STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225374	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Place Nursing & Rehabilitation Center	579 Buck Island Road West Yarmouth, MA 02673

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide care and services consistent with professional standards for five Residents (#7, #84, #63, #4, and #72), out of a total sample of 17 residents. Specifically, the facility failed:1. For Residents #7 and #84, to ensure air mattress settings were implemented as ordered by the physician;2. For Resident #63, to ensure physician's orders for blood pressure medication administration were followed;3. For Resident #4, to ensure physician's orders for oxygen flow rate were followed; and4. For Resident #72, to ensure physician's orders for wound dressing treatments were followed. Findings include: Review of [NAME], Manual of Nursing Practice 11ed, dated 2019, indicated the following:-The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. Review of the facility's policy titled Air Mattress Use, dated April 2023, indicated but was not limited to: - It is the policy of the facility to utilize air mattresses in a way that is medically appropriate and beneficial to the health and care of residents. - Order for air mattress is initiated by provider with a signed/electronically signed order. - Order for air mattress is entered into resident's electronic medical record and includes prescribed mattress pressure setting according to patient weight – pressure setting will match air mattress order in care plan and orders to check function of air mattress every shift. - Every shift nursing assesses functionality of air mattress to ensure proper fit, correct mattress pressure settings and appropriate resident positioning. A. Resident #7 was admitted to the facility in September 2025 with diagnoses including muscle weakness and spinal stenosis. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Minimum Data Set (MDS) assessment, dated 9/22/25, indicated he/she had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Furthermore, the MDS assessment indicated he/she was at risk for developing pressure ulcers or injuries and had one unhealed stage III pressure ulcer. Review of Resident #7's Physician's Orders indicated but were not limited to the following: - 9/17/25: air mattress – draw sheet only, no chuck, soaker pads or blankets; check pressure setting and function every shift; set between 100-150 every shift. On the following dates and times, the surveyor made the following observations of Resident #7's air mattress settings: - 9/24/25 at 8:30 A.M. and 1:33 P.M.: air mattress set to 210 - 9/25/25 at 8:35 A.M. and 1:15 P.M.: air mattress set to 210 - 9/26/25 at 8:47 A.M.: air mattress set to 210 Review of Resident #7's September Treatment Administration Record (TAR) indicated his/her air mattress settings were checked every shift. During an interview on 9/26/25 at 12:13 P.M., Unit Manager (UM) #1 said all air mattresses are ordered by a physician or nurse practitioner (NP), and their function and settings are checked every shift by the nurse assigned to the resident. UM #1 and the surveyor entered Resident #7's room and observed the air mattress settings to be set to 210. UM #1 said the air mattress settings were too high based on the physician's orders. During an interview on 9/26/25 at 12:24 P.M., the Director of Nursing (DON) said all residents who require the use of an air mattress need a physician's order which indicates the settings of the air mattress. The DON said nurses should check for air mattress settings and function every shift. The DON said settings should match physician's orders for the air mattress. B. Resident #84 was admitted to the facility in September 2025 with diagnoses including muscle weakness, difficulty in walking, and heart failure. Review of Resident #84's MDS assessment, dated 9/22/25, indicated he/she was cognitively intact as evidenced by a BIMS score of 13 out of 15. Furthermore, the MDS assessment indicated he/she was at risk for developing pressure ulcers or injuries and had a pressure reducing device on his/her bed. Review of Resident #84's Physician's Orders indicated but were not limited to the following: - 9/17/25: air mattress to prevent pressure to bony prominences; draw sheet only, no chuck, soaker pads or blankets; check pressure setting and function every shift set between 150-200. On the following dates and times, the surveyor made the following observations of Resident #84's air mattress settings: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/24/25 at 9:00 A.M.: air mattress set to 210 - 9/25/25 at 8:50 A.M. and 1:13 P.M.: air mattress set to 210 - 9/26/25 