| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215362 | A. Building<br>B. Wing | 04/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Restore Health Rehabilitation Center | 4615 Einstein Place<br>White Plains, MD 20695 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to provide necessary care and services to maintain the highest practicable physical well-being of residents by failing to ensure complete and thorough bathing and hygiene care and failing to provide an alternative method for showering when residents were unable to use a shower chair, for 3 of 3 sampled residents (Resident #9, Resident #10, and Resident #17).Findings: Resident #10 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease, epilepsy, bipolar disorder, hypertension, polyneuropathy, low back pain, muscle spasm, dementia, hypothyroidism, chronic pain, hyperlipidemia, GERD, and anxiety. Review conducted on 4/1/26 at 11:00 AM of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #10 was cognitively intact and dependent on shower/bathe (the ability to bathe self including washing, rinsing, and drying self; excludes washing of back and hair and does not include transferring in and out of tub/shower). The assessment also indicated that Resident #10 was always incontinent of both bowel and bladder. Review conducted on 4/1/26 at 12:11 PM of the care plan initiated on 6/12/23 revealed that Resident #10 had limited ability to transfer self related to Parkinson's disease, generalized weakness, and unsteady gait, with interventions including, but not limited to, keeping the call light within reach. The care plan did not indicate how much assistance Resident #10 required for bathing or showering and did not address showers or bathing preferences. Observation conducted on 4/1/26 at 10:41 AM revealed that GNA #13 provided bathing, incontinence care, and bed linen change to Resident #10 while the resident was in bed. During the observation, GNA #13 rinsed only portions of Resident #10's face, including the forehead, cheeks, chin, and nose; however, GNA #13 did not wash or rinse the ears, back of the ears, or back of the neck. GNA #13 proceeded to provide upper body care but did not wash or rinse Resident #10's hands, fingers, or fingernails. GNA #13 continued bathing and washed and rinsed the resident's arms, underarms, legs, and feet; however, GNA #13 did not wash or rinse the resident's back at any time during the bathing process.During interview on 4/1/26 at 11:18 AM, GNA #13 indicated that they did not wash certain areas during bathing, including the back of the ears and neck, and stated that those areas were missed during care. GNA #13 further indicated that they did not routinely wash the resident's hands, fingers, and fingernails during bathing and instead would clean the resident's hands at mealtime. Resident #17 was admitted to the facility on [DATE] with diagnoses of hemiplegia, polyneuropathy, benign prostatic hyperplasia, hypertension, pain, depression, and atrial fibrillation. Review conducted on 4/2/26 at 12:52 PM of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #17 was moderately impaired and dependent on shower/bathe self (the ability to bathe self, including washing, rinsing, and drying self; excludes washing of back and hair and does not include transferring in and out of tub/shower). Review conducted on 4/2/26 at 12:54 PM of the care plan initiated on 5/18/25 indicated that Resident #17 had limited ability to transfer self related to impaired mobility. Review conducted on 4/2/26 at 12:56 PM of progress notes dated 9/6/26 at 8:24 PM written by Staff Nurse #6 indicated that Resident #17 was alert and oriented times four. Review conducted on 4/2/26 at 12:57 PM of progress notes dated 2/25/26 at 12:52 PM written by NP #7 indicated that Resident #17 was oriented times two with impaired insight. Review (continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | conducted on 4/2/26 at 12:58 PM of point of care history dated 3/4/26 through 4/2/26 indicated that GNA #36 was the only staff member documented to have provided Resident #17 with a shower. During interview on 4/2/26 at 12:25 PM, GNA #36 indicated that Resident #17 did not receive showers due to pain and inability to tolerate a shower chair. GNA #36 indicated that the resident received bed baths and confirmed that the resident had never received a shower and that no alternative method, such as a shower bed, was available. During interview on 4/2/26 at 12:38 PM, Resident #17 indicated that they had never received a shower and stated that no one had attempted to provide a shower. Resident #17 indicated that not receiving a shower made them feel not clean. During interview on 4/2/26 at 11:23 AM, Staff Nurse #22 indicated that Resident #17 was not able to tolerate sitting in a shower chair and that the facility did not have a shower bed to provide an alternative method for showering. Resident #9 was admitted to the facility on [DATE] with diagnoses of diabetes, hypertension, congestive heart failure, benign prostatic hyperplasia, peripheral vascular disease, gastritis, xerosis cutis, osteoarthritis, and pressure ulcer.Review conducted on 3/31/26 at 9:55 PM of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #9 had a PASRR Level II