STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195392	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Winnsboro	804 Polk Street Winnsboro, LA 71295

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview the facility failed to treat the resident with respect and dignity and care in a manner and in an environment that promotes or enhances his or her quality of life for 1 (#76) of 1 residents reviewed for dignity. The facility failed to ensure that Resident #76's privacy was maintained. Findings: Review of the record for Resident #76 revealed diagnoses of congestive heart failure, metabolic encephalopathy, and drug-induced subacute dyskinesia and aphasia. Review of Resident #76's Minimal Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment for daily decision making. Further review of the MDS revealed the resident was dependent on staff for Activities of Daily Living (ADL) and had limited range of motion on both sides other upper and lower extremities. Observations of Resident #76 on 07/07/2025 at 9:00 a.m., 11:30 a.m., 1:30 p.m., and 4:00 p.m. revealed the resident was lying in bed in the fetal position on her right side with her brief exposed and no linens on the resident's bed. On 07/07/2025 at 11:30 a.m., an interview with S7Certified Nursing Assistant (CNA) revealed she was not aware of a reason that Resident #76 did not have bed linens. On 07/07/2025 at 11:45 a.m., an interview with S5CNA revealed she was not aware of a reason that Resident #76 did not have bed linens. S5CNA made no attempt to find linen for the resident. On 07/08/2025 at 10:00 a.m., an interview with S3Licensed Practical Nurse (LPN) confirmed she was unaware of a reason that Resident #76 did not have bed linens. Observation on 07/09/2025 at 11:32 a.m. revealed Resident #76 lying in bed with no bed linen and no sheets on the resident. On 07/09/2025 at 2:20 p.m., an interview was conducted with S2Director of Nursing (DON). S2DON confirmed residents are to be provided linen/covers and S2DON was informed of the findings related to dignity.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #74 On 07/07/2025 at 10:39 a.m. observation of Resident #74's room revealed the room was excessively dirty with debris and clutter and the room had a strong smell of urine. Further observation revealed a liquid that appeared to be urine all over bathroom floor. Further observation revealed that Resident #74's wheelchair had an excess of dirt and debris with both arm rests damaged. Interview with S2Director of Nursing (DON) on 07/09/2025 at 2:25 p.m. confirmed that staff had problems with keeping Resident #74's room clean and had to move all items out of room recently. S2DON confirmed that the wheelchair was damaged. Resident #76 On 07/07/2025 at 11:00 a.m. an observation of Resident #76's room revealed no linen/covers on her bed. Further observation revealed that her oxygen concentrator was dirty and there was a pair of shoes that were not the resident's lying on floor in her space. On 07/09/2025 at 2:25 p.m. an interview with S2DON confirmed linen/sheets should be available to all residents and that she was unaware why Resident #76 did not have bed linen. Resident #1 On 07/07/2025 at 1:47 p.m., observation of Resident #1's room revealed dirt and grime on the suction machine, unlabeled creams and substance on bed side table, and overall dirty. Further observation revealed the oxygen concentrator had dirt and debris on all days of survey. On 07/09/2025 at 2:30 p.m. an interview with S2DON confirmed that the equipment and bedside table were dirty and in need of cleaning. Based on record reviews, observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 5 (#1, #25, #71, #74, and #76) of 7 (#1, #5, #25, #70, #71, #74, and #76) sampled residents reviewed for environmental issues and the facility failed to maintain a safe, clean, and sanitary environment in the laundry area. The facility failed to ensure: 1. Resident #25 and #71's wheelchairs were free from dirt and debris; 2. Resident #71 and 74's padding on their wheelchair arm rests were intact and free of cracking; 3. Resident #1, #74, and #76's rooms were properly cleaned and free of odor; and 4. Resident #76's bed had linens in place. Findings: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #25 Review of records for Resident #25 revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, major depressive disorder, chronic kidney disease, and osteoarthritis. Observations on 07/07/2025 at 11:00 a.m. and on 07/08/2025 at 8:40 a.m. revealed Resident #25 had an excess of dirt and debris