at 9:04 A.M.: air mattress set to 210 Review of Resident #84's September TAR indicated his/her air mattress settings were checked every shift. During an interview on 9/26/25 at 12:15 P.M., UM #1 said all air mattresses are ordered by a physician or NP, and their function and settings are checked every shift by the nurse assigned to the resident. UM #1 and the surveyor entered Resident #84's room and observed the air mattress settings to be set to 210. UM #1 said the air mattress settings were too high based on the physician's orders. During an interview on 9/26/25 at 12:24 P.M., the DON said all residents who require the use of an air mattress need a physician's order which indicates the settings of the air mattress. The DON said nurses should check for air mattress settings and function every shift. The DON said settings should match physician's orders for the air mattress. 2. Resident #63 was admitted to the facility in August 2025 with diagnoses which included hypertension (high blood pressure). Review of Resident #63's Physician's Orders included but was not limited to: -Metoprolol Tartrate (a beta-blocker that affects the heart and circulation used to treat high blood pressure) 25 milligrams (mg), give one half tab (12.5 mg) by mouth two times a day, hold for systolic blood pressure (the pressure in the arteries during the contraction of the heart muscle, the top number of a blood pressure reading) less than 100, or heartrate less than 55. On 9/25/25 at 8:35 A.M., the surveyor observed Nurse #1 during morning medication administration. Nurse #1 prepared Resident #63's medication including his/her metoprolol tartrate. Prior to administering medication Nurse #1 obtained Resident #63's blood pressure resulting in a reading of 102/59 and heart rate of 62. Nurse #1 told Resident #63 that the metoprolol tartrate would not be administered due to his/her blood pressure reading. Review of Resident #63's September 2025 Medication Administration Record (MAR) indicated but was not limited to: -On 9/18/25, Nurse #1 did not administer Resident #63 his/her metoprolol tartrate and his/her blood pressure was 106/77 with a heartrate of 62. - On 9/25/25, Nurse #1 did not administer Resident #63 his/her metoprolol tartrate and his/her blood pressure was 102/59 with a heartrate of 62. Review of Resident #63's nursing progress note, dated 9/18/25, indicted his/her metoprolol tartrate was not administered because his/her vitals were too close to the parameter. Review of Resident #63's progress note, dated 9/25/25, indicted his/her metoprolol tartrate was not administered because his/her blood pressure was too close to the parameter. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/25 at 12:18 P.M., Nurse #1 said she did not administer Resident #63's metoprolol tartrate because his/her blood pressure was too close to the parameter. During an interview on 9/29/25 at 2:25 P.M., Nurse #3 said when a medication order had a parameter the medication would be administered unless it was indicated in the order. Nurse #3 said the physician order should be followed. During an interview on 9/29/25 at 3:40 P.M., the DON said medication orders with a specified parameter should be followed as the order reads. 3. Resident #4 was admitted to the facility in September 2023 with diagnoses which included chronic obstructive pulmonary disease (COPD- chronic lung disorders resulting in blocked air flow in the lungs). Review of Resident #4's MDS assessment, dated 9/3/25, indicated he/she received oxygen. Review of Resident #4's Physician's Orders indicted but were not limited to: -oxygen at 1.5 liters per minute (LPM) via nasal canula (NC) every shift, dated 2/6/25 On the following dates and times of survey, the surveyor observed Resident #4 in bed being administered oxygen set at 2 LPM: -9/24/25 at 8:23 A.M -9/25/25 at 2:15 P.M., and -9/29/25 at 10:31 A.M. During an interview on 9/29/25 at 2:25 P.M., Nurse #3 reviewed Resident #4's physician's orders and said his/her oxygen order was for 1.5 LPM. Nurse #3 observed Resident # 4's oxygen setting and said it was set to 2 LPM and should have been set to 1.5 LPM. During an interview on 9/29/25 at 3:40 P.M., the DON said physician's orders should be followed. 