screening due to intellectual disability, was rarely or never understood, and was severely impaired. The MDS assessment indicated that Resident #9 was at risk of developing pressure ulcers/injuries and had a diabetic foot ulcer with moisture-associated skin damage (MASD). Review conducted on 4/1/26 at 1:04 PM of the care plan initiated on 2/21/25 indicated that Resident #9 had limited ability to transfer self related to a fall with left tibia fracture status post ORIF, with interventions including follow PT/OT recommendations and keeping the call light within reach. The care plan did not indicate the amount of assistance required for bathing or address resident preferences for bathing or showering or alternative methods for showering. Review conducted on 4/1/26 at 1:07 PM of wound consult notes dated 10/23/25, 12/4/25, 12/24/25, and 12/31/25 written by the wound physician indicated that Resident #9 may shower with wound dressing protected from moisture. During interview on 4/1/26 at 1:40 PM, GNA #13 indicated that Resident #9 received bed baths and did not receive showers due to wounds and discomfort with use of a shower chair. During interview on 4/1/26 at 2:15 PM, GNA #17 indicated that Resident #9 did not receive showers and received bed baths while in bed due to inability to tolerate a shower chair. During interview on 4/2/26 at 10:26 AM, Staff Nurse #19 indicated that Resident #9 was admitted with a left post-surgical wound and later developed a left heel deep tissue injury. Staff Nurse #19 indicated that the left heel wound healed and later reopened, but both wounds eventually healed. Staff Nurse #19 indicated that Resident #9 was admitted with diabetic ulcers. Staff Nurse #19 indicated that wound cultures were obtained and were negative for all wounds. Staff Nurse #19 indicated that Resident #9's wounds were always dressed appropriately and protected from moisture and would not prevent the resident from having a shower. During interview on 4/2/26 at 11:23 AM, Staff Nurse #22 indicated that Resident #9 was not able to tolerate sitting in a shower chair and that the facility did not have a shower bed to provide an alternative method for showering. During interview on 4/2/26 at 11:37 AM, the Director of Nursing (DON) indicated that due to the lack of a shower bed, residents who were unable to tolerate a shower chair received bed baths. The DON indicated that the facility should exhaust all options to meet the needs of residents. During interview on 4/2/26 at 11:39 AM, the Administrator indicated that the facility did not have a shower bed available for residents to use. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure adequate supervision and safe positioning during activities of daily living (ADL) care for a dependent resident who required staff assistance with bed mobility. This deficient practice was determined to be past noncompliance that resulted in the resident falling from the bed during care and sustaining multiple fractures for 1 of 3 sampled residents (Resident #7). Findings:Resident #7 was admitted to the facility with diagnoses including fracture of right humerus, chronic heart failure, atrial fibrillation, anemia, hypertension, chronic pain, obesity, and osteoarthritis.Review conducted on 3/31/26 at 5:46 PM of the quarterly Minimum Data Set (MDS) assessment dated [DATE], completed by the MDS Coordinator, revealed that Resident #7 was cognitively intact (BIMS score of 15) and was dependent on staff for toileting hygiene.Review conducted on 3/31/26 at 5:46 PM of the same MDS assessment, completed by the MDS Coordinator, revealed that Resident #7 required partial/moderate assistance with bathing and was always incontinent of bowel and bladder.Review conducted on 3/31/26 at 5:46 PM of the same MDS assessment, completed by the MDS Coordinator, revealed that Resident #7 required substantial to maximum assistance for rolling left and right, defined as the ability to roll from lying on back to left and right side and return to lying on back in bed.Review conducted on 3/31/26 at 5:57 PM of the care plan, developed by the interdisciplinary team, revealed that Resident #7 required extensive assistance with ADL care, including being a three-person assist with ADLs, and had fall risk interventions including use of environmental supports such as handrails and frequent monitoring.Review conducted on 3/31/26 at 6:13 PM of a nursing progress note dated 12/14/25 at 8:11 AM, written by Staff Nurse #6 (LPN), revealed that Resident #7 was found on the floor after reportedly letting go of a grab rail while being cleaned during ADL care.Review conducted on 3/31/26 at 6:17 PM of a physician progress note dated 12/14/25, written by the attending physician, indicated that Resident #7 experienced a fall during care and later reported generalized pain.Review conducted on 3/31/26 at 6:20 PM of a nursing progress note dated 12/14/25 at 7:16 PM, written by Staff Nurse #9, revealed that Resident #7 reported severe generalized pain following the fall.Review conducted on 3/31/26 at 6:22 PM of a physician progress note dated 12/15/25 at 4:58 AM, written by the physician, revealed that Resident #7 presented with lethargy, pain, and suspected fractures following the fall.Review conducted on 3/31/26 