on her wheelchair frame. Observation with S1Administrator on 07/08/2025 at 2:30 p.m. confirmed that Resident #25's wheelchair had an excess of dirt and debris and needed to be cleaned. Resident #71 Review of records for Resident #71 revealed the resident was admitted on [DATE] with diagnoses including systemic lupus erythematous, chronic obstructive disease, depression, and polyosteoarthritis. Observations on 07/07/2025 at 10:00 a.m. and 07/08/2025 at 8:37 a.m. revealed resident #71's wheelchair arm padding was cracked with exposed foam underneath. Observation on 07/08/2025 at 8:37 a.m. revealed Resident #71 had dirt and debris on his wheelchair frame. Observation with S1Administrator on 07/08/2025 at 2:30 p.m. confirmed the wheelchair's arm padding for Resident #71 was damaged and needed to be replaced. S1Administrator also confirmed Resident #71's wheelchair had dirt and debris and needed to be cleaned. Laundry Area Observation of the laundry area on 07/09/2025 at 10:30 a.m. revealed the following: -disinfectant supplies stored in the sink upon entry into the laundry room; -clothing/shoes stacked on top of 2 of 2 washing machines; -the filter on the washing machine with thick build-up of dust/lint; the label specified that the filter is to be changed daily; -lint buildup between washers, behind washers, and on walls; -laundry detergents that were actively in use were stored directly on the floor; -3 empty chemical containers on the floor; -the corner of room with washers had random piles of linen, clothing, shoes, etc. on the floor; some items were in plastic laundry baskets/some were not; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Shelving in room with the washers had random water resistant resident care supplies (wedge, bolster, etc) covered in a thick layer of dust; -empty laundry basket on the floor; and -heel protectors on the floor. On 07/09/2025 at 10:45 a.m. an interview with S16Housekeeping Supervisor revealed there is a daily laundry list completed by the staff, but was unable to produce a completed daily checklist. On 07/09/2025 at 10:48 a.m., S10Licensed Practical Nurse confirmed all of the above findings in the laundry area.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to complete a discharge summary for 1 (#89) of 1 closed records reviewed. Findings: Review of the facility's undated Discharge Transfer of a Resident Policy and Procedure revealed the following in part: Procedure- discharge: 6. Complete a discharge summary and post discharge plan of care form Review of Resident #89's record revealed an admission date of 03/31/2025 and discharge date of 04/30/2025. Further review of the record revealed no documentation of a discharge summary completed for Resident #89. An interview on 07/09/2025 at 8:45 a.m. with S2Director of Nursing (DON) confirmed Resident #89 was discharged from the facility on 04/30/2025. S2DON further confirmed there was no documentation of a discharge summary for Resident #89.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record reviews and interviews, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed and transmitted timely for 4 (#34, #35, #55, and #59) of 4 sampled residents reviewed for resident assessment. Findings: Review of the records for Resident #34, #35, and #55 revealed each of these residents had a Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/27/2025. Further review of the record revealed these 3 MDS Assessments were not transmitted to state until 07/07/2025 for each of these residents. Review of the record for Resident #59 revealed an Annual MDS Assessment with an ARD date of 05/27/2025 was not transmitted to the state until 07/07/2025. An interview on 07/08/2025 at 2:50 p.m. with S13MDS Coordinator and S14MDS Coordinator confirmed the facility failed to complete and transmit MDS Assessments timely for Resident #34, #35, #55, and #59.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene for 2 (#11, #22) of 6 (#11, #14, #22, #56, #70, #74) residents reviewed for ADL care. Findings: Resident #22 Review of Resident #22's record revealed an admission date of 01/23/2025 with diagnoses that included cerebral infarction with hemiplegia and hemiparesis, chronic obstructive pulmonary disease, and congestive heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident #22 had no cognitive impairment. Further review revealed Resident #22 required partial/moderate assistance with personal hygiene. Review of Resident #22's active care plan revealed she required assistance for all ADLs and needed assistance with hygiene and grooming