4. Resident #72 was admitted to the facility in November 2021 with diagnoses including: skin tear left shin, skin tear right shin status post fall. Review of the MDS assessment, dated 9/15/25, indicated Resident #72 had a moderate cognitive impairment, as evidenced by a BIMS score of 9 out of 15. Further review of the MDS indicated Resident #72 was receiving non-surgical dressing changes related to skin tear(s). Review of Resident #72's Physician's Orders indicated but was not limited to: -Wound care orders: left shin skin tear- Cleanse with normal saline, pat dry, apply non-adherent gauze followed by dry protective dressing and kerlix wrap, every evening shift, dated 9/12/25. -Wound care orders: right shin skin tear- Cleanse with normal saline, pat dry, apply non-adherent gauze followed by dry protective dressing and kerlix wrap, every evening shift, dated 9/11/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wound care orders: left shin skin tear- Cleanse with normal saline, pat dry, apply non-adherent pad followed by dry protective dressing, every evening shift, dated 9/26/25. -Wound care orders: right shin skin tear- Cleanse with normal saline, pat dry, apply non-adherent pad followed by dry protective dressing, every evening shift, dated 9/26/25. Review of Resident #72's medical record indicated the Resident had the following allergies: -adhesive -wound dressing adhesive Review of Resident #72's provider notes, dated 9/22/25, indicated Resident #72 had skin tears to both left and right lower extremities with allergies documented for adhesive, wound dressing adhesive. Review of Resident #72's care plan indicated but was not limited to: -Problem: Resident #72 has skin tear to left and right shin -Intervention: Nursing to follow treatment as ordered and update physician/provider if indicated. Review of Resident #72's September 2025 TAR indicated the right and left lower leg treatment orders were signed off as ordered on the evening shift of 9/23/25, 9/24/25, 9/25/25, 9/26/25, 9/27/25, and 9/28/25. On the following dates and times, the surveyor observed Resident #72 sitting in his/her wheelchair with bordered gauze adhesive dressing on his/her right and left lower legs: -9/24/25 8:50 A.M. -9/25/25 10:54 A.M., and -9/29/25 1:57 P.M. During an interview on 9/29/25 at 10:54 A.M., Resident #72 said the wound dressings were done every evening and his/her legs were itchy from the dressing. Resident #72 showed the surveyor his/her lower extremities and the surveyor observed adhesive bandages on both lower extremities. During an interview on 9/29/25 at 3:36 P.M., Nurse #4 reviewed Resident #72's left and right lower dressing wound orders and allergies. Nurse #4 said Resident #72's lower leg wounds should not have been covered with bordered adhesive gauze and a bordered adhesive gauze was not ordered by the physician. During an interview on 9/29/25 at 4:02 P.M., the DON said nursing should follow the physician's orders as prescribed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to initiate the grievance process on behalf of one Resident (#52), out of a total sample of 17 residents. Specifically, for Resident #52, the facility failed to initiate an investigation when his/her pants were determined to be missing, file a grievance for the missing pants, and follow the grievance process, resulting in a 19-day delay in offering and/or providing alternative clothing.Findings include:Review of the facility's policy titled Grievance Policy, dated August 8, 2017, indicated but was not limited to the following:-All residents and/or their representatives have the right to voice grievances without discrimination or reprisal or fear of discrimination or reprisal.-Director of Social Services is the grievance official who is responsible for overseeing the grievance process.-Upon receipt of a grievance, the staff person receiving the grievance shall notify the appropriate nurse manager or supervisor.-An attempt to resolve the grievance shall be made immediately.-A written copy of the grievance will be provided to the grievance official.-Any staff member can assist the resident and/or representative in the completion of the grievance form.-Review of any grievances should be completed within 7 days.-All grievances will be filed in the grievance binder in the Director of Social Services/Grievance Officials office. Resident #52 was admitted to the facility in September 2025 with diagnoses which included a fall at home sustaining a neck fracture.Review of the Minimum Data Set (MDS) assessment, dated 9/10/25, indicated Resident #52 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact.During an interview on 9/24/25 at 1:42 P.M., Resident #52 said he/she was admitted to the facility a couple of weeks ago and had multiple pairs of pants that were sent down to the laundry to be labeled and cleaned, and the pants never were returned. During an interview on 9/25/25 at 8:55 A.M., Resident #52 said he/she has reported the missing pants to multiple nurses and certified nursing assistants (CNAs), however, does not recall their names. Resident #52 said no one has ever talked to him/herReview of the grievance book and grievance logs