at 6:25 PM of a nursing progress note dated 12/15/25 at 6:43 AM, written by Staff Nurse #10, revealed that Resident #7 exhibited abnormal positioning of the arm and increased pain with movement.Review conducted on 3/31/26 at 6:31 PM of a nursing progress note dated 12/15/25 at 12:02 PM, written by Staff Nurse #5, revealed that Resident #7 required transfer to the hospital for further evaluation due to worsening condition following the fall.Review conducted on 3/31/26 at 6:34 PM of a nurse practitioner progress note dated 12/15/25 at 9:58 PM, written by Nurse Practitioner #4, revealed that Resident #7 was transferred to the hospital due to concern for head/neck injury and functional decline following the fall.Review conducted on 3/31/26 at 6:37 PM of documentation by the Director of Nursing dated 12/19/25 revealed that Resident #7 was hospitalized and diagnosed with multiple fractures, including bilateral humerus fractures and fractures of the femur.Review of policies and procedures conducted on 4/1/26 at 6:51 PM revealed that facility staff were required to perform resident care in accordance with established standards for safe positioning, assistance, and fall prevention during activities of daily living (ADL) care. Policies indicated that staff should utilize appropriate turning techniques, including use of a turning pad, maintain control of the resident during repositioning, ensure proper body alignment, and return the bed to a safe position to prevent falls.Review of facility-provided timeline conducted on 4/2/26 at 12:55 pm revealed that the facility identified the root cause of the incident as improper turning and repositioning during ADL care. The timeline further indicated that staff required re-education on safe turning and repositioning<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | techniques following the incident, including return demonstration of proper technique.During interview on 4/1/26 at 2:25 PM, Staff Nurse #6 indicated that Resident #7 was found lying on the floor after being turned during care. Staff Nurse #6 confirmed that the side rail on the side from which the resident fell was down at the time of the incident.During interview on 4/1/26 at 5:45 PM, GNA #11 indicated that they provided incontinence care to Resident #7 on the day of the incident. GNA #11 stated that Resident #7 required extensive assistance with turning and repositioning and was unable to turn independently. GNA #11 indicated that they first positioned themselves on one side of the bed and pulled the resident toward them prior to assisting the resident to turn onto their side facing the window. GNA #11 stated that they provided care while the resident was in that position. GNA #11 indicated that they then returned the resident to a supine position (lying on their back). GNA #11 stated that they then moved to the opposite side of the bed and assisted the resident to turn toward the door. GNA #11 indicated that during this second turn, they instructed the resident to hold onto the side rail while care was being provided. GNA #11 did not indicate that the resident was repositioned toward the center of the bed prior to the second turn. GNA #11 stated that while they were cleaning the resident's rectal area, they were not holding the resident and were positioned on the opposite side of the bed. GNA #11 stated that the resident let go of the side rail and fell from the bed. GNA #11 confirmed that the bed remained in the highest position at the time of the fall.During interview on 4/1/26 at 1:54 PM, GNA #13 indicated that Resident #7 required hands-on assistance to turn and could not reposition independently.During interview on 4/1/26 at 2:27 PM, GNA #17 indicated that Resident #7 could not turn independently and required staff assistance for repositioning and ADL care.During interview on 4/1/26 at 3:30 PM, GNA #14 indicated that Resident #7 was unable to turn independently and required hands-on assistance for repositioning during care. During interview on 4/2/26 at 2:41pm Staff Nurse #10 indicated that upon entering the room to assess Resident #7, the resident had already been placed back in bed by GNA #11 and Staff Nurse #7. Staff Nurse #10 indicated that during follow-up, GNA #11 reported that while providing care, the resident was turned and positioned close to the edge of the bed and subsequently fell.During interview on 4/2/26 at 2:01 pm, the Director of Nursing (DON) indicated that the resident was positioned too close to the edge of the bed during repositioning. The DON stated that while staff were removing linen from under the resident, the resident went over the edge of the bed. The DON indicated that the facility had since provided education to staff on proper turning and repositioning techniques, including demonstration and return demonstration using a mannequin, and reinforced that such incidents should be reported.The facility provided the following corrective action plan.Resident #7 had a fall on 12/14/25 at 6:50 AM. It was reported to the Third Eye provider (telehealth video provider call) on 12/14/25 at 7:00 AM by Staff Nurse #7, who had already completed an initial assessment. When asked by Staff Nurse #7, Resident #7 stated, I let go of the grab bar railing and rolled