STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlawn Rehabilitation & Nursing Center	59 West Front Street Skowhegan, ME 04976

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, interviews, facility documentation and manufacturer's instructions, the facility failed to ensure that the laundry room equipment was maintained according to manufacturer's instructions and in a correct and safe operating condition for 4 of 4 days of survey (7/28/25, 7/29/25, 7/30/25 and 7/31/25). This has the potential to affect all residents.The manufacturer's instructions, dated 2007, noted in the Safety and Maintenance Instructions:10. Do not tamper with the controls.18. Keep the washer in good condition. 24. Never operate the washer with any guards and/or panels removed.25. DO NOT operate the washer with missing or broken parts. 26. DO NOT bypass any safety devices. 27. Failure to install, maintain, and or operate this washer according to the manufacturer's instructions may result in conditions which can produce bodily injury and or property damage. Maintenance Instructions:1. Weekly-Check the machine for leaks. On 7/30/25 at 9:00 a.m., a surveyor observed the following in the laundry:The control panel keypad on the left washing machine was missing 4 buttons and the control panel keypad on the right washing machine was missing 1 button. There was a bucket under a leak from the left washing machine that also had a wire running from the washing machine and hanging down in the bucket and then running out a wall attached to other wires. On 7/30/25 at 9:05 a.m., in an interview, the Laundry/Housekeeping supervisor confirmed the findings. She went on to state that the control panels have been broken with holes in them for many months and that the left washer has leaked for many months. There is a bucket under the leak which overflows every night and floods the laundry room floor by morning. On 7/30/25 at 10:40 a.m., in an interview, the Maintenance Director stated that the two washers have been in their current broken state for four or five months. When asked by a surveyor, he stated that he has no documented preventive maintenance program for the washers, but he does get a reminder monthly on his computer to look at them. The Maintenance Director also stated that the company that services their washers has stated that they can't get the parts to repair the machines and that administration has known they are broken and not repairable. At this time, the Maintenance Director confirmed the finding that the two washing machines were not maintained in a safe operating condition. On 7/29/25 at 9:00 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine.On 7/30/25 at 9:17 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine.On 7/31/25 at 8:30 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 37 of 37 beds. This has the potential to affect the safety of all residents.On 7/28/25 at 2:12 p.m., a surveyor observed in room [ROOM NUMBER], Resident #24 (R24)'s exposed bedframe at the head of the bed had a 4.83-inch wide by 4-inch long opening which created a risk for the entrapment of body parts. The foot of the bed had a 4-inch gap between the mattress and the footboard creating a risk for entrapment of body parts. The resident was not in bed at the time of the observation. At 2:15 p.m., during an interview with a surveyor and the Licensed Practice Nurse #1 (LPN1), R24's mattress was observed and confirmed to be offset from the bedframe, and the exposed the bedframe created the potential for entrapment of body parts. LPN1 stated the bed should have a bumper for the foot of the bed to prevent injuries. On 7/29/25 at 3:48 p.m., in room [ROOM NUMBER], two surveyors observed a resident sleeping in bed. A 5-inch space was observed between the mattress and footboard creating a potential space for entrapment of body parts. At 5:51 p.m., in room [ROOM NUMBER], two surveyors observed a Certified Nursing Assistant #1 (CNA1) assisting a resident in bed. The bed was observed to have a 5.5-inch space between the mattress and the footboard, partially filled with a 2-inch mattress extender. On 7/30/25 at 10:51 a.m., during an interview with two surveyors, the Maintenance Director stated he has never done bed assessments. He stated the facility has a Bionix System but only uses it for the handrails. He stated he does not know how to assess the bed mattresses and/or bed frames, or if there are specific measurements to know. At this time, two surveyors confirmed that there is not a maintenance program to identify areas of possible entrapment through regular inspection of all bed frames, mattresses, and bed rails.

