STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195501	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvest Manor Healthcare and Rehabilitation Center	839 North Range Avenue Denham Springs, LA 70726

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility failed to prepare and serve food in accordance with professional standards for food safety by failing to ensure staff wore a facial hair restraint while serving residents' food from the steam table. This deficient practice had the potential to affect 164 residents who received food from the facility's kitchen.Findings: An observation was made of the breakfast meal service in the facility's kitchen on 08/11/2025 at 8:45 a.m. S4CK was plating food on the serving line. S4CK had a mustache and beard with no facial hair restraint. An interview was conducted with S3DM on 08/11/2025 at 8:49 a.m. S3DM observed S4CK on the serving line and stated he should have had on a facial hair restraint. An interview was conducted with S1ADM on 08/12/2025 at 12:50 p.m. He stated dietary staff with facial hair should wear a facial hair restraint while preparing and serving food.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews, and record review, the facility failed to maintain an effective pest control program so the facility was free of roaches in the facility's kitchen. This deficient practice had the potential to affect 164 residents who received food from the facility's kitchen.Findings: Review of the facility's policy titled, Pest Control and Procedure, and dated 09/01/2019, revealed the following, in part:Policy: Each facility will have an effective pest control plan in place with resident safety as the top priority. Contingency plans will also be in place should active pest activity be identified. Review of the facility's Maintenance Log revealed an entry on 06/25/2025 for roaches in the kitchen on the serving table. An observation was made of the facility's lunch service in the kitchen on 08/11/2025 beginning at 11:27 a.m. There was a hole in the caulk between the cinderblock wall and the steam table. The following was observed coming from the hole onto the steam table and toward the uncovered food on the steam table:11:30 a.m. - a roach the size of a grain of rice. S3DM killed the roach.11:31 a.m. - a roach the size of a grain of rice. S3DM killed the roach.11:32 a.m. - a roach the size of a black bean. S3DM killed the roach.11:33 a.m. - a roach the size of a black bean.11:35 a.m. - a roach the size of a sunflower seed. S3DM killed the roach.11:36 a.m. - a roach the size of a grain of rice. S3DM killed the roach.11:38 a.m. - a roach the size of a grain of rice. S3DM killed the roach.11:39 a.m. - a roach the size of a grain of rice. S3DM killed the roach. An interview was conducted with S3DM on 08/11/2025 at 11:40 a.m. S3DM confirmed the bugs seen were roaches and they were crawling on the steam table with uncovered food. An interview was conducted with S4CK on 08/11/2025 at 11:42 a.m. He stated he had seen roaches on the steam table before. A telephone interview was conducted with a local pest control company representative on 08/12/2025 at 8:13 a.m. He stated he reported to the facility's kitchen on the night of 08/11/2025. He confirmed there was a roach infestation behind the kitchen's steam table. He stated the infestation was in the same area where it was identified in June 2025. He stated the continued roach activity was unacceptable. He stated one roach in a kitchen was too many. An interview was conducted with S1ADM on 08/12/2025 at 9:04 a.m. He confirmed it was not sanitary to have roaches by food.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, interviews, and record review, the facility failed to ensure the resident group had a private space large enough for all residents who wanted to attend resident council meetings. This deficient practice had the potential to affect all residents who wished to attend resident council meetings. The facility had a current census of 165.Findings: Review of the Resident Council Meeting Minutes dated 08/06/2025 revealed the following, in part:Administration: Residents were wondering what's going on with the enclosed area. Review of the Resident Council Meeting Minutes dated May 2025 through August 2025 revealed the following amount of residents were in attendance:05/07/2025 - 15 residents06/04/2025 - 13 residents07/02/2025 - 9 residents08/06/2025 - 14 residents A meeting was held with members of the resident council on 08/11/2025 at 1:10 p.m. in the facility's cafe. Residents #41, #56, #80, #81, and #156 were in attendance. During the resident council meeting, the glass doors leading to the dining room were closed. The walls leading to the main hallways of the facility had 8 feet openings, one each side, therefore, the room was not enclosed or private. There was a staff member who entered the