tasks. On 07/07/2025 at 9:23 a.m., 07/08/2025 at 9:30 a.m., and 07/08/2025 at 2:14 p.m., observations revealed Resident #22 was observed in bed in her room and she had long facial hair on her chin. On 07/09/2025 at 8:58 a.m., observation of Resident #22 with S9Certified Nursing Aide (CNA) revealed Resident #22 had long facial hair on her chin. An interview with S9CNA revealed Resident #22 allows them to shave her without any problem. S9CNA confirmed the resident's face was not groomed and the facial hair needed to be shaved. On 07/09/2025 at 2:05 p.m., S2Director of Nursing (DON) was notified of the above findings and she confirmed Resident #22 was dependent on staff for ADL care. Resident #11 Review of Resident #11's record revealed an admission date of 03/18/2024 with diagnoses including type 2 diabetes mellitus with ketoacidosis without coma, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic combined systolic (congestive) and diastolic heart failure, hypertension, functional dyspepsia, polyosteoarthritis, hyperlipidemia, morbid obesity, and chronic kidney disease. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating no cognitive impairment. Further review of the MDS revealed Resident #11 required assistance with ADLs and has functional limitation in range of motion on one side of upper extremities. An observation on 07/07/2025 at 8:50 a.m. and 07/08/2025 at 9:25 a.m. of Resident #11 revealed her fingernails were long and needed to be trimmed. Further observation revelaed Resident #1 had limited in range of motion to her right hand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/08/2025 at 9:25 a.m. with Resident #11 revealed she's unable to trim her own fingernails and she asked a staff member to cut her fingernails on 07/07/2025. An interview on 07/09/2025 at 1:00 p.m. with S11Licensed Practical Nurse (LPN) revealed that Resident #11 required extensive assistance with ADLs including nail care. S11LPN confirmed Resident #11's fingernails were trimmed by the nurse on the hall or the treatment nurse due to the resident having diabetes. Interview on 07/09/2025 at 1:05 p.m. with S2DON was notified of the above findings and confirmed Resident #11 required assistance from staff for nail care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (#1) of 1 residents reviewed for position/mobility. The facility failed to ensure hand rolls and an elbow splint were provided for Resident #1's hand and arm contractures. Findings: Review of the record for Resident #1 revealed diagnoses of traumatic hemorrhage of cerebrum, hemiplegia, aphasia, and bilateral hand contractures. Review of the quarterly Minimal Data Set assessment dated [DATE] for Resident #1 revealed functional limitation in range of motion on both sides for upper extremity and impairment on both sides of lower extremity. Resident's cognitive skills for daily decision making were severely impaired. Observations on 07/07/2025 at 8:30 a.m. revealed Resident #1 had bilateral contractures with no splints in place. On 07/07/2025 at 1:30 p.m. and 07/07/2025 at 4:00 p.m., observations revealed no hand splints were in place. Further observation revealed no elbow splint in place. All observations on 07/08/2025 revealed no splints in place for Resident #1. Review of the current physician orders for Resident #1 revealed an order for an elbow splint for right elbow due to diagnosis of contracture of right elbow. Review of the care plan for Resident #1 revealed the following focus: assistance for all activities of daily living (ADLs), (total care due to traumatic hemorrhage, hemiplegia). I have impaired physical mobility related to contractures of right arm, bilateral hands, bilateral lower extremities and left wrist. I have history of traumatic hemorrhage. I have a right elbow splint and bilateral hand rolls. Interview with S3Licensed Practical Nurse (LPN) on 07/08/2025 at 1:30 p.m. confirmed Resident #1 did not have hand rolls or elbow splint in place. Interview with S6Certified Nursing Assistant (CNA) on 07/09/2025 at 7:52 a.m. confirmed Resident #1 did not have splints in place. S6CNA stated she last worked on the weekend and the splints were not present. On 07/09/2025 at 2:25 p.m, S2Director of Nursing (DON) was notified of the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to ensure the resident's environment remained free of accident hazards by failing to ensure bed rails were properly secured for 1 (#5) of 2 (#5, #11) residents reviewed for accident hazards. Findings: Review of the medical record for Resident #5 revealed an admission date of 