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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** Based on observations and interview, the facility failed to provide a safe and comfortable environment for 1 of 6 residents reviewed for accidents (Resident #24 [R24]). In addition, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a safe, sanitary, orderly, and comfortable environment on 2 of 2 units (East and West) and the main lobby for 1 of 1 facility tour (7/31/25). 1. On 7/28/25 at 2:30 p.m., during an interview with two surveyors and the Maintenance Director, R24's bed chord was observed crossing the floor from the foot of the bed to the opposite wall and confirmed to be a trip hazard. On 7/29/25 at 3:30 p.m., during an observation with two surveyors, the Licensed Practical Nurse (LPN1) and the Maintenance Director, the following was observed and confirmed in room [ROOM NUMBER]: The television cable was running along the floor at the foot end of R24's bed creating a trip hazard. The cable for the bed remote was on the floor at the foot end of the bed creating a trip hazard. The power cord for R24's bed was observed unplugged and resting on the floor creating a trip hazard. On 7/29/25 at 3:32 p.m., LPN1 stated the bed is unplugged because R24 walked around the bed and unplugged the bed to plug in his/her fan. LPN1 stated there are not enough outlets to accommodate R24's appliances (including the bed, nebulizer machine, cell phone charger, oxygen concentrator, and fan) without running them across the floor. On 7/29/25 at 3:35 p.m., during an interview with the two surveyors, the Maintenance Director stated he addressed these concerns with management, but they declined the installation of additional electrical outlets. At this time two surveyors confirmed the environment was unsafe when cords and cables were crossing the floor in an area where the resident ambulates, and R24 wants his/her fan to stay running to maintain a comfortable environment temperature. 2. On 7/31/25 from 9:45 a.m. to 10:10 a.m., an Environment Tour was completed with the Maintenance Director and a surveyor in which the following findings were observed: East Wing Shower Room/Bathroom - The floor was dirty around the base of the toilet. The ceiling was cracked and stained around the shower exhaust vent. Resident room [ROOM NUMBER] - The wooden windowsills were chipped/gouged and missing sealant exposing untreated wood. Main lobby- The lower part of the corner wall, in the main lobby headed toward the [NAME] Wing, was chipped/gouged and missing sealant exposing untreated wood. West Wing Shower room (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The patient sit-to-stand lift had dirt and food debris on the foot base area. The ceiling vent was hanging down, missing a screw and in disrepair. The inside of the entrance door had laminate that was ripped/torn creating an uncleanable surface. On 7/31/25 at 10:10 a.m., in an interview with a surveyor, the Maintenance Director confirmed the findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on record reviews, interviews, and facility policy review, the facility failed to update/implement interventions on the current comprehensive care plan for the areas of smoking for 1 of 2 residents reviewed for smoking (Resident [R]43), hearing aids and dental for 1 of 1 resident (R17) reviewed, nutrition for 1 of 2 (R1) residents reviewed, and mobility for 1 of 2 (R19) residents reviewed. 1.Review of R1's care plan updated 7/10/25 states Monitor and document intake and output as per facility policy. Review of R1's Nutrition: amount eaten lacked documented intakes during: Breakfast on 7/1/25, 7/6/25, 7/19/25, 7/20/25, 7/22/25, 7/23/25, 7/24/25, 7/30/25 Lunch on 7/1/25, 7/3/25, 7/6/25, 7/9/25, 7/14/25, 7/17/25, 7/23/25 Dinner on 7/11/25, 7/13/25, 7/27/25, 7/30/25 During an interview on 7/30/25 at 4:15 p.m., the above was discussed with Director of Nursing (DON). 