STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegra Nursing and Rehab	434 W North St Jackson, MI 49202

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview and record review, the facility failed to provide necessary care and services to ensure a resident's abilities in activities of daily living (ADL) did not diminish in two (Resident #20 and Resident #24) of two residents reviewed for comprehensive care planning, resulting in increased levels of assistance provided by staff with ADL care. Findings Include: Resident #20 (R20) Review of the medical record reflected R20 was an initial admission to the facility on [DATE] and readmitted on [DATE]. Diagnoses of Spinal stenosis, Lumbar region without neurogenic claudication (narrowing of the spinal canal of the lower back), Lumbosacral plexus disorders (cause a painful mixed sensorimotor disorder of the corresponding limb), abnormalities of gait and mobility, benign prostatic hyperplasia with lower urinary tract symptoms (inability to completely empty the bladder), dysphagia (difficulty swallowing), muscle weakness and chronic pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/19/2025 revealed R20 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R20 required 1 person assistance for all care. During an interview and observation on 04/14/25 at 10:10 AM, R20 stated he was scheduled to receive two shower/baths a week, on Wednesdays and Saturday's afternoons. Observation of facial hair was more than a week's growth per R20. Record review revealed he has had three bed bathes in the last month, 03/16/25, 03/17/25 and 04/02/25. During an interview on 04/15/25 at 10:22 AM, DON B stated it would be documented where the CNAs were providing the shower/bath that was preferred or as to why R20 did not receive his shower/bath. DON B also stated the CNAs document as to how many times they asked R20 to shower/bath and what his response was and if the nurse had been notified. DON B stated the expectation would be that the shower/bath would have been offered by the next shift. DON B stated that would be documented in a progress note. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review did not reveal that R20 was asked three times to take a shower/bath or that the CNAs reported that to the nurse. No supporting documentation to reflect this resident was asked, that he refused to take a shower or receive a bed bath. During an interview on 04/16/25 at 9:50 AM, DON B stated the CNAs are not documenting that the shower/bath was completed. DON stated the CNAs were providing the showers/baths but not documenting it. A document was later provided in a statement that certain CNAs provided baths on certain days during the past 30 days, however there was no documentation to support this in the electronic medical record. Resident #24 (R24) Review of the medical record reflected R24 was an initial admission to the facility on [DATE]. Diagnoses of Stroke, Intracerebral hemorrhage affecting left non-dominant side with spasms, mild cognitive impairment and other abnormalities of gait and mobility. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/20/2024 revealed R24 had a Brief Interview of Mental Status (BIMS) of 12 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R24 is a mild to moderate assistance of all care. During an interview on 04/14/25 at 9:49 AM, R24 stated she was supposed to get a shower two times a week. R24 stated her preference was showers over bed bathes and was not receiving them. R24 also stated her preference is to have a shower daily, but at this time she was not even receiving them two times a week. R24 also stated she had not refused any showers or bathes. R24 stated that her roommate had even told her she stunk and needed a shower. Record review revealed R24 had three showers/bed bathes in the last month on 03/23/2025, 03/29/2025 and 04/10/2025. Record review did not indicate why R24 did not received showers or bathes two times a week as scheduled. Progress notes from 03/02/2025 up to this date were read and no documentation was present as to why she has not received her showers or bathes. During an interview on 04/15/25 at 1:52 PM, Certified Nursing Assistant (CNA) H stated R24 got her showers on afternoon shift, not day shift so she could not tell writer why she had not had any showers or bathes lately. During an interview on 04/15/25 at 3:41 PM, Director of Nursing (DON) B stated there should have been some documentation in the progress notes as to why R24 did not receive her showers. DON B also stated there should have been some documentation from the CNAs under task tab, as to how many times R24 was asked to take a shower and what her response was and that the CNA's notified the nurse. Record review did not reveal that R24 had been asked three times to shower/bathe or that the CNA reported the refusals to the nurse.