area and opened the glass door to enter the dining room during the meeting. During the resident council meeting, the residents verbalized concerns about the resident council not having a private space large enough for all residents who wanted to attend. The residents verbalized there was an attempt to meet in the facility's conference room, which was not large enough for all residents who wanted to attend. The residents verbalized this had been an ongoing issue discussed in previous resident council meetings. Observations were made of the facility's conference room on 08/11/2025 and 08/12/2025. The conference room contained a large table with chairs surrounding it. The area was not large enough to hold all residents who wished to attend resident council meetings. The area was unable to accommodate wheelchairs around the table. A telephone interview was conducted with S8AD on 08/12/2025 at 10:02 a.m. She stated the Resident Council Meeting Minutes dated 08/06/2025, which revealed residents were wondering what's going on with the enclosed area, was referring to the residents asking about a private space for them to meet that was large enough for everyone who wanted to attend. She stated the concern had been brought up in resident council meetings multiple times. She confirmed there was not a private space large enough for all residents who wanted to attend resident council meetings. She stated the resident council attempted to meet in the facility's conference room one month, but it would not accommodate all of the residents who wanted to attend. She stated the residents wanted a private space with less background noise and no staff walking by the room openings. An interview was conducted with S1ADM on 08/12/2025 at 9:06 a.m. He stated the facility's cafe was where the resident council met. He confirmed the facility's cafe was not a private space. He confirmed there had been concerns from the resident council about not having a private space to meet. He stated the conference room was a private space where the resident council could meet. He stated he was unaware of the resident council attempted to meet in the facility's conference room. He stated the resident council should have a private space to meet.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review and interviews, the facility failed to ensure residents with an identified mental health diagnosis were referred for a Preadmission Screening and Resident Review (PASARR) Level II evaluation as required for 2 (#5 and #24) of 3 (#5, #24, and #36) residents reviewed for PASARR.Resident #5A review of Resident #5's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Hereditary and Idiopathic Neuropathy. Further review revealed an additional medical diagnosis of Manic Episode with an onset date of 06/01/2023.Further review revealed no review for a PASARR Level II evaluation and determination had been submitted for Resident #5 following her diagnosis of Manic Episode.Resident #24A review of Resident #24's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Depression. Further review revealed an additional medical diagnosis of Bipolar Disorder with an onset date of 03/17/2025.Review of Resident #24's PASARR Level I dated 03/06/2025 revealed no mental health diagnoses were selected. Further review revealed no review for a Level II evaluation and determination had been submitted for Resident #24 following his diagnosis of Bipolar Disorder.An interview was conducted on 08/13/2025 at 1:00 p.m. with S12SSD. She reviewed Resident #5's PASARR Level I dated 12/07/2020 and diagnoses. She stated Resident #5 had a diagnosis of Manic Episode acquired on 06/01/2023 and should have had a new Resident Review conducted at that time. She reviewed Resident #24's PASARR Level I dated 03/06/2025 and diagnoses. She stated Resident #24's PASARR Level I revealed no mental health diagnoses were checked. She stated Resident #24 had a diagnosis of Bipolar Disorder and should have had a new Resident Review conducted in 03/2025.An interview was conducted on 08/13/2025 at 2:35 p.m. with S2DON. She reviewed Resident #5's PASARR Level I dated 12/07/2020 and diagnoses. She stated Resident #5 had a diagnosis of Manic Episode acquired on 06/01/2023 and should have had a new Resident Review conducted at that time. She reviewed Resident #24's PASARR Level I dated 03/06/2025 and diagnoses. She stated Resident #24's PASARR Level I revealed no mental health diagnoses were checked. She stated Resident #24 had a diagnosis of Bipolar Disorder and should have had a new Resident Review conducted in 03/2025.