>On 08/11/2025 at 11:23 a.m., a concurrent interview and observation was conducted with S10LPN (Licensed Practical Nurse) in Resident #116’s room. S10LPN confirmed that Resident #116’s CPAP mask was not stored in a plastic bag and it should have been.<br><br>On 08/13/2025 at 1:41 p.m., an interview was conducted with S11IP (Infection Preventionist). S11IP confirmed that CPAP masks should be stored in a plastic bag when not in use.<br><br>Resident #89<br><br>Review of Resident #89’s electronic health record revealed she was admitted to the facility on [DATE] with diagnoses, which included, but were not limited to, dysphagia following cerebral infarction, type 2 diabetes mellitus, emphysema, and asthma.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #89’s August 2025 physician’s orders revealed an order dated 07/30/2025, which read in part: check oxygen saturation every shift. Apply oxygen at 2L (Liters) per nasal cannula as needed for oxygen saturation less than 92%.<br><br>Review of Resident #89’s care plan read in part… I have diagnoses of emphysema and persistent asthma. Interventions included: Oxygen as ordered and as needed.<br><br>On 08/11/2025 at 9:00 a.m., an observation was made of Resident #89’s room. An oxygen concentrator was observed running and oxygen tubing was observed on the side of the garbage can on the floor.<br><br>On 08/11/2025 9:06 a.m., an observation and interview was conducted with S18LPN (Licensed Practical Nurse) who confirmed the oxygen tubing should not have been on the floor, and the tubing had to be thrown discarded.<br><br>Resident #30<br><br>Review of Resident #30’s electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, pneumonia, abscess of lung with pneumonia, acute respiratory failure with hypoxia, and chronic respiratory failure with hypoxia.<br><br>Review of Resident #30’s August 2025 physician’s orders revealed an order dated 07/31/2025 Oxygen at 2 liters per nasal cannula continuous, Monitor every shift every for shortness of breath/dyspnea. Further review revealed an order dated 08/04/2025 Albuterol Sulfate Nebulization Solution 2.5 mg (milligrams) inhale orally via nebulizer two times a day for sob (shortness of breath) for 10 days.<br><br>Review of Resident #30’s care plan read in part…I have diagnosis of acute hypoxic respiratory failure, chronic hypercapnic respiratory failure, right upper lobe PNA (pneumonia) with lung abscess, cough. Interventions included: Change nebulizer mask and tubing every Sunday 6-2 shift prn (as needed) usage. Change O2 (oxygen) tubing every Sunday 6-2 shift while in use.<br><br>Review of Resident #30’s MAR (medication administration record) and TAR (treatment administration record) for August 2025 revealed no evidence that Resident #30’s nebulizer mask and tubing, and O2 tubing were changed.<br><br>On 08/11/2025 at 10:26 a.m., an observation was made of Resident #30 with Oxygen at 2 liters per nasal cannula in progress. There was no date on the oxygen tubing. Further observation revealed a nebulizer mask and tubing on the counter top. There was no date on the nebulizer mask and tubing.<br><br>On 08/11/2025 at 10:30 a.m., S12LPN (Licensed Practical Nurse) was asked to enter Resident #30’s room. S12LPN observed the oxygen tubing and confirmed the tubing was not labeled with the date it was changed. S12LPN also observed the nebulizer mask and tubing and confirmed the mask and tubing were not labeled with the date it was changed.<br><br>On 08/13/2025 at 12:04 p.m., an interview and record review was conducted with S2DON (Director of Nursing) who confirmed Resident #30’s nebulizer mask and oxygen tubing should have been labeled with the date it was changed, but was not. S2DON reviewed Resident #30’s MAR and TAR for August 2025 and confirmed there was no evidence that Resident #30’s nebulizer mask and tubing, and O2 tubing were changed, but should have been. |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to make an appointment with a dentist in a timely manner for 1 (#3) of 1 (#3) residents investigated for dental care. Findings:Record review revealed Resident #3 was admitted to the facility on [DATE] with accumulative diagnoses including cerebral infarction, diabetes mellitus, speech and language deficits following cerebral infarction, dysarthria following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and depressive disorders.Record review of Resident #3's physician orders dated 08/06/2025 read in part: Consult dentist related to dental pain right upper gums has broken teeth with redness/tenderness.Record review of Resident #3's care plan read in part, I require dental care. I am experiencing dental pain and a potentially abscessed tooth. Interventions included refer resident and follow up with dentist as needed. Assess oral cavity and dentition. Monitor for any irritation, sores, loose or missing teeth and complaints discomfort or pain.Review of Resident #3's Minimum Data Set (MDS) admission dated 06/30/2025 revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated severely impaired cognition. On 08/11/2025 at 10:24 a.m., an observation revealed Resident #3's oral cavity had missing teeth. Further observation revealed resident's bottom left tooth was dark in color.On 08/11/2025 at 11:51 a.m., an observation revealed Resident #3's during the lunch meal. The resident was served white beans, rice, carrots, and corn bread. The consumed 25% of meal, and was observed having difficulty chewing his food. The resident would not close his mouth fully to bite down and chew the food. Resident was observed with facial grimaces while eating.On 08/12/2025 at 2:15 p.m., an interview was conducted with S8SSD (Social Services Director) who stated she was responsible for arranging dental consults for the residents. She stated the process when she receive an order for a resident to have a dental consultation, was to complete a referral form for the resident. Then, the resident is added to the list to be seen when the dentist comes to the facility. She confirmed that the dental team was in the facility on 08/11/2025 and on 08/12/2025 and Resident #3 was not seen. S8SSD stated she was not aware that Resident #3 had an order written on 08/06/2025 for him to be seen by the dentist due to dental pain and possible abscess. On 08/13/2025 at 7:56 a.m., an interview was conducted with S18LPN (Licensed Practical Nurse). S18LPN confirmed she entered a dental consult order into the computer for Resident #3. She stated that the order should have gone to S8SSD and the ward clerk. She stated she was not aware if S8SSD or the ward clerk had received the order and completed the referral. She confirmed she did not follow up on the order, but assumed the order had been completed. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, and interview, the facility failed to store food in accordance with professional standards for food service, and ensure expired foods were removed from the kitchen.This had the potential to affect the 166 residents that consumed food from the kitchen.Findings:On 08/12/2025, a review of the facility's policy titled, Food Receiving and Storage, with a last revision date of 11/2022, revealed in part. Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Dry Food Storage.4. Dry foods that are stored in bins are removed from original packaging, label and dated ( used by date). Such foods are rotated using a first in-first out system. On 08/11/2025 at 8:30 a.m., an initial tour of the kitchen was conducted with S7DD (Dietary Director). During the tour, S7DD confirmed: 15 cups of prune juice on the shelf in the dry storage room, had an expiration date of 07/03/2025; 4 loafs of bread had a best use by date of 07/24/2025; 22 loafs of bread had a best by date of 08/06/2025; and 10 loafs of bread with a best by date of 08/08/2025. She stated the expired and past the best by date items should have discarded by the date printed on the food items. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection. This was evidenced by staff failing to perform appropriate hand hygiene during the provision of care and services, and failing to appropriately dispose of medical waste.Findings:A.<br><br>Review of the facility’s Handwashing/Hand Hygiene Policy and Procedure, with a review date of October 2023, read in part: “…Indication for Hand Hygiene: 1. hand hygiene is indicated: e. after touching the resident's environment…”<br><br>Review of a document titled “Medical Waste, Handling of”, with a revision date of 09/2010, which read in part: “Purpose – is to provide a definition of and guidelines for the safe and appropriate handling of medical waste…General Guidelines – 1. Medical waste includes human blood and blood soiled articles contaminated items (i.e., soiled dressings)… 4. Disposable items, which are contaminated with excretions or secretions from residents believed to be infectious, must be placed in red plastic bags and sealed…”<br><br>Observations of the dining room on 08/12/2025 at 11:58 a.m. revealed S17CNA (Certified Nursing Assistant) feeding two residents. S17CNA repeatedly touched the utensils and cups of the two residents without performing hand hygiene.<br><br>An interview with S17CNA was conducted on 08/12/2025 at 12:05 p.m. S17CNA confirmed that she had not used hand sanitizer between feeding the two residents. She stated she did not have the sanitizer in her pocket at the time she assisted the two residents, and she should have had hand sanitizer and utilized it while assisting the residents.<br><br>On 08/12/2025 at 11:45 a.m., an observation on Hall A revealed a treatment cart positioned against the wall. The treatment cart had a trash can attached with the lid of the trash can opened. A red biohazard trash bag was observed lining the trash can. A yellow soiled discarded personal protective gown was observed hanging half way outside of the red trash bag, along with other discarded materials, and a smaller bio hazard trash bags.<br><br>On 08/12/2025 at 12:30 p.m., another observation was made of the same treatment cart on Hall A. The cart’s trash can lid was open and inside the trash can was more red biohazard bags and a yellow soiled personal protective gown hanging out of the trash can.<br><br>On 08/12/2025 at 2:41 p.m., an observation and subsequent interview was conducted with S11IP (Infection Preventionist). After making an observation of the treatment cart on Hall A, S11IP confirmed that the treatment cart’s trash was overflowing with soiled personal protective gowns and biohazard bags. She confirmed the soiled personal protective gowns and the read biohazard bags were not contained and discarded appropriately.<br><br>B.<br><br>On 08/13/2025, a review of the facility’s policy titled “Handwashing/Hand Hygiene” with a revision date of October 2023, read in part: This facility considers hand hygiene the primary means to prevent the spread of health-care associated infections. Policy Interpretation (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and Implementation: Administrative Practices to Promote Hand Hygiene 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare- associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors. Indications for Hand hygiene 1. Hand hygiene is indicated: a. after contact with blood, body fluids, or contaminated surfaces…<br><br>On 08/12/2025 at 9:07 a.m., S21CNA (Certified Nursing Assistant) was observed walking down Hall W with a plastic bag containing laundry items in her bare hands. S21CNA opened the hopper room and discarded the bag. She did not perform hand hygiene. S21CNA immediately walked across the hall and removed linen from the clean linen cart. During an interview with S21CNA, she stated that she brought dirty linen from a resident’s room and disposed of it in the hopper room. S21CNA confirmed she did not wash or sanitize her hands before picking up the clean linen, and should have.<br><br>On 08/12/2025 at 9:16 a.m., S22CNA was observed walking towards the hopper room on Hall W with a bag containing linen. She opened the hopper room, disposed of the linen, and did not perform hand hygiene. S22CNA walked back down the hall and uncovered a clean linen cart parked in the hallway. During an interview with S22CNA, she stated the bag she took to the hopper room contained dirty linen from a resident’s bed. She confirmed she did not perform hand hygiene before handling the covered clean linen cart and stated she should have.<br><br>On 08/12/2025 at 2:20 p.m., an interview was conducted with S11IP (Infection Preventionist). She stated that all staff were aware of proper hand hygiene practices and the CNAs should have sanitized their hands between contact with the contaminated and clean surfaces. |