over to the floor.GNA #11, who was providing care for Resident #7 at the time of the incident, stated that they were providing ADL care to Resident #7, who was holding onto the 1/4 rail, and while they were washing the resident's back side, the resident let go of the 1/4 rail and rolled off the bed. During the call with the Third Eye provider, an exam was conducted via video, and the provider indicated there was no evidence of injury, and determined that the resident should remain in the facility.On 12/14/25, immediately after placing the resident back into bed, verbal education was provided to GNA #11 by Staff Nurse #7 and Staff Nurse #10 regarding safe turning and repositioning of residents as well as safety during ADL care.Facility-wide education was initiated for GNAs on fall prevention in the elderly. Education for those not present at the time was to be provided at a later date and during new hire orientation.On 12/15/25 at 4:58 AM, Staff Nurse #7 contacted the Third Eye provider due to the resident presenting as lethargic and complaining of right-sided pain. An exam was conducted via video, which resulted in the provider ordering stat laboratory tests and stat x-rays.On 12/15/25 at 12:02 PM, the Nurse Practitioner assessed the resident, and an order was placed to transfer the resident to the emergency department for status post fall with right-sided pain.On 12/15/25 at 2:47 PM, the resident's<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | responsible party presented to the facility and reported that the resident was being seen in the hospital due to confusion.On 12/15/25, the Director of Nursing (DON) contacted the hospital to obtain the status of the resident, who remained under observation in the emergency department.On 12/16/25, interviews were conducted with GNA #11, Staff Nurse #10, and Staff Nurse #7 by the DON to determine the root cause of the fall. The root cause was identified as improper turning and repositioning during ADL care. Education continued for staff, including return demonstration of proper technique.Education was provided to unit managers by the DON regarding incident and fall audits, including proper investigation of falls, documentation, interventions, care planning, and state agency notification.Facility-wide interviews were conducted with alert and oriented residents, and no additional concerns were identified. Nursing leadership examined residents unable to communicate, and no new skin abnormalities or injuries were noted.On the afternoon of 12/18/25, the resident's responsible party presented to the facility and reported that the resident had been admitted to the hospital and continued to be treated for confusion.On 12/18/25 at approximately 4:00 PM, the DON contacted the hospital to obtain a clinical update. The treating nurse informed facility staff that the resident was admitted due to multiple fractures. Hospital documentation indicated bilateral humerus fractures, right knee fracture, impacted fracture of the distal femur, hairline fracture of the distal femur, and nondisplaced fracture along the intercondylar notch of the femur, with osteoporosis.On 12/18/25, the incident was reviewed in the QAPI meeting, and training was provided. Education for staff not present was to be conducted at a later date and during orientation for new employees.On 12/22/25 at 10:37 PM, the resident was readmitted to the facility.On 12/23/25 at approximately 12:30 PM, therapy staff, the DON, the Assistant Director of Nursing, and a Unit Manager entered the resident's room to coordinate repositioning and provide ADL care. The resident's responsible party was present. Following assessment, therapy staff explained the clinical need to reposition the resident to prevent skin breakdown and promote circulation.On 12/24/25 at approximately 4:45 PM, the resident was transferred from a bed with a pressure-relieving mattress to a bed with an air mattress with built-up sides using six staff members for assistance.On 1/19/26, staff were re-educated by the DON regarding falls documentation and follow-up. Education for those not present was to be provided at a later date and during orientation.On 1/22/26, a QAPI meeting was held, during which falls and falls with major injury were discussed. Nursing leadership proposed a return-to-acute charted performance improvement plan and fall reduction action plan for 2026-2027.On 2/26/26, a QAPI meeting was held to discuss falls and incidents in the facility. Nursing leadership introduced a return-to-acute charted performance improvement plan and fall reduction action plan for 2026-2027 to reduce the likelihood of similar events.In February 2026, abuse and neglect education was provided to facility staff. Education for those not present was to be provided at a later date and during orientation.Continuous monitoring and auditing included daily discussion of incidents and accidents during clinical morning meetings, daily monitoring of high fall risk residents, interdisciplinary team discussions, and weekly analysis of falls compiled into QAPI and DON reports. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that resident records were accurate and reflected the care and services provided, by documenting that showers were provided when staff interviews revealed that showers were not performed, for 2 of 3 sampled residents (Resident #9 and Resident #17).Findings included:Resident #17 was admitted to the facility on [DATE] with diagnoses of hemiplegia, polyneuropathy, benign prostatic hyperplasia, hypertension, pain, depression, and atrial fibrillation.Review conducted on 4/2/26 at 12:52 PM of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #17 was moderately impaired and dependent on shower/bathe self (the ability to bathe self, including washing, rinsing, and drying self; excludes washing of back and hair and does not include transferring in and out of tub/shower).Review conducted on 4/2/26 at 12:54 PM of the care plan initiated on 5/18/25 indicated that Resident #17 had limited ability to transfer self related to impaired mobility.Review conducted on 4/2/26 at 12:58 PM of point of care history dated 3/4/26 through 4/2/26 indicated that Resident #17 was documented to have received showers, with GNA #36 identified as the staff providing care. GNA #36 documented in the point of care history that they provided a shower on 3/30/26, 3/26/26, 3/19/26, 3/16/26, 3/12/26, 3/9/26, and 3/5/26.Review conducted on 4/3/26 at 9:50 AM of the GNA shower/skin worksheet provided by the facility indicated that GNA #36 provided a bed bath to Resident #17 on 3/30/26, 3/26/26, 3/19/26, 3/16/26, 3/12/26, 3/9/26, and 3/5/26.During interview on 4/2/26 at 12:25 PM, GNA #36 indicated that Resident #17 did not receive showers due to pain and inability to tolerate a shower chair. GNA #36 indicated that the resident received bed baths and confirmed that the resident had never received a shower. GNA #36 further indicated that they were instructed to document in the electronic system that a shower was provided; however, on the shower paper sheet, they documented the actual care provided, which was a bed bath.Resident #9 was admitted to the facility on [DATE] with diagnoses of diabetes, hypertension, congestive heart failure, benign prostatic hyperplasia, peripheral vascular disease, gastritis, xerosis cutis, osteoarthritis, and pressure ulcer.Review conducted on 3/31/26 at 9:55 PM of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #9 had a PASRR Level II screening due to intellectual disability, was rarely or never understood, and was severely impaired. The MDS assessment indicated that Resident #9 was at risk of developing pressure ulcers/injuries and had a diabetic foot ulcer with moisture-associated skin damage (MASD).Review conducted on 4/1/26 at 1:04 PM of the care plan initiated on 2/21/25 indicated that Resident #9 had limited ability to transfer self related to a fall with left tibia fracture status post ORIF, with interventions including following PT/OT recommendations and keeping the call light within reach. The care plan did not indicate the amount of assistance required for bathing or address resident preferences for bathing or showering or alternative methods for showering.Review conducted on 4/1/26 at 12:54 PM of point of care history dated 12/28/25 through 1/27/26 indicated that GNA #36 documented on 1/15/26 and 1/26/26 that they provided a shower to Resident #9.Review conducted on 4/3/26 at 9:50 AM of the GNA Q-shift skin/shower worksheet provided by the facility indicated that GNA #36 provided a bed bath to Resident #9 on 1/15/26 and 1/26/26.During interview on 4/2/26 at 12:24 PM, GNA #36 indicated that they recalled Resident #9 and had never provided a shower. GNA #36 indicated that they documented showers in the system but provided bed baths. GNA #36 indicated that they were instructed to document showers despite not providing them. GNA #36 indicated that Resident #9 was not able to stand or transfer safely to a shower chair and was transferred using a mechanical lift. GNA #36 indicated that they had never attempted to provide a shower due to safety concerns and had not observed other staff provide a shower. GNA #36 indicated that the resident required at least a two-person assist.During interview on 4/1/26 at 1:40 PM, GNA #13 indicated that Resident #9<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | received bed baths and did not receive showers due to wounds and discomfort with use of a shower chair.During interview on 4/1/26 at 2:15 PM, GNA #17 indicated that Resident #9 did not receive showers and received bed baths while in bed due to inability to tolerate a shower chair.During interview on 4/2/26 at 12:25 PM, GNA #36 indicated that staff were instructed to document in the electronic system that a shower was provided even when a shower was not performed, and that actual care provided was documented on a separate paper shower sheet.During interview on 4/2/26 at 11:37 AM, the Director of Nursing indicated that staff were expected to document only the care and services actually provided in the electronic medical record.During interview on 4/2/26 at 11:39 AM, the Administrator indicated that staff were expected to document only the care and services actually provided. The Administrator further indicated that the nurse who instructed staff to document showers that were not performed was no longer employed at the facility and had been terminated. The Administrator did not disclose the reason for the termination. |