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the risks and benefits were reviewed with the resident and/or resident representative, and informed consent was obtained prior to bed rail installation for 2 (#3 and #70) of 3 (#3, #70 and #146) residents reviewed with bed rails.Review of the facility's policy dated 11/25/2014 and titled Side Rail Policy and Procedure revealed the following:Purpose: To provide intervention as warranted to assist resident in reaching the highest level of functioning. Policy: We use side rails as appropriate to resident need in creating better bed mobility and positioning, as ordered by the physician. Procedure: 1. Obtain a physician's order and consent for use of side rails. Essential Points:A.) Always explain the purpose to the resident and family before obtaining an order for side rails. Resident #3Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Dementia and Unspecified Mood Disorder. Further review of the Clinical Record revealed no documentation related to the explanation of risks and benefits associated with the use of bed rails and informed consent with resident and/or resident representative. Review of the Physician Orders revealed the following:Order Date: 05/13/2025- May use 1/4 side rails x 2 as needed for bed mobility Resident #70Review of Resident #70's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Dementia, Unspecified Mood Disorder and Hemiplegia with Hemiparesis. Further review of the Clinical Record revealed no documentation related to the explanation of risks and benefits associated with the use of bed rails and informed consent with resident and/or resident representative. Review of the Physician Orders revealed the following:Order Date: 04/25/2023- 1/4 side rails x 2 as needed for bed mobility/positioning On 08/11/2025 thru 08/13/2025 observations were made of Resident #3's and Resident #70's beds with 1/4 side rails in place at the top of the bed in the upright position. On 08/13/2025 at 3:00 p.m., an interview was conducted with S2DON. She reviewed Resident #3's and Resident #70's medical record and confirmed there were no informed consents for bed rail use signed by the resident and/or resident representative. She stated she was unaware the admission, Physician Order for 1/4 side rails required the facility to obtain informed consents prior to use. On 08/13/2025 at 4:20 p.m., an interview was conducted with S1ADM with S11RDO present. S1ADM and S11RDO stated the facility was unaware they needed to obtain informed consents from the resident and/or resident representative prior to the use of 1/4 side rails.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review and interviews, the facility failed to ensure a resident's medical record was complete and accurate by failing to ensure baths were documented as provided for 1 (#149) of 4 (#9, #56, #64, and #149) residents reviewed for activities of daily living.Review of Resident #149's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Hereditary and Idiopathic Neuropathy, Muscle Wasting and Atrophy, Chronic Respiratory Failure, Heart Failure, and Chronic Pain Syndrome.Review of Resident #149's Quarterly MDS with an ARD of 06/11/2025 revealed she required substantial/maximal assistance from staff for bathing.Review of the Facility's CNA Schedules dated 08/04/2025, 08/06/2025, 08/08/2025, and 08/11/2025 revealed S9CNA was assigned to Resident #149's hall.Review of Resident #149's ADL-Bathing Documentation dated August 2025 revealed she was scheduled to receive a bath on Mondays, Wednesdays, and Fridays. Further review revealed no documented bath on 08/04/2025, 08/06/2025, 08/08/2025, and 08/11/2025.An interview was conducted with S9CNA on 08/13/2025 at 1:10 p.m. She stated Resident #149 was scheduled to receive baths every Monday, Wednesday, and Friday. She confirmed she was assigned to Resident #149 on 08/04/2025, 08/06/2025, 08/08/2025, and 08/11/2025 and was responsible for providing a bath. She stated she provided baths to Resident #149 on 08/04/2025, 08/06/2025, 08/08/2025, and 08/11/2025. She reviewed Resident #149's ADL-Bathing Documentation dated 08/04/2025, 08/06/2025, 08/08/2025, and 08/11/2025 and confirmed there was no bath documented. She confirmed the baths she provided to Resident #149 should have been documented. An interview was conducted with S2DON on 08/13/2025 at 2:35 p.m. She confirmed if a bath was provided, it should have been documented on the resident's ADL-Bathing Documentation.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to promote and facilitate residents' self-determination through support of the residents' choice about aspects of his or her life in the facility that were significant to the resident for 1 (#11) of 36 residents in the initial pool. The facility failed to ensure Resident #11 had a choice to participate in a sewing activity. Review of the Medical Record for Resident #11 revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Depressive Disorder, Mild Cognitive Impairment, and Type 2 Diabetes Mellitus.Review of the most recent MDS (Minimum Data Set) for Resident #11 with an ARD (Assessment Reference Date) of 07/23/2025 revealed Resident #11 had a BIMS (Brief Interview for Mental Status) of 12, which indicated the resident was moderately cognitively impaired. Further review of the MDS revealed the following:Section GG- Resident #11 had no impairment to her upper and lower extremities and required supervision for transfers. Section D- Resident #11 felt down and depressed for several days. Review of the most current Care Plan for Resident #11 revealed the following:Problem: Resident #11 had a diagnosis of Depression. 