2.Review of R17's care plan updated 7/17/25 care plan states: communication: ensure hearing aids are place appropriately. Observations of R17 on 7/28/25, 7/29/25 and 7/30/25 lacked evidence of hearing aid use. During an interview on 7/30/25 at 2:32 p.m., DON confirmed that R17 did have hearing aids that should be used. 3.Review of R17's clinical record revealed provider note dated 5/20/25 states: Patient lost filling in [his/her] right lower molar. [He/She] needs a referral to dentist. During an interview on 7/30/25 at 12:56 p.m., R17 stated that [his/her] tooth with the missing filling hurts whey eating and especially when [he/she] brushes, [his/her] teeth bleed. Review of R17 care plan lacks evidence it was updated to reflect any measures to take for missing filling. During an interview on 7/30/25 at 12:54 p.m. DON stated they did put a referral in for a dentist appointment, and they are waiting for an appointment, but they should have updated the care plan to put measures in place for the missing filling while they are waiting for the appointment. 4.R43 was admitted in July, 2025 and is an active cigarette smoker. Observations were made of R43's smoking outside on 7/26/25, 7/27/25, on 7/28/25, and 7/29/25. Review of R43's care plan lacked evidence that goals and interventions were placed in the area of smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/25 at 4:35 p.m., R43 states he/she keeps cigarettes in the top drawer of the dresser and goes out to smoke approximately 2 times a day. R43 states he/she's been smoking since he/she was a small child. During an interview with a surveyor on 7/30/25 at 9:01 a.m. the above was discussed with DON. 5. Review of R19's Care Plan Report with a revision date of 3/26/25 states: Focus: Risk for Injury to self or other residents secondary to use of power chair (motorized wheelchair for mobility). On 7/31/25 at 1:35 p.m. in an interview with a surveyor, the DON stated that R19 no longer uses a power chair, hasn't used one for many months, due to safety, and confirmed that R19's care plan has not been updated to reflect that R19 does not use a power chair (motorized wheelchair for mobility).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications were stored in a locked compartment for 1 of 3 medication areas (East Medication Storage Room), opened insulin was labeled with an open date, and expired medications were removed from the available for use supply in 2 of 3 medication storage rooms (West Medication Storage Room and East Medication Storage Room).On 7/29/25 at 9:30 a.m., during an observation and interview with two surveyors and the Licensed Practical Nurse #1 (LPN1), the following were observed and confirmed to be on the shelf and available for use in the [NAME] Medication Storage room:1 open box containing 650 milligrams (mg) Acetaminophen Suppositories with an expiration date of 12/20241 tube containing 1 ounce (oz) Vagicaine Anti-itch Cream, with an expiration date of 6/30/241 box containing Miconazole Vaginal Antifungal 7 day treatment with an expiration date of 5/24/251 pre-filled 3mL insulin pen labeled Lantus Solostar (Insulin Glargine) 100u/mL , the pen was labeled with conflicting open dates (cap labelled with an open date of 6/27/25, pen base labelled as opened 6/25/25). LPN1 stated, insulin should be discarded 28 days after opening.2 open vials, 10 milliliter (mL) of insulin aspart 100 units (u)/mL,one vial had an open date of 6/18/25one vial was open and undated. LPN1 was unable to determined when the vial was opened or when it would expire.3 open vials, 10 mL of insulin glargine 100 u/ mL,one vial had an open date of 5/12/25one vial had an open date of 6/30/25one vial observed to be open and undated. LPN1 was unable to determined when the vial was opened or when it would expire. On 7/29/25 at 10:07 a.m., two surveyors observed and confirmed with LPN1 that insulin medications including vials, quick pens, needles and lancets were stored in an unlocked cabinet in an unsecured area behind the East Wing nurse station.On 7/29/25 at 10:08 a.m., during an observation with two surveyors and LPN1, the following was observed and confirmed, on the shelf and available for use in the East Wing Medication Storage area:1 open vial, 10mL insulin lispro 100ui/mL, with an open date of 6/24/251 tube of Halobetasol Propionate cream 0.05% with an expiration date of 4/2025