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview, and record review the facility failed to provide for one out of one resident (Resident #6) care and services to prevent and promote healing of pressure ulcers resulting in worsening wounds. Findings Include: Resident #6 (R#6) Review of the medical record reflected R6 was an initial admission to the facility on [DATE] and readmitted on [DATE].R6 was admitted to hospice on 08/24/2024. Diagnoses of cerebral atherosclerosis, Diabetes Mellitus with neuropathy, pressure ulcer of the sacral region, stage 4, history of a stroke, benign prostatic hyperplasia with urinary symptoms and suprapubic catheter, spinal stenosis in the cervical region, left side hemiplegia and hemiparesis following the stroke and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/03/2025 revealed R6 had a Brief Interview of Mental Status (BIMS) of 08 (moderately impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R6 is dependent of all care and required a mechanical left and 2 persons to transfer from bed to chair and back to bed. R6 required 1 person to reposition him as he cannot do it independently. During an interview on 04/14/25 11:51 AM, R6 stated he had some old pressure ulcers and some new ones too. R6 stated he had pain with the pressure ulcers. Writer asked R6 for permission to observe his wound care to his pressure ulcers and he stated yes. During an interview on 04/15/25 at 7:32 AM, Registered Nurse (RN) I was informed that this writer had received permission from R6 to observe wound care on him today. During an interview and observation on 04/15/25 on 8:15 AM, R6, stated he had pain all over his body, and he reported that the pain was a little more manageable since he had his pain medications scheduled, instead of medication as needed. R6 stated the facility staff reposition him once or twice a shift, and then he stays in that position for the rest of the shift. R6 stated he went to a hospital for the suprapubic catheter to be placed a while back, after the foley catheter created a mechanical pressure ulcer (caused by unrelieved mechanical pressure in combination with friction, shearing forces and moisture) so bad it split his penis open. R6 also stated that was the most painful thing ever. R6 stated both the facility nurse and hospice nurse were currently taking care of his pressure ulcers. R6 stated the hospice nurse comes in 2 x a week, and the facility nurses do the wound care on the other days. R6 added that another nurse comes in about weekly to assess his pressure ulcers too. Observation of R6 with no heel protectors on his feet, they were observed across his room on top of a plastic container with drawers in it. A concaved low air loss mattress was on his bed. No specialty cushion on his geri chair, sitting on a pillow. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed R6 was readmitted on [DATE] with one stage 3 pressure ulcer of the penis and one stage 4 on the sacral. Treatment to the sacral pressure ulcer dated 07/09/24 was to clean with normal saline apply gauze daily. Treatment for the stage 3 penis pressure ulcer is cleanse under the penis with wound wash, apply inter-dry every shift. Minimum Data Set (MDS) 3.0 Section M-Skin Conditions, under M0210 dated 07/19/24. Unhealed Pressure Ulcers/Injuries revealed R6 had one stage 3 pressure ulcer and one unstageable. On 07/12/24 a progress notes for wound care evaluation, follow up to penis and sacral unstageable 4.2 x 3. 4, unable to determine depth. Wound care dressing order changes to using Dankins wound wash, with comfort foam apply Medi-Honey to slough area and cover with comfort foam dressing every shift. On 07/13/24 treatment for stage 4 sacral pressure ulcer wound, reads cleanse with Dankins wound wash, pack dry 1/4 strength Dankins- soaked gauze and cover with comfort foam. Treatment changes for the stage 3 penis pressure ulcer to wash wound with wound wash, apply oil emulsion dressing to wound bed cover with ABD pad daily. On 07/19/24 Wound care visit, Sacral 3 x 2.4 x 6, unable to determine depth. No change in orders. Stage 3 penis pressure ulcer wound measurement 4.2cm x 2.3cm x 0.2cm (area x length x width x depth). On 07/20/24 treatment- cleanse sacral pressure ulcer with wound cleanser, pat