07/23/2025 Resident #11 expressed feeling down, depressed or hopelessInterventions: Encourage Resident #11 to participate in the facilities daily activitiesAn observation was conducted on 08/11/2025 during the initial pool process, Resident #11 was noted to be sitting at the desk in her room painting with watercolor. An interview was conducted with Resident #11 at that time. She stated she loved to paint and sew and had been sewing since she was a young age. She stated she spoke with S1ADM about wanting a sewing machine and was told she could not have a sewing machine because it was not safe. An interview was conducted with S8AD on 08/13/2025 at 2:17 p.m. She stated she assessed Resident #11 for her activity preferences and was aware she wanted to sew. She stated administration would not approve the sewing activity due to a safety hazard. She stated she thought there were a couple of residents who could utilize a sewing machine under supervision. An interview was conducted with S16PT and S17COTA, on 08/13/2025 at 2:45 p.m. They stated Resident #11 painted watercolors in her room and did not have any upper or lower extremity impairments. They stated Resident #11 would be safe to utilize a sewing machine with supervision. An interview was conducted with S15CNA on 08/13/2025 at 2:51 p.m. She stated Resident #11 transferred independently and painted watercolors in her room. An interview was conducted with Resident #11's daughter on 08/13/2025 at 3:03 p.m. She stated when her mother was first admitted to the facility they inquired about a sewing machine and was told it was not allowed. She stated Resident #11's life had always revolved around sewing and painting. She stated she sewed at home until she was admitted to the facility and began sewing at a very young age. She stated she noticed a difference in her mom's mood by complaining all the time and recognized her mom was miserable at the facility without being able to sew. An interview was conducted with S14CRN on 08/13/2025 at 3:45 p.m. He stated a resident would need a special assessment to determine if a sewing machine was safe for them to utilize. He confirmed all residents in the facility should be assessed for activities of their choice and had the right to participate in those activities. An interview was conducted with S2DON on 08/13/2025 at 3:47 p.m. She stated she was not aware of any residents requesting a sewing machine at the facility. She stated she could not determine if Resident #11 would be safe to utilize a sewing machine because she did not know her well enough and had not completed a sewing machine safety assessment. An interview was conducted with S1ADM on 08/13/2025 at 4:10 p.m. He denied Resident #11 or S8AD requested a sewing machine. He stated he was only aware of a resident council meeting discussion on the difference between an unsafe smoker and a sewing machine. He stated it would not be safe for any residents to utilize a sewing machine at the facility independently or supervised. He stated the facility would need to assess the resident's safety of utilizing a sewing machine but this was not normally used for (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities in the facility with or without supervision. He confirmed residents had rights to participate in their activity preferences and the facility should do their best to accommodate the resident and keep them safe as well. An interview was conducted with S11RDO on 08/13/2025 at 4:12 p.m. He stated a sewing machine would not be something they wanted in the facility. He confirmed residents had the right to participate in their activity preferences and the facility should do their best to accommodate the resident and keep them safe as well.