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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, interviews, and review of the facility's Food Storage policy/procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the three-bay pot sink and the walk-in freezer. Additionally, the facility failed to ensure foods were dated and/or discarded after best used by date in the walk-in refrigerator and on a beverage cart on a unit for 2 of 2 tours (7/28/25, and 7/29/25). The facility's Food Storage policy/procedure, dated 3/4/25, noted under Procedure: …All containers or storage bags must be legible and accurately labeled and dated. Refrigerated Food Storage: All foods must be covered, labeled, dated and routinely monitored to assure foods are used by their use by dates or discarded. 1.On 07/28/25 from 11:10 a.m. to 11:55 a.m., two surveyors completed an initial kitchen tour in which the following findings were observed: - The maintenance man was observed in the kitchen with no hair or face protection for his facial and head hair. - The three bay pot sink had 2 chemical hoses hanging down in the sinks. - The dry storage room had two 46-ounce containers of thickened water that had best use date of May 26, 2025, available for use. - The walk-in refrigerator has a 16-ounce package of whipped topping with no thaw date. The manufacturer's directions noted the product was only good for 2 weeks after thawing. - The walk-in freezer had a large open box of hamburger buns on the floor and a package of bread sticks on a shelf, stored under the freezer compressor, that had ice buildup on and/or in them. On 07/28/2025 at 11:55 a.m., in an interview with the surveyor, the Food Service Director confirmed the findings. 2. On 7/29/25 at 8:08 a.m., a surveyor and the Director of Nursing [DON], observed an open container of thickened water with a best used by date of “MAY 26,2025”, on the beverage cart in the East Wing hallway, and available for use. At this time, the DON confirmed the finding.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, the facility's laundry room and equipment presented safety hazards to the employees by having a frayed/ripped power supply wire for the washing machines for 3 of 4 days of survey (7/28/25, 7/29/25, and 7/30/25) by not having safe and properly functioning washing machines for 2 of 2 washing machines and for having broken floor tiles for 4 of 4 days of the survey (7/28/25, 7/29/25, 7/30/25, and 7/31/25).On 7/30/25 at 9:05 a.m., a surveyor observed the following in the laundry room:- The entire laundry room tiled floor was heavily soiled with dirt. - There were approximately 16 cracked/broken and loose floor tiles, creating a trip hazard for staff. - There was exposed/untreated cement flooring in front of, to the sides of, and behind the two washing machines.- The control panel on the left washing machine was missing 4 buttons. - The control panel on the right washing machine was missing 1 button. - There was a bucket under a leak from the left washing machine that also had a wire running from the washing machine and hanging down in the bucket and then running out a wall attached to other wires. - The power supply wire for the equipment is observed compromised with protective sheath broken and internal wires exposed at the point of connection to the wall. - The surrounding environment is heavily soiled with dryer lint increasing the flammability of the environment. On 7/30/25 at 9:05 a.m., in an interview with a surveyor, the Laundry/Housekeeping supervisor confirmed the findings. She went on to state that the control panels have been broken, with holes in them, for many months and that the left washer has leaked for many months. She stated that staff use their fingers or a wooden dowel to stick them into the control panel holes to activate the washing machines. The Laundry/Housekeeping supervisor showed the surveyor how she puts her finger in the control panel holes to run the machine. There is a bucket under the leak which overflows every night and floods the laundry room floor by morning. They have to mop up water that is all over the floor in front of the washing machines. She stated that she did not know how long the power cord to the machines were ripped open, but the staff have to go by it when they clean behind the washing machines.On 7/30/25 at 10:40 a.m., in an interview with a surveyor, the Maintenance Director, stated that the washers have been in their current broken state for 4 or 5 months. He went on to state that the staff use their fingers or the wooden rod to access the computer board behind the broken control panel to operate the washing machines and he knows this is not safe. At this time, the Maintenance Director confirmed the finding that the two washing machine's missing