dry, apply skin prep to peri area, Dankins wound cleanser-soaked gauze to the wound bed, cover with sacral foam dressing daily. On 07/23/24 treatment reviewed, sent guardian a request for a debridement of sacral. On 07/26/24 Stage 4 sacral pressure ulcer measurements were 5.6 x 3.8 x 4.2. Stage 3 penis pressure ulcer wound measurement 1.8cm x 1.9cm x 1.3cm. On 08/02/24 Wound care evaluation, sacral pressure ulcer measurements 5.3 x 3.2 unable to measure the depth. Stage 3 penis pressure ulcer wound measurement 4.5cm x 2.4cm x 0.2cm. On 08/06/24 R6 sent to hospital for abnormal labs and change in mental status. On 08/17/24 readmitted from hospital stay of 10 days, Sacral pressure ulcer measurements following debridement at the hospital. 14.9 x 4.2 x 4.8. Wound vac intact and dressing changes Monday, Wednesday and Fridays. Stage 3 penis pressure ulcer wound measurement not taken. On 08/19/24 Wound care team assessment of sacral pressure ulcer wound 4.22cm x 4.7cm with large amounts of serosanguinous fluid. Stage 3 penis pressure ulcer wound measurement 4.18cm x 2.54cm x 0. 1cm. On 08/24/24- admitted to hospice. On 08/26/24 Stage 4 Sacral pressure ulcer wound measured 4.95cm x 4.98cm x 4.2 cm. Continued to have large amounts of serosanguinous fluid. Wound vac was discontinued. Stage 3 penis pressure ulcer wound measurement of 2.04cm x 0.94cm x 0.1cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 Stage 4 sacral pressure ulcer wound treatment of wash wound with wound wash, pat dry, put Dankins wound wash-soaked gauze in the wound, covered with a bordered foam dressing. On 09/02/24 Stage 4 sacral pressure ulcer wound measured 3.3cm x 2.5cm, no depth reported. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 09/03/24 and 09/10/24 Interdisciplinary Team (IDT) reviewed wound interventions current and remain in place. 09/04/24 Stage 4 sacral pressure ulcer wound measured 5.3cm x 4.3cm x 3.4cm undermining (the formation of a narrow passageway or track under the skin, extending from the wound's edge into the deep tissue). Stage 3 penis pressure ulcer wound measured 2.7cm x 1.4cm, no depth. 09/09/24 Stage 4 sacral pressure ulcer wound measured 4.4cm x 4.8cm x 3.5cm undermining. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 09/16/24 Stage 4 sacral pressure ulcer wound measured 3.5cm x 4.6cm x 3.2cm x 2.1 undermining. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 09/24/24 Stage 4 sacral pressure ulcer wound measured 4.7cm x 3.5cm no depth taken. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 09/30/24 Stage 4 sacral pressure ulcer wound measured 4.5cm x 2.7cm x 2.3 undermining. Stage 3 penis pressure ulcer wound measured 2.9cm x 3.3cm x 1.2cm, no depth. 10/01/24 Treatment for stage 4 sacral pressure ulcer is wash wound bed with wound wash, pat dry, place Dermacol (wound care dressing)to wound bed, insert Dermablue (used for moderate to heavy exuding partial to full thickness) cut to fit over Dermacol, cover with sacral dressing, change daily. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 10/07/24 Stage 4 sacral pressure ulcer wound measured 4.2cm x 2.4cm x1.4cm x 1.1cm undermining. Stage 3 penis pressure ulcer no wound assessment or measurement not taken. 10/16/24 Stage 4 sacral pressure ulcer wound measured 3.3cm x 1.5cm no depth measured. Stage 3 penis pressure ulcer wound measured 2.7cm x 1.2cm, no depth measured. 10/21/24 Stage 4 sacral pressure ulcer wound measured 3.7cm x 2.6cm x1.3cm with 1cm undermining. Stage 3 penis pressure ulcer no wound assessment or measurement taken. 10/28/24 Stage 4 sacral pressure ulcer wound measured 3.0cm x 1.9cm x 1.6cm x 0.6cm undermining. Stage 3 penis pressure ulcer no wound assessment or measurements taken. 11/04/24 Stage 4 sacral pressure ulcer wound measured 2.4cm x 1.2cm x 0.8cm x 0.6 undermining. Stage 3 penis pressure ulcer no wound measured 3.3cm x 1.6cm, no depth documented. 11/11/24 Stage 4 sacral pressure ulcer wound measured 3cm x 1.5cm x 0.3cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/18/24 Stage 4 sacral pressure ulcer wound measured 3cm x 1.5cm x 0.3cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. 11/25/24 Stage 4 sacral pressure ulcer wound measured 3.3cm x 2.4cm x 0.3cm. Stage 3 penis pressure ulcer wound measured 4.2cm x 1.9cm. 12/09/24 Stage 4 sacral pressure ulcer wound measured 2.4cm x 1.5cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. 12/17/24 Stage 4 sacral pressure ulcer wound measured 2.7cm x 1.3cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. 