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interviews and record review, the facility failed to transmit Minimum Data Set (MDS) Assessments in the required timeframe for 1(#166) of 1 (#166) resident reviewed for resident assessment. Findings:Review of Resident #166's Clinical Record revealed an admission date of 02/25/2025. Further review of Resident #166's Clinical Record revealed a discharge date of 03/14/2025. On 08/12/2025 at 8:49 a.m., a review of Resident #166's Discharge MDS with an Assessment Reference Date (ARD) of 03/14/2025 revealed the assessment was completed, but not transmitted, with a status of completed but not accepted. On 08/13/2025 at 2:03 p.m., an interview was conducted with S10LPN. She confirmed she was responsible for entering MDS Assessments and they should be transmitted within 14 days of the assessment completion. She reviewed Resident #166's Discharge MDS Assessment and confirmed it was transmitted on 08/13/2025, and was not transmitted within the required timeframe. On 08/13/2025 at 2:30 p.m., an interview was conducted with S2DON. She reviewed Resident #166's Discharge MDS with ARD of 03/14/2025. She confirmed she was discharged on 03/14/2025 and her Discharge MDS Assessment was not transmitted until 08/13/2024, which was not within the required timeframe.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (#20) resident out of a total of 36 sampled residents by failing to ensure Resident #20 was accurately coded for pain medication and opioid use.Review of Resident #20's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Pain in Left Ankle and Joints of Left Foot and Pain Unspecified. Review of Resident #20's Significant Change MDS with an ARD of 05/21/2025 revealed Section J0100.B. Pain Management- Received PRN pain medications or was offered and declined, was coded 0. No, and Section N0415. H. Opioid: is taking, was coded No. Review of Resident #20's current Physician Orders revealed an order for Norco oral tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth every 6 hours as needed for pain with a start date of 07/01/2024. Review of Resident #20's May 2025 MAR revealed the resident received the ordered pain medication Norco oral tablet 5-325 mg (Hydrocodone-Acetaminophen), as needed for pain on the following dates: 05/01/2025-05/06/2025, 05/08/2025-05/11/2025, 05/13/2025-05/15/2025, 05/20/2025, 05/22/2025-05/25/2025, and 05/29/2025. On 08/13/2025 at 2:08 p.m., an interview was conducted with S10LPN. She reviewed Resident #20's Significant Change MDS assessment with an ARD of 05/21/2025 and reviewed her MAR for May 2025. S10LPN confirmed Resident #20 was taking pain medication Norco as needed at that time. She further confirmed Resident #20's 05/21/2025 MDS was not coded accurately for pain medication as Section J0100.B. was coded no and opioid use as Section N0415. H. was also coded no. She confirmed both sections mentioned above were coded no, and should have been coded as yes since Resident #20 had received PRN pain medication and was taking an opioid during that time. On 08/13/2025 at 2:17 p.m., an interview was conducted with S2DON. She reviewed Resident #20's Significant Change MDS assessment with an ARD of 05/21/2025 and reviewed her MAR for May 2025. S2DON confirmed Resident #20 was taking pain medication Norco as needed at that time. She further confirmed Resident #20's 05/21/2025 MDS was not coded accurately for pain medication as Section J0100.B. was coded no and opioid use as Section N0415.H. was also coded no. She confirmed both sections mentioned above were coded no, and should have been coded as yes since Resident #20 had received PRN pain medication and was taking an opioid during that time.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record reviews, the facility failed to ensure the services provided as outlined in the comprehensive care plan met professional standards of quality by failing to ensure nursing staff primed insulin pen needles prior to administering insulin for 2 (#106 and #114) of 3 (#86, #106, and #114) residents reviewed for insulin administration.Findings: Review of the facility's insulin pen needles manufacturer's guidelines revealed the insulin pen needle should always be primed with two units of insulin after applying the needle and prior to drawing up the insulin dose. Resident #106Review of Resident #106's Clinical Record revealed an admission date of 04/30/2024. Further review revealed a Physician's Order for Regular Insulin 100 unit/mL subcutaneously per sliding scale before meals and at bedtime. Resident #106's Regular Insulin sliding scale order was 4 units of insulin for a blood glucose level of 200 to 250 mg/dL. An observation was made of S5LPN administering Regular Insulin 100 unit/mL to Resident #106 on 08/12/2025 at 11:09 a.m. Resident #106's blood glucose level was 219 mg/dL. S5LPN sanitized the insulin pen stopper, applied the insulin pen needle, dialed up 4 units of insulin, and administered the insulin. S5LPN did not prime the insulin pen needle prior to administering the insulin. An interview was conducted with S5LPN on 08/12/2025 at 11:18 a.m. S5LPN confirmed she did not prime the insulin pen needle prior to administering insulin to Resident #106 and should have. Resident #114Review of Resident #114's Clinical Record revealed an admission date of 11/24/2021. Further review revealed a Physician's Order to inject 5 units of Insulin Lispro 100 unit/mL subcutaneously three times daily. An observation was made of S6LPN administering