09/23/2019 with diagnoses that included chronic obstructive pulmonary disease, bipolar disorder, dementia, and hyperlipidemia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 which indicated the resident had moderately impaired cognitive skills for daily decision making. Further review revealed Resident #5 was dependent with bed mobility. Review of the current plan of care addressed Resident #5's need for staff assistance with all activities of daily living. The resident required half side rails for turning and repositioning. Observations on 07/07/2025 at 9:15 a.m. and 07/08/2025 at 9:16 a.m. revealed the half side rail on Resident #5's left side of the bed was loose. On 07/09/2025 at 9:56 a.m., an observation of Resident #5's left side rail with S15Maintenance Supervisor confirmed the side rail was loose.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #1 Review of the record for Resident #1 revealed an admit date of 05/01/2005 with diagnoses of hemiplegia, unspecified affecting unspecified side, and traumatic hemorrhage of cerebrum. Review of the current physician orders for Resident #1 revealed an order for oxygen therapy as follows: oxygen saturation level each shift, apply oxygen if saturation less than 92% at 2 liters per nasal cannula. Review of the care plan revealed a plan for at risk for respiratory infection related to Covid with interventions to administer oxygen as ordered. Observation of Resident #1 on 07/07/2025 at 8:23 a.m. revealed the oxygen concentrator flow set to three liters. Further observation revealed that the oxygen nasal cannula was lying on the floor. Further observation revealed that the concentrator was filthy with white debris splattered on it. Observation of Resident #1 on 07/07/2025 at 1:30 p.m. revealed the oxygen concentrator on and the flow set for three liters. Further observation revealed that the oxygen nasal cannula was lying on side of the bed. Observation of Resident #1 on 07/07/2025 at 4:15 p.m. revealed that the oxygen concentrator was on and set for 3 liters. Further observation revealed that the oxygen nasal cannula was lying on the bed. Observation of Resident #1 on 07/08/2025 at 9:44 a.m. revealed that the oxygen concentrator was set on 3 liters. Further observation revealed that the oxygen nasal cannula was on side of Resident #1's face and was not in her nostrils. Further observation revealed that the concentrator was filthy with food splatters on it. Interview with S3Licensed Practical Nurse (LPN) on 07/08/2025 at 1:30 p.m. revealed that Resident #1 had recently returned from the hospital on [DATE] with an order for continuous oxygen therapy at 3 liters a minute. S3LPN confirmed that Resident #1 is sometimes non-compliant and removes her nasal cannula. Interview with S6Certified Nursing Assistant (CNA) on 07/09/2025 at 7:52 a.m. confirmed that Resident #1 was supposed to have oxygen on at all times. Further interview with S6CNA confirmed that the oxygen concentrator was filthy and was in need of cleaning. Observation on 07/09/2025 at 2:25 p.m. with S2DON present, S2DON confirmed that the oxygen concentrator was not clean. S2DON was notified at this time that Resident #1 not receiving oxygen as ordered. Based on observations, record reviews, and interviews, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 3 (#1, #5, #22) of 4 (#1, #5, #22, and #76) residents reviewed for respiratory care. The facility failed to ensure: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) the residents' oxygen concentrators and filters on the back of the concentrators were free from dust and grime build up (#1, #22), 2.) a resident had the correct oxygen flow rate (#1), and 3.) a resident's nebulizer tubing was changed timely (#5). Review of the facility's undated oxygen policy and procedures, revealed in part the following: Purpose: To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. Procedure: 1. Check physician's order for liter flow and method of administration. 5. Prefilled, sealed, disposable humidifiers may be changed per facility procedure. e. Set the flow meter to the rate ordered by the physician. g. Change tubing per facility procedure. 