12/22/24 Rear right trochanter/hip deep tissue injury, apply comfort foam to right hip, no measurements. Per the Resident Assessment Instrument 3.0 (RAI) manual dated October 2023, version 1.18.11-page M-27, a Deep Tissue Injury (DTI) is identified by a Purple or maroon area of discolored intact skin due to damage of underlying soft tissue . The manual further revealed, Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative. 12/24/24 Stage 4 sacral pressure ulcer wound measured 2.7cm x 1.3cm. Stage 3 penis pressure ulcer wound measured 3.3cm x 1.7cm. Deep Tissue Injury to right heel measured 2.7cm x 2.0cm in house acquired. Rear right trochanter/hip deep tissue injury, apply comfort foam to right hip, no measurements. 12/30/24 Stage 4 sacral pressure ulcer wound measured 2.2cm x 1.3cm. Stage 3 penis pressure ulcer wound measured 3.7cm x 2.0cm. Right heel deep tissue injury measuring 2.5cm x 2.1cm. Rear right trochanter/hip deep tissue injury, apply comfort foam to right hip, no measurements. 01/07/25 Stage 4 sacral pressure ulcer wound measured 2.5cm x 0.7cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Rear right trochanter/hip deep tissue injury, apply comfort foam to right hip, no measurements. 01/13/25 Stage 4 sacral pressure ulcer wound measured 4.1cm x 3.4cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Rear right trochanter/hip deep tissue injury, apply comfort foam to right hip, no measurements. 01/20/25 Stage 4 sacral pressure ulcer wound measured 5cm x 4.6cm. Unavoidable wound assessment completed. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Rear Right Trochanter/hip with new in house acquired deep tissue injury measuring 6.6cm x 3.3cm. 01/21/25 Rear right trochanter/hip, no longer a deep tissue injury, now stage 3, clean with wound cleaner, pat dry, apply xeroform to wound bed, cover with comfort foam daily, no measurements taken. 01/21/25 Treatment to Stage 4 sacral pressure ulcer wound. Wash wound with Dankins wound wash, pat dry, place calcium alginate to fit wound bed and cover with bordered dressing daily. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Stage 3 right hip pressure ulcer wound, cleanse with wound wash, pat dry, apply xeroform to wound bed, cover with comfort foam daily, no measurements taken. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/24/25 Stage 3 rear right trochanter/ hip pressure ulcer wound, cleanse with wound wash, pat dry, apply Medi-Honey covering slough, cover with comfort foam daily, no measurements taken. 01/27/25 Stage 4 sacral pressure ulcer wound measured 3.4cm x 2.2cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Rear right Trochanter deep tissue injury measuring 7.1cm x 3. 1cm. 01/31/25 Stage 4 sacral pressure ulcer wound measured 2.7cm x 2cm. Stage 3 penis pressure ulcer no wound assessment or measurements taken. Rear right Trochanter/hip not assessed or measured. 02/11/25 Stage 4 sacral pressure ulcer wound measured 2.53cm x 2.09cm. Stage 3 penis pressure ulcer wound measurements 5.12cm x 1.41cm, no depth recorded. Rear right Trochanter/hip now unstageable measured 5.6cm x 2.87cm. Record review revealed R6 was having unmanaged pain in February 2025 due to the progression of pressure ulcers. R6 had Morphine Sulfate Solution 20mg/ml. Give 0.5ml/10mg by mouth every 4 hours as needed for pain. This medication was administered 7 different times for a pain level of 7-9 on a scale of 0-10. March 29, 2025, R6 had scheduled MS (morphine sulfate) Contin 30mg oral tab extended release. Give 1 tablet by mouth two times a day for pain, do not crush. pain level #7 to 9 recorded on the MAR. R6 was able to manage the pain much better once his pain medication was scheduled. 02/17/25 Stage 4 sacral pressure ulcer wound measured 2.52cm x 1.76cm. Stage 3 penis pressure ulcer wound measurements 2.81cm x 1.35cm, no depth recorded. Rear right Trochanter/hip measured 5.1cm x 3. 08cm, not documented as unstageable. 02/19/25 01/21/25 Stage 3 rear right Trochanter/hip not assessed or measured. Treatment to clean wound with wound wash, pat dry, apply Medi-Honey to wound bed, cover with an ABD pad, secure with tape, not assessed or had measurements taken. 02/21/25 01/21/25 Stage 3 rear right trochanter/hip pressure ulcer wound, cleanse with wound wash, pat dry, apply Santyl (debridement agent) to wound bed, cover with comfort foam daily, no measurements taken. 