Insulin Lispro 100 unit/mL to Resident #114 on 08/11/2025 at 9:13 a.m. S6LPN applied the insulin pen needle, dialed up 5 units of insulin, and administered the insulin. S6LPN did not prime the insulin pen needle prior to administering the insulin. An interview was conducted with S6LPN on 08/11/2025 at 9:16 a.m. She stated insulin pen needles should always be primed prior to dialing up the ordered dose of insulin. An interview was conducted with S2DON on 08/12/2025 at 12:25 p.m. She stated insulin pen needles should always be primed with two units of insulin prior to dialing up and administering the ordered dose of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195501	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide foot care and treatment in accordance with professional standards of practice for a resident with Diabetes. The facility failed to schedule and complete podiatry appointments for toenail evaluation and care for 1 (#11) of 5 (#9, #11, #56, #64 and #149) residents sampled for Activities of Daily Living (ADLs). Review of the Medical Record for Resident #11 revealed the resident was admitted to the facility on [DATE] with diagnosis, which included Type 2 Diabetes Mellitus.Review of the most recent MDS (Minimum Data Set) for Resident #11 with an ARD (Assessment Reference Date) of 07/23/2025 revealed Resident #11 had a BIMS (Brief Interview for Mental Status) of 12, which indicated the resident was moderate cognitively impaired. Further review revealed Resident #11 required supervision for bathing. Further review of Resident #11's medical record revealed no documentation of a Podiatry referral nor nail care provided by a Podiatrist.An observation was conducted of Resident #11 on 08/11/2025 at 9:30 a.m. Abnormally thickened toenails was noted on both big toes. Resident #11 stated she had discomfort when the bedsheets were against her toes and wearing shoes. She stated when her friends visited they brought nail clippers for her to trim her own toenails. She stated she requested to see a podiatrist since January 2025 but still had not seen a Podiatrist. An interview was conducted with S18DSS on 08/13/2025 at 11:40 a.m. She stated they contracted with an outside provider for podiatry and they conducted visits at the facility every 3 months. She stated a resident, nurse, or CNA can make a request for the resident to be evaluated by the podiatrist. She stated once she received the request, she notified the outside provider and the outside provider would reach out to the resident or RP to get the services started. She confirmed Resident #11 and Resident #11's daughter requested to be evaluated by the Podiatrist but could not recall when the request was made. She reviewed Resident #11's chart her emails and confirmed she did not have any documentation of the request. She confirmed she received an email from the daughter on 07/19/2025 but Resident #11 requested an appointment prior to receipt of the email. She confirmed the contracted provider did not have any documentation Resident #11 wanted to begin the services. An interview was conducted with Resident #11's daughter on 08/13/2025 at 3:03 p.m. She stated her mother had been asking since January 2025 to see a podiatrist and after months of Resident #11 requesting to see the podiatrist, she emailed S18DSS on 07/19/2025. She stated S18DSS responded and informed her Resident #11 needed a diagnosis of DM or PVD. Resident #11's daughter stated she informed S18DSS that Resident #11 did have a diagnosis of Diabetes. An interview was conducted with the S2DON on 08/13/2025 at 3:45 p.m. She S18DSS would be notified of a residents request to see the podiatrist and S18DSS should notify the contracted provider to begin services on the next visit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure resident's food preferences were honored for 1 (Resident #31) of 19 (#2, #13, #19, #31, #37, #44, #52, #66, #74, #79, #80, #82, #83, #94, #117, #134, #143, #144, and #159) residents observed for dinning. This deficient practice had the ability to affect 166 residents served from the facility's kitchen. Findings: Review of Resident ##31's Clinical Record revealed he was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus. Review of Resident #31's current Physician Orders revealed the following, in part: Low Concentrated Sweets Diet with regular texture and regular/ thin consistency liquids, extra large portions. Review of Resident #31's Care Plan revealed the following:Problem: Receives a therapeutic diet with extra large portions.Intervention: Maintain current listing of food likes and dislikes; meals served as ordered by Physician. Problem: At risk for weight loss related to therapeutic dietIntervention: Meals served as ordered by Physician; Maintain current listing of food likes and dislikes. Review of Dietary Profile dated 07/10/2025 per S3DM revealed