control panel buttons, the constant leaking of water and the crack/broken floor tiles create potential safety hazard concerns for the staff working in the laundry room. On 7/29/25 at 9:00 a.m., the surveyor observed both washing machine control panels keypads missing buttons, a leak from under the left washing machine and the power supply wire for the equipment to be frayed and ripped. On 7/30/25 at 9:17 a.m., the surveyor observed both washing machine control panels keypads missing buttons, a leak from under the left washing machine and the power supply wire for the equipment to be frayed and ripped. On 7/31/25 at 8:30 a.m., the surveyor observed both washing machine control panels keypads missing buttons and a leak from under the left washing machine.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interview, the facility failed to provide education and/or obtain informed consent from a resident's representative regarding the use of bed rails for 1 of 6 residents reviewed for accidents (Resident #7 [R7]).On 7/30/25, R7's clinical record was reviewed and indicated the following:On 4/30/24, R7 completed an advanced directive identifying a representative to make medical decisions on his/her behalf.On 6/20/25, R7 had a Brief Interview for Mental Status score of 5, which indicated severe cognitive impairment.On 6/30/25, Informed Consent Regarding Side Rail Usage was provided to R7 to sign, indicating having considered all of the above (Risks in the use of side rails), I hereby consent to rails. The clinical record lacked evidence that education was provided for the resident representative to give informed consent.On 7/30/25 at 8:37 a.m., during an interview with a surveyor and the Director of Nursing (DON), R7's clinical record was reviewed. The DON stated R7's son/daughter is responsible for R7, and the bed rail consent should have been completed with the resident representative. At this time the surveyor confirmed the clinical record lacked evidence that education was provided on the risks of side rail use and/or that informed consent was obtained from R7's representative.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) which included the participation of the resident and resident's representative after a Minimum Data Set (MDS) Quarterly Assessment, for 1 of 17 residents whose care plans were reviewed (Resident #2 [R2]).A clinical record review indicated R2 was admitted in 2021. The latest MDS Quarterly assessment was completed on 5/16/25. A review of R2 clinical record lacked evidence that a care plan meeting was held at any point as of 7/31/25 by the IDT that included, to the extent possible participation of R2 and/or his/her representative to review the Care Plan. On 7/31/25 at 9:15 a.m., in an interview with a surveyor, the Social Services Director confirmed that R2 clinical record lacked evidence that a care plan meeting was held after the last Quarterly assessment was completed on 5/16/25.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (indicates the type of medical interventions to receive, such as cardiopulmonary resuscitation [CPR] in the event of a medical emergency) was accurate in the resident electronic clinical record for 1 of 7 residents reviewed for advanced directives (Resident #24 [R24]).On [DATE], Resident #24 medical record was reviewed. The electronic record indicated a code status of DNR/DNI (Do Not Resuscitate / Do Not Intubate). The electronic record and the paper chart also contained a Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE], indicates a code status of Attempt Resuscitation/CPR. On [DATE] at 8:50 a.m., during an interview with a surveyor and the Director of Nursing, the medical record was reviewed for R24's advanced directive regarding code status. At this time the surveyor confirmed R24's advance directive regarding code status had conflicting information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlawn Rehabilitation & Nursing Center	59 West Front Street Skowhegan, ME 04976