02/26/25 Stage 4 sacral pressure ulcer wound measured 1.93cm x 1.63cm x 1.5cm depth. Stage 3 penis pressure ulcer wound measurements 3.76cm x1.88cm x0.1cm depth. Stage 3 rear right trochanter/hip measured 4.25cm x 3.56cm x 1.25cm. 02/28/25 Treatment for sacral wash with wound wash, pat dry and pack with Hydrogelon (dressing to absorb large amounts of fluids) a sponge and cover with bordered dressing daily. Stage 3 rear right trochanter/hip pressure ulcer wound, cleanse with wound wash, pat dry, apply Santyl to wound bed and pack Dankins moistened gauze over wound bed, cover with foam bordered gauze dressing daily, no measurements taken. 03/04/25 Stage 4 sacral pressure ulcer wound measured 2.09cm x 1.6cm x 2cm depth. Stage 3 penis pressure ulcer wound measurements 6.72cm x 1.68cm, no depth recorded. Stage 3 rear right trochanter/hip measured 4.85cm x 3.46cm, no depth documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/07/25 Stage 4 sacral pressure ulcer wound measured 2.34cm x 1.85cm x 2.2cm depth. Stage 3 penis pressure ulcer wound measurements 4.84cm x 2.38cm, no depth recorded. Stage 3 rear right trochanter/hip measured 4.92cm x 4.05cm x 1.6cm. 03/08/25 Stage 3 rear right trochanter/hip pressure ulcer wound, cleanse with wound wash, pat dry, pack with Dankins moistened gauze, cover with foam bordered gauze daily, no measurements taken. 03/14/25 Stage 4 sacral pressure ulcer wound measured 1.9cm x 1.3cm x 1.2cm with 2.5cm undermining. Stage 3 penis pressure ulcer wound measurements 5.9cm x 2.3cm x 0.2cm. Stage3 rear right trochanter/hip measured 4.8cm x 3.3cm x 1.5cm with undermining at 3 o'clock. 03/20/25 Stage 4 sacral pressure ulcer wound measured 1.6cm x 0.7cm x 0.5cm with 3.3cm undermining. Stage 3 penis pressure ulcer wound measurements 2.3cm x 0.1cm. Stage 3 rear right trochanter/hip measured 4.23cm x 3.38cm x 2.4cm. 03/27/25 Stage 4 sacral pressure ulcer wound measured 2.35cm x 2.65cm x 1.16cm. Stage 3 penis pressure ulcer wound measurements 3.92cm x 2.07cm. Stage 3 rear right trochanter/hip measured 4.68cm x 3.9cm, no depth documented. 04/03/25 Stage 4 sacral pressure ulcer wound measured 2.9cm x 1.3cm x 1.5cm. Stage 3 penis pressure ulcer wound measurements 4.9cm x 2cm x 0.1cm. Stage 3 rear right trochanter/hip measured 4.6cm x 1. 5cm, no depth documented. Record review of the Skin Management Policy, last updated on 08/14/24, stated it was in the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries.residents with pressure injuries and lower extremity ulcers will be evaluated, measured and staged weekly in accordance with practice guidelines until resolved . 04/10/25 Stage 4 sacral pressure ulcer wound measured 2.3cm x1.2cm x 0.9cm with 2.5cm undermining. Stage 3 penis pressure ulcer wound measurements 5.5cm x 2.3cm x0.1cm. Stage 3 rear right trochanter/hip measured 2.9cm x 2.4cm x 1.9cm. 04/11/25 Treatment for Stage 4 sacral pressure ulcer wound, cleanse with wound wash/normal saline, apply collagen dressing to wound bed and pack undermining at 12 o'clock with Collagen. Apply normal saline moistened gauze over wound care. Cover with bordered foam or super absorbent dressing. Unstageable rear right trochanter/ hip pressure ulcer wound washed with normal saline or wound wash, apply collagen dressing to wound bed and pack undermining with collagen. Apply saline moistened gauze over the wound area and fill wound. Cover with bordered foam or super absorbent dressing, as needed and every day shift. During an interview and observation on 04/15/25 at 9:59 AM, CNA K stated R6 didn't have anything special for a cushion on his geri chair, he was sitting on a pillow. R6 did not have his heel protectors on. During an observation on 04/15/25 at 11:13 AM, R6 was sitting up in his geri chair, in the same position, as he was when he came downstairs to the activities at 9:59 AM. His feet were dangling down and toes resting on the floors. R6 did not have his heel protector boots on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/25 at 11:32 AM CNA K stated they reposition R6 about every 2 hours, and it should be documented under their charting in PCC. Record review revealed R6 was not on a turning/repositioning schedule. CNA's documentation reflected that R6 was only repositioned 1-2 times during a shift. Care plan also documents that R6 needs to be repositioned as he cannot do it himself, he is dependent on the facility staff to reposition him. During an interview and observation on 04/15/25 at 1:18 PM, Register Nurse (RN) I was setting up to complete wound care on R6 with the assistance of CNA K. RN I donning with a disposable gown and gloves after washing her hands. CNA K followed the same practice of washing her hands, putting on a disposable gown and gloves. CNA K assisted by holding R6 from side to side to support