the following in part: Provide and serve diet as ordered to include food preferences. Review of Resident #31's meal tickets with food preferences revealed the following:Breakfast: No juice or punch, no carrots, no scrambled eggs, no sweet potatoes, no white potatoes, skim milk and water, grits in bowl, 2 boiled eggs. Lunch: No juice or punch, no carrots, no scrambled eggs, no sweet potatoes, no white potatoes, extra vegetables in bowl. Dinner: No juice or punch, no carrots, no rice, no scrambled eggs, no sweet potatoes, no white potatoes, extra vegetables in bowl. On 08/12/2025 at 8:45 a.m., an observation was conducted of Resident #31's breakfast tray, which included two boiled eggs, 2 link sausages, grits, a biscuit, and prepackaged juice (not sugar free). On 08/12/2025 at 12:10 p.m., an observation was conducted of Resident #31's lunch tray, which included fried chicken breast, green peas, one serving of zucchini and tomatoes, a roll, prepacked juice (not sugar free), and glass of water. On 08/13/2025 09:30 a.m., an observation was conduction of Resident #31's breakfast tray, which included two boiled eggs, 2 link sausages, grits, a biscuit, and prepackaged juice (not sugar free). On 08/13/2025 at 9:30 a.m., an interview was conducted with Resident #31. She stated due to her history of Diabetes she attempted to maintain her blood glucose levels with what she ate. She reported the facility often served her rice, white potatoes, non-sugar free juice, even though this was on her preference list, and often forgets to serve her the extra serving of vegetables. On 08/13/2025 at12:15 p.m., an observation was conducted of Resident #31's lunch tray, which included 6 meatballs with gravy over rice in a bowl, one serving of mixed vegetables, pineapple cobbler, a roll, prepackaged juice (not sugar free), and whole milk. On 08/13/2025 at 3:49 p.m., an interview was conducted with S13CNA who stated she worked the 2:00 p.m. to 10:00 p.m. shift. She stated CNA staff were responsible for reading meal tickets when delivering trays and should return the meal to the kitchen if the meal did not match the resident's preferences. She observed Resident #31's lunch meal tray, which was still in her room and confirmed the meal ticket read no rice. S13CNA stated she would not have served this meal to the resident, and would have requested a different tray from the kitchen. On 08/13/2025 at 3:55p.m., an interview was conducted with S3DM. She reviewed Resident #31' food preferences and confirmed Resident #31 did not want juice or rice. She observed Resident #31's meal tray from lunch on 08/13/2025, confirmed there was rice, and only one serving of vegetables, with juice and whole milk. She stated Resident #31 should not have received the juice, milk, or rice on her tray, and should have received an extra serving of vegetables. S3DM confirmed that resident's meal preferences should be honored. On 08/13/2025 at 4:40 p.m., an interview was conducted with S1ADM. He was informed of Resident #31's food preferences not being honored. S1ADM confirmed residents' food preferences should always be honored.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to ensure nursing staff sanitized insulin pen stoppers prior to applying insulin pen needles for 2 (#86 and #114) of 3 (#86, #106, and #114) residents reviewed for insulin administration.Findings: Review of Insulin Lispro Manufacturer's Insert revealed the following, in part:Preparing your Pen:Step 1:Pull the Pen Cap straight off.Wipe the Rubber Seal with an alcohol swab. Resident #86 Review of Resident #86's Clinical Record revealed an active Physician's Order for Insulin Lispro 100 unit/mL subcutaneously before meals and at bedtime per sliding scale. An observation was made of S7LPN administering Insulin Lispro 100 unit/mL to Resident #86 on 08/11/2025 at 10:56 a.m. S7LPN applied the insulin pen needle to the insulin pen without sanitizing the insulin pen stopper. S7LPN administered the insulin. An interview was conducted with S7LPN on 08/12/2025 at 10:58 a.m. She confirmed she did not sanitize the insulin pen stopper prior to applying the insulin pen needle. Resident #114Review of Resident #114's Clinical Record revealed an active Physicians' Order for Insulin Lispro 100 unit/mL subcutaneously three times daily. An observation was made of S6LPN administering Insulin Lispro 100 unit/mL to Resident #114 on 08/11/2025 at 9:13 a.m. S6LPN applied the insulin pen needle to the insulin pen without sanitizing the insulin pen stopper. S6LPN administered the insulin. An interview was conducted with S6LPN on 08/11/2025 at 9:16 a.m. She confirmed she did not sanitize the insulin pen stopper prior to applying the insulin pen needle. An interview was conducted with S2DON on 08/12/2025 at 12:25 p.m. She stated insulin pen stoppers should always be sanitized prior to applying the insulin pen needle.