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an Interdisciplinary Care Plan Meeting (IDT) was held within 7 days after a Minimum Data Set (MDS) for 1 of 17 residents reviewed (Resident [R]17).Review of Resident [R]17 clinical record revealed Minimum Data Set (MDS) dated [DATE]. Further review of R17 clinical record revealed an Interdisciplinary Meeting (IDT) meeting was held 7/28/25 (17 days late).During an interview on 7/29/25 at 3:00 p.m., the Social Services Director (SSD) stated she is supposed to schedule IDT meetings within 7 days of the MDS completion. At this time SSD confirmed R17's IDT meeting was held yesterday (7/28/25). SSD stated she originally scheduled the meeting for 7/24/25 (6 days late) but thinks the family couldn't make it on the 24'th so it was rescheduled to 7/29/25. At this time the SSD confirmed the original IDT meeting would not have been within the 7 days of the MDS completion. The surveyor then asked if SSD offered/provided a copy of the care plan after each IDT meeting. SSD confirmed she has not been offering residents/families copies of the care plan, but she will start.During an interview on 7/29/25 at 3:32 p.m. in the presence of 5 surveyors the above was discussed with Director of Nursing.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observations and interviews the facility failed to ensure hearing aids were in use for 1 of 1 resident reviewed for communication (Resident #[R] 17).Observations of R17 on 7/28/25, 7/29/25 and 7/30/25 lacked evidence of hearing aid use.Review of R17 care plan updated 7/17/25 states Communication: ensure hearing aids are place appropriately .Review of R17 New admission Personal Item Inventory dated 10/13/24 states [he/she] was admitted with both left and right hearing aids. Interview on 7/30/25 at 1:10 p.m., Licensed Practical Nurse #2 (LPN2) stated [he/she] was not aware that R17 had hearing aids.During an interview on 7/30/25 at 1:05 p.m., R17 stated [he/she] does have hearing aids, and they are in a box in [his/her] room, [his/her] sister mailed batteries, but [he/she] can't get them in and is waiting for someone to help [him/her]. R17 further stated she really needs them because [he/she] has a hard time hearing during activities and keeps having the Activity Director repeat what she's saying.Interview on 7/30/25 at 1:15 p.m. Certified Nursing Assistant #3 (CNA3) stated she was unaware that R17 had hearing aids.Interview on 7/30/25 at 1:23 p.m., CNA5 stated she was unaware that R17 had hearing aids. During an interview on 7/30/25 at 2:32 p.m. with a surveyor DON confirmed R17 wore hearing aids and they should be used.

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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. Based on observation and interview, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection on 2 of 4 days of survey (7/28/25 and 7/29/25).On 7/28/25 at 11:45 a.m., a surveyor observed Resident #24 (R24)'s oxygen tubing labeled 7/28/25, connected to an oxygen concentrator. The filter on the concentrator was observed to be heavily soiled with dust/debris. On 7/29/25 at 3:30 p.m., during an interview with two surveyors and the Licensed Practical Nurse (LPN1), R24's oxygen concentrator was observed to have new tubing related to the addition of humidification dated 7/29/25. The nasal cannula tubing was observed to be dated 7/28/25. The concentrator filter was observed to be heavily soiled with dust/debris. LPN1 stated the filter should be washed with tubing changes. At this time the surveyor confirmed the filter was not cleaned with the tubing change and was heavily soiled with dust/debris.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for two trash receptacles for an area outside by a dumpster for 1 of 4 days of survey (7/28/25).On 07/28/2025 from 11:10 a.m. to 11:55 a.m., two surveyors completed an initial kitchen tour in which the following finding was observed: - There were two of three, approximately 30 to 40 gallon trash receptacles, that had the swing lids open and exposed trash hanging out. On 7/28/25 at 11:55 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 records reviewed (Resident #1 [R1]). R1 is has diagnoses to include paraplegia, Chronic kidney Disease (CKD) and Diabetes Mellitus (DM).Review of R1's care plan updated 7/10/25 states Monitor and document intake and output as per facility policy.Review of R1's Nutrition: amount eaten lacked evidence of documented intakes during:-Breakfast on 7/1/25, 7/6/25, 7/19/25,7/20/25, 7/22/25, 7/23/25, 7/24/25, 7/30/25-Lunch 7/1/25, 7/3/25, 7/6/25, 7/9/25,7/14/25, 7/17/25, 7/23/25-Dinner 7/11/25, 7/13/25, 7/27/25, 7/30/25.During an interview on 7/30/25 at 4:15 p.m., the above was discussed with Director of Nursing.