9. At regular intervals, check and clean oxygen equipment, masks, tubing, and cannula. Review of the facility's undated nebulizer/continuous positive airway pressure (CPAP) cleaning policy and procedure revealed, in part: Purpose: To keep Nebulizer or CPAP machine and equipment clean. Policy: Resident's Nebulizer or CPAP will be kept clean when in resident room. 3. Tubing, mouthpiece and mask to be changed out weekly and as needed. Findings: Resident #22 Review of the record for Resident #22 revealed diagnoses of chronic obstructive pulmonary disease (COPD), congestive heart failure, and cerebral infarction. Review of the Resident #22's current physician's orders revealed an order dated 02/04/2025 to administer oxygen at 2 liters per nasal cannula. Further review revealed an order dated 06/09/2025 to clean filter and concentrator (free from dust) as needed for oxygen therapy. Review of Resident #22's active care plan revealed she had COPD and chronic lung disease and needed oxygen when she had a respiratory crisis. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/07/2025 at 9:23 a.m., 07/08/2025 at 9:30 a.m., and 07/08/2025 at 2:14 p.m., observations revealed Resident #22 was observed in bed in her room with oxygen at 2 liters per nasal cannula. Further observation revealed there was dust and grime build up on the outside of her oxygen concentrator and on the filter on the back of the concentrator. On 07/09/2025 at 2:05 p.m., observation of resident #22's oxygen concentrator with S2Director of Nursing (DON) revealed there was a buildup of dust on the resident's oxygen concentrator and the filter on the back of the oxygen concentrator. S2DON confirmed resident #22's oxygen concentrator was in need of cleaning. Resident #5 Review of the medical record for Resident #5 revealed an admission date of 09/23/2019 with diagnoses that included chronic obstructive pulmonary disease, bipolar disorder, dementia, and hyperlipidemia. Review of the physician's orders revealed ipratropium-albuterol solution 0.5-2.5 (3) milligrams/3 milliliters 1 vial inhale orally four times a day for productive cough. Review of the current plan of care addressed Resident #5's chronic obstructive pulmonary disease with interventions that included administration of medications as ordered by the physician. Review of the July 2025 Medication Administration Record (MAR) revealed Resident #5 last received ipratropium-albuterol solution 0.5-2.5 (3) milligrams/3 milliliters inhaled orally on 07/03/2025 at 4:00 p.m. On 07/07/2025 at 9:15 a.m., the nebulizer mask tubing at Resident #5's bedside was dated 06/09/2025. On 07/08/2025 at 9:16 a.m., the nebulizer mask tubing at Resident #5's bedside was dated 06/09/2025. On 07/08/2025 at 9:16 a.m., S4LPN confirmed the nebulizer mask tubing at Resident #5's bedside was dated 06/09/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195392	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Winnsboro	804 Polk Street Winnsboro, LA 71295

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations of the medication administration, record review, and interview, the facility failed to ensure that it was free from a medication error rate of 5% or greater. The facility had a 5.41 % medication error rate with 2 medication errors out of 37 opportunities. Findings: Resident #72 Observation of the medication pass for Resident #72 on 07/08/2025 at 8:06 a.m. revealed S4Licensed Practical Nurse (LPN) administered 10 oral medications to resident #72. Further observation of the medication pass revealed S4LPN administered the phosphate binder medication Sevelamer Carbonate (Renvela), 800 milligrams, 2 tablets. Interview with Resident #72 on 07/08/2025 at 8:06 a.m. confirmed that he had already eaten his breakfast meal. Review of the pharmacy label and the current physician orders revealed the following: Sevelamer Carbonate tablet, 800mg, take 2 tablets (1600mg) by mouth three times daily before meals and take one tablet before snacks. Review of the current physician orders for Resident #72 revealed an order for the medication Ondansetron HCl Oral Tablet 8 mg, take 1 tablet by mouth one time a day every Tuesday, Thursday, and Saturday on dialysis days related to nausea and vomiting. This medication was not observed to be administered during the medication pass. Interview with S4LPN on 07/09/2025 at 12:10 p.m. confirmed that she administered the medication Sevelamer Carbonate 800mg, 2 tablets, after resident #72 had completed his breakfast. Further interview with S4LPN revealed that she administered the medication Ondansetron 8mg after medication pass observation was completed. She confirmed that she did not attempt to notify the Director of Nursing (DON) or this surveyor prior to administering medication. On 07/09/2025 at 2:25 p.m., S2DON was made aware of 2 medication errors for resident #72. Surveyor explained to S2DON that 2 medication errors were made during the medication pass resulted in a medication error rate greater than 5%.