his body while the nurse performed wound care. 1) Right hip/trochanter- RN I removed the soiled dressings from the right hip/ trochanter and disposed of them in a trash can. RN I removed gloves, hand sanitized and put on new gloves on. Proceeded with cleaning the wound with a spray wound cleaner and a gauze dressing. RN I removed her gloves, hand sanitized and put new gloves on as she opened packages of Collagen to put down on the wound bed and in the tunneling at 4:00 and 5:00 o'clock. RN I then covered the pressure ulcer with a bordered edge dressing which was dated and initialed. RN I stated the floor nurses do not measure the wound between the wound care team Nurse Practitioner visits on Thursday unless told to. 2) RN I then removed the soiled dressing from the sacral wound pressure ulcer and threw it in the trash. RN I then washed her hands and put on new gloves. RN I then cleaned the sacral wound with a spray wound wash and a gauze dressing, then placed Collagen into wound bed, covered with sacral shaped dressing, dated and initialed. 3) Observation of a new open area behind the left hip/ gluteal area. Both RN I and CNA K stated that was a new open area, size of a dime. No care was provided to this area at this time. 4) RN I then went on to complete the wound care on his penis. RN I washed her hands, put on new gloves, his soiled dressing had fallen off in his brief, so RN I used a spray wound wash to clean the open area the length of his shaft, removed her gloves, washed her hands and put on new gloves. RN I then applied an emollient dressing to wrap around his penis and overlapped the edges to stay in place. RN I and CNA K replaced the brief under R6 and replaced it with a new brief. Record review did not reveal any documentation to support that R6 was repositioned every two hours as R6 stated he was not, and the documentation revealed this resident was repositioned 1-2 times a shift, again, not every two hours as care plan stated. Documentation did not support any non-pharmacological intervention being used. Only new intervention was the coordination of care with the hospice team and offer R6 mandarin oranges when he eats less than 50% of his meals. Documentation of an unavoidable pressure ulcer assessment was provided for stage 4 sacral pressure ulcer only. Care plan included pressure reducing mattress, chair cushion, repositioning devices, turning/repositioning/ offloading program and heels up. R6 was not turned, repositioned/offloading, and did not have his heel protectors on him all 3 days of this survey. Under wound evaluation tab, it revealed that R6's stage 3 pressure ulcer on his penis had worsened up to a negative 97%. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/16/25 at 7:31 AM, R6 was sleeping on his left side, heel protections were not on his feet. During a phone interview on 04/16/25 at 9:07 AM, hospice nurse L stated she made her visit late yesterday afternoon to see R6. Stated she did not do the dressing changes yesterday as the floor nurse already did them. Stated she would complete dressing changes and assessments with measurements once a week, this week would be Friday. Writer asked if she would provide care, assess and measure the wounds the day after the wound care team NP would be doing the day prior. Hospice nurse L stated she would usually try to make that visit the beginning of the week, so R6 is getting assessments and measurements of the wounds twice a week. Writer asked hospice nurse L if she had been informed that this resident had a new pressure ulcer near his left hip, she stated no. Writer asked for the prior weekly wound assessments that hospice completed, as they were not in the paper chart binder left behind the desk, or the PCC electronic medical record. Hospice nurse L stated that this writer could contact the office to gain access to whatever documents are needed. Writer called the hospice agency and requested the wound assessments, identification and measurements. Provided email address and request so they had writers contact information. During an interview on 04/16/25 at 11:28 AM, writer asked DON B if she had been alerted of the new open pressure ulcer by his left hip that was found during the dressing changes of his other pressure ulcers yesterday morning. DON B stated she was behind on her emails and was going to look. During an interview and observation on 04/16/25 at 11:30 AM, writer observed RN I, DON B and corporation nurse donning up to observe the new reported pressure ulcer by the left hip. Observation of a now stage 2 now with a dark