failed to indicate a grievance form had been completed for Resident #52.During an interview on 9/29/25 at 2:17 P.M., CNA #2 said if clothes are reported missing, she will go look for the item. If the item cannot be located, she will alert the nurse and/or Unit Manager (UM). CNA #2 said she does not complete grievance forms.During an interview on 9/29/25 at 2:17 P.M., UM #1 said when he is notified a resident has a missing clothing, he will look for the items and if not located notify social services. UM #1 said he does not complete a grievance or offer a grievance form to the resident.During an interview on 9/29/25 at 2:42 P.M., Social Worker (SW) #1 said when a resident is missing clothing, she or the nurse will complete a grievance form. SW #1 said she was not aware Resident #52 was missing any clothing. SW #1 said the staff should have completed a grievance form so the missing items could be tracked and the grievance resolved with a response given to the Resident within seven days of reporting the missing items.During an interview on 9/29/25 at 3:37 P.M., the Administrator said any staff member, resident or family member can complete a grievance. All grievance forms are located at both nursing stations. The Administrator said if clothing goes missing and it is not found within 24 hours a grievance should be completed to track the missing items. The Administrator said she was not aware Resident #52 was missing any pants, and it should have been reported as a grievance and resolved by now.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an accurate medical record was maintained for one Resident (#83), out of three closed records reviewed. Specifically, the facility failed to ensure Resident #83's medical record accurately reflected an emergent transfer to the hospital due to change in medical status. Findings include:Review of the facility's policy titled Emergency Medical Transfer, undated, indicated but was not limited to the following:- It is the policy of [Facility name] to ensure that each Resident is offered access to a more intensive level of care when care needs increase while honoring rights to accept or refuse this higher level of care.- Document Emergency Medical assessment and transport in resident record. Resident #83 was admitted to the facility in June 2025 with diagnoses including hypertension and muscle weakness. Review of Resident #83's medical record indicated a discharge summary form completed by the physician indicating Resident #83 was discharged from the facility and admitted to the hospital on [DATE]. Further review of Resident #83's Social Service progress notes indicated he/she was transferred to the hospital on 6/27/25 due to a change in medical status. Review of Resident #83's medical record failed to indicate any nursing documentation related to the hospital transfer including but not limited to a transfer form, progress note and/or assessment. During an interview on 9/26/25 at 11:00 A.M., the Director of Nursing (DON) said the Resident was transferred to the hospital on 6/27/25 due to a change in medical status. The DON said the transfer was emergent and rescue services were called. The DON said nursing staff did not complete the necessary documentation including a transfer form and progress note after the Resident was transferred and should have completed this documentation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were accurately labeled and stored in accordance with acceptable professional standards. Specifically, in one of two medication carts reviewed, the facility failed to ensure medications were stored in their original packaging.Findings include:Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, dated as revised 6/30/25, indicated but was not limited to:-Facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received. On 9/25/25 at 8:55 A.M., the surveyor, with Nurse #1 present, observed a medicine cup containing several unlabeled medications in the top drawer of the [NAME] Unit, front medication cart. The medicine cup included four medications:-one round white pill,-one round brown pill,-one yellow oval pill, and-one transparent yellow capsule During an interview on 9/25/25 at 8:56 A.M., Nurse #1 said she could not identify the four medications, and the medications should not have been in a medication cup in the medication cart. Nurse #1 said the medication should have been disposed of. During an interview on 9/29/25 at 3:40 P.M., the Director of Nursing (DON) said medications should not be left without identifiers, unlabeled, in a cup inside of the medication cart. The DON said if medications were prepared and not administered, then those medications should have been destroyed.