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	195392	A. Building B. Wing	07/09/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, policy review and interviews, the facility failed to store food and discard expired items in accordance with professional standards for food service safety. This deficient practice had the potential to effect the 63 residents that received meals prepared in the facility's kitchen. Findings: Review of the facility's Dietary Service policy and procedures dated 07/21/2016 revealed, in part, sanitary conditions are maintained in the storage, preparation, and distribution of food. On 07/07/2025 at 8:15 a.m. during an initial tour of the kitchen, observations revealed the following: -dust/grime build up on air vent near entrance to the kitchen; -grime/old food build up on base of large can opener; -large amount of old grease buildup in lower compartment of deep fryer and on the floor underneath the fryer; -2 commercial ovens have dark stains/old food buildup on inside of the oven doors and interior of both ovens; and -microwave had a large amount of old food splatters on inside top and sides of the microwave; -walk-in refrigerator had a large bin that had packages of cheese stored in it that had a lid with dirt/grime; and -walk-in freezer had multiple broken pieces of ice that was scattered on the floor and a large box of hashbrowns was open to air and had ice buildup noted on the hashbrowns. Further observation during the initial tour of the kitchen dry storage room revealed the following: -old foil and food particles were underneath the oatmeal and grits containers, and the 2 small plastic storage containers for the oatmeal and grits were not dated; -2 rolling carts (had 3 shelves each) had old food/grime build-up on all the shelves; -large bin with packages of noodles had a lid that had dirt/grime and was broken; -large bin with individual packets of salt and pepper had a lid that had dirt/grime and was broken; -large bin with individual packages of lemonade drink mixes had a lid that had dirt/grime; (continued on next page)

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	195392	A. Building B. Wing	07/09/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-multiple large cans were dented (2 marinara sauces, 1 mandarin orange, 2 apple, 1 tropical fruit, and 1 cream of chicken soup); -large round plastic container that had rice stored in it was not labeled with a date; and -large plastic container that had flour stored in it was not labeled with a date. On 07/07/2025 at 8:40 a.m., an observation with S14Dietary Manager of the above findings was conducted. S14Dietary Manager confirmed food was not stored and labeled properly and kitchen was not cleaned properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195392	A. Building B. Wing	07/09/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to maintain electrical equipment in safe operating condition for 1 (#70) of 7 (#1, #5, #25, #70, #71, #74, #76) residents reviewed for environment. The facility failed to ensure that Resident #70's bed control was properly maintained and in safe working order. Findings: Review of the medical record for Resident #70 revealed an admission date of 06/17/2024 with diagnoses that included Alzheimer's disease, cerebrovascular disease, aphasia, dysphagia, repeated falls, and transient ischemic attack. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview of Mental Status score of 6 which indicated Resident #70 had severe cognitive impairment. On 07/08/2025 at 9:28 a.m., an observation of Resident #70's room revealed a bed remote with exposed wires. On 07/09/2025 at 10:02 a.m., an observation with S15Maintenance Supervisor of Resident #70's bed control confirmed exposed wires.