pink closed wound bed. Writer asked RN I if the size of the new pressure ulcer near the left hip today was about the same as yesterday, she stated yes, it's the same size but was not open today like it was yesterday. DON B took a picture of the new pressure ulcer near the left hip and stated she was going to call the provider for directions. During an interview on 04/16/25 at 11:58 AM, CNA K stated she did a check and change of R6's brief at the end of her shift yesterday, she stated the new pressure ulcer by the left hip was still red and open at the end of the day as it was during the wound care yesterday afternoon at approximately 1:15PM, while assisting RN I was performing wound care. Writer asked her if she reported this new pressure ulcer to anyone yesterday and she stated no, because the nurse was there. Record review of the intervention guideline used by the facility regarding which action should be put in place based on pressure ulcers developing, recommends a turning schedule and protection boots.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to ensure the attending physician documented in the medical record the rationale for not implementing the pharmacy recommendation for one (R11) of five reviewed. Findings include: Review of the medical record revealed R11 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and catatonic schizophrenia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/23/25 revealed R11 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 1/7/25 revealed an order for carbamazepine (anticonvulsant medication) 600 milligrams (mg) one time a day. R11 had been prescribed this medication since 2021. Review of the New Admission Medication Review dated 12/15/24 revealed a high drug therapy problem identified was that carbamazepine requires lab monitoring. The recommended action for the provider was Recommend a baseline carbamazepine level and repeat routinely. Carbamazepine blood concentrations should be completed periodically to optimize efficacy and reduce toxicity (levels should be drawn prior to morning dose). CBC with differential, platelets, hepatic function tests, renal function and electrolytes, eye examinations (including intraocular pressure measurements) may also be completed periodically (suggest every 6 months. The action taken/comments section was blank. The physician did not sign the form. There was no indication in the medical record that the physician acknowledged this recommendation. Review of the Consultant Pharmacist Recommendation to Physician dated 1/3/25 revealed Recommend a baseline carbamazepine level and repeat routinely. Carbamazepine blood concentrations must be completed periodically to optimize efficacy and reduce toxicity (levels should be drawn prior to morning dose). CBC with differential, platelets, hepatic function tests, renal function and electrolytes, eye examinations (including intraocular pressure measurements) should also be completed periodically (suggest every 6 months. The physician/prescriber response was written as CBC, CMP [every] 6 months, opth [ophthalmology] [follow-up] routinely. The physician/prescriber signed the document on 1/8/25. R11 had the CBC, CMP and eye exam completed, but there was no documentation in the medical record as to why the carbamazepine level was not obtained per the pharmacy recommendations. In an interview on 04/16/25 at 10:08 AM, Director of Nursing (DON) B reported today she called the Nurse Practitioner who reported carbamazepine was being used for catatonic schizophrenia and not seizures, therefore a carbamazepine level was not necessary. Medical record documentation by the attending physician, explaining the rationale, was requested. On 04/16/2025 at 10:32 AM, DON B reported the rationale was not documented in the medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 10:57 AM, the Nurse Practitioner made an addendum to their note dated 4/9/25 which revealed Patient does not have history of Seizures, she remains on Carbamazepine for catatonic schizophrenia as a mood stabilizer. Will continue to monitor CBC, Liver function. Carbamazepine level is not indicated for a therapeutic dosing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to ensure medication laboratory monitoring was completed for one (R46) of five reviewed. Findings include: Review of the medical record revealed R46 admitted to the facility on [DATE] with diagnoses that included borderline personality disorder, post-traumatic stress disorder, anxiety, and depression. The MDS with an ARD of 2/8/25 revealed R46 scored 14 out