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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 and interviews, the facility failed to adhere to infection prevention and control standards of practice to prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to:1. Clean and disinfect shared equipment between residents for three of four Residents (#63, #37, and #25) observed during medication administration; and 2. Perform hand hygiene as indicated for three of four Residents (#63, #37, and #25) observed during medication administration. Findings include: 1. Review of the facility's policy titled Cleaning and Disinfecting Non-Critical Resident-Care Items under Environmental Infection Control, dated June 2011, indicated but was not limited to the following: -Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). -For disinfection, use Environmental Protection Agency (EPA) registered and facility approved low-level disinfectant solution. -Clean and disinfect the surface area used to clean equipment. On 9/25/25 at 8:35 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #63. While in Resident #63's room, Nurse #1 placed shared medical equipment, a wrist blood pressure cuff and thermometer, on Resident #63's bed without providing a protective barrier to prevent contact with his/her bed linens. Nurse #1 utilized the wrist blood pressure cuff and thermometer on Resident #63. After administering medication and exiting Resident #63's room, Nurse #1 placed the wrist blood pressure cuff and thermometer on the medication cart. Nurse #1 failed to disinfect the shared equipment after use. On 9/25/25 at 8:49 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #37. While in Resident #37's room, Nurse #1 placed shared medical equipment, a wrist blood pressure cuff and thermometer, on Resident #37's bed without providing a protective barrier to prevent contact with his/her bed linens. Nurse #1 utilized the wrist blood pressure cuff and thermometer on Resident #37. After administering medication and exiting Resident #37's room, Nurse #1 placed the wrist blood pressure cuff on the nurses' station counter and left the thermometer on the medication cart. Nurse #1 failed to disinfect the shared equipment after use. On 9/25/25 at 9:40 A.M., the surveyor observed Nurse #6 prepare and administer medications to Resident #25. While in Resident #25's room, Nurse #6 used shared medical equipment (scissors) to open lidocaine patches (used to treat pain, locally). Nurse #6 failed to disinfect the scissors prior to use and then placed the scissors on Resident #25's bed without a protective barrier underneath to prevent contact with the Resident's bed linens. Prior to exiting Resident #25's room, Nurse #6 failed to disinfect the scissors and placed the contaminated scissors into her uniform pocket. During an interview on 9/29/25 at 3:40 P.M., the Director of Nursing (DON) said infection control practices should be followed and items should be wiped down between residents. 2. Review of the facility's policy titled Handwashing/Hand Hygiene under General Infection Control Practices, dated August 2019, indicated but was not limited to the following: -Use of alcohol-based hand rub containing at least 62% alcohol: or, alternatively, soap (antimicrobial or non-antimicrobial) and water before preparing or handling medications, and before and after direct contact with residents, after contact with objects (e.g., medical equipment), before and after entering isolation precaution settings. Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms) sign indicated but was not limited to: -In addition to standard precautions Staff and Providers must: -Clean hands prior to entering and when exiting the room On 9/25/25 at 8:35 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #63. Resident #63 had a CDC enhanced barrier precautions sign posted on the doorframe of his/her room. Nurse #1 failed to perform hand hygiene prior to entering and exiting Resident #63's room. On 9/25/25 at 8:49 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #37. Resident #37 had a CDC enhanced barrier precautions sign posted on the doorframe of his/her room. Nurse #1 failed to perform hand hygiene prior to entering and exiting Resident #37's room. On 9/25/25 at 9:40 A.M., the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor observed Nurse #6 prepare and administer medications, including applying a lidocaine patch, to Resident #25. Resident #25 had a CDC enhanced barrier precautions sign posted on the doorframe of his/her room. Nurse #6 failed to perform hand hygiene prior to entering Resident #25's room. Nurse #6 failed to don (put on) gloves prior to applying a lidocaine patch to Resident #25. Nurse # 6 failed to perform hand hygiene after coming in contact with Resident #25's skin and medicated patch. During an interview on 9/29/25 at 3:40 P.M., the DON said infection control practices should be followed and hand hygiene should be performed between residents and as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225374	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayflower Place Nursing & Rehabilitation Center	579 Buck Island Road West Yarmouth, MA 02673

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)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nurse staffing information which included the current date and actual hours worked per shift for licensed and unlicensed staff including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA), and the resident census was posted daily as required. Findings include: On 9/24/25 at 7:16 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 9/25/25 at 7:00 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.On 9/29/25 at 7:04 A.M., the surveyor did not observe any nurse staffing posting in the lobby, hallways or nursing units.During an interview on 9/29/25 at 12:43 P.M., the Scheduler said she has been managing the nursing schedule for the facility for the past two years. The Scheduler said she completes a nursing schedule daily which includes all nurses and certified nursing assistants working for that day. The Scheduler said she does not complete a daily staffing posting including the resident census. The Scheduler said she was not aware that this had to be posted and updated daily for residents and visitors to see.During an interview on 9/29/25 at 3:50 P.M., the Administrator said the daily nursing staffing sheet with the resident census should be updated daily and posted in a highly visible area for everyone to see. The Administrator said it has not been posted in the facility as it should have been.