of 15 (cognitively intact) on the BIMS. Review of the Physician's Order dated 9/4/24 revealed an order for Depakote 125 mg by mouth two times a day for mood stabilization/borderline personality/depression. Review of the Consultant Pharmacist Recommendation to Physician dated 9/8/24 revealed This resident is taking Depakote. The recommended routine lab work includes VPA [valproic acid] level and Ammonia level. The Response was listed as Obtain scheduled lab work as follows: VPA/Ammonia [every] 6 months. The Physician signed the form, but the date was not legible. Review of R46's laboratory results for the last 12 months, revealed no VPA or ammonia levels were obtained. In an interview on 04/15/25 at 11:59 AM, DON B reported they called the laboratory to inquire if there were any results for VPA and ammonia levels for R46. DON B reported they did not have record of R46 having their VPA and ammonia levels checked.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45038 Based on observation, interview, and record review the facility failed to serve food at the preferred temperature for one resident (#16) of one resident reviewed for food palatability resulting in dissatisfaction during meals. Findings Included: Resident #16 (R16) Review of the medical record revealed R16 was admitted to the facility 09/16/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD) respiratory failure, asthma, dysphagia (difficulty swallowing), chronic pain, hypomagnesemia (low magnesium), myocardial infarction (heart attack), recurrent dislocation of right shoulder, venous insufficiency, persistent mood disorder, hearing loss, constipation, spinal stenosis, bipolar disorder, major depression, anxiety, and gastro-esophageal reflux. The most recent Minimum Data Set (MDS), with an assessment reference date of 03/20/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 8 (moderately impaired cogitation) out of 15. During observation and interview on 04/14/2025 at 11:27 a.m. R16 was observed sitting up in her wheelchair at her bedside. R16 explained that the meals at the facility were frequently cold. Review of R16's medical record demonstrated that she was to receive a Regular diet Level 3 (mechanical soft) texture, with thin consistency. In an interview on 04/15/25 at 11:10 a.m. Certified Dietary Manager (CDM) D explained that if residents consume meals in their rooms, that the food is delivered to the units by means of a food cart. CDM D explained that the nursing staff would then deliver those trays to the residents. During observation on 04/15/2025 at 11:44 a.m. the food cart was observed to arrive on the second floor. Nursing staff was observed to immediately start passing trays on the 200-hall unit. At 11:49 a.m. R16's food tray was observed to be taken into her room. R16 was observed sitting up in her wheelchair at her bedside. Her food tray was observed to be covered. R16's food tray was placed on her overbed table, and the cover was removed. It was observed that R16 had been given ground turkey with gravy, stuffing, and carrots. Certified Dietary Manager (CDM) D was asked to get a temperature of R16's food items on her food tray. CDM D was observed to obtain a temperature of 131 degrees Fahrenheit for the ground turkey with gravy, a temperature of 123 degrees Fahrenheit for the stuffing, and a temperature of 115 degrees Fahrenheit for her carrots. R16 was then observed to sample her ground turkey with gravy and stated, It is not hot enough. R16 was observed to taste the stuffing and did not have a comment. R16 was then observed to sample the carrots and stated, They are cold. CDM D offered R16 to have her food heated up or a substitution for the food obtained, she denied both offers. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/15/2025 at 11:56 a.m. Certified Dietary Manager (CDM) D explained that the appropriate temperatures for R16's lunch tray should have been at a temperature of 140 degrees Fahrenheit or above for the ground turkey and gravy, 140 degrees Fahrenheit or above for the stuffing, and 135 degrees Fahrenheit for the carrots. CDM D could not explain why R16's lunch meal had not been at an acceptable temperature. 38905 During a tour of lunch service, at 11:25 AM on 4/14/25, an interview with Certified Dietary Manager D found that hot food on the steam table should be 140F or above. A temperature of the plates in the plate warmer at this time were observed to be 90F when using an infra red thermometer. At 12:03 PM on 4/14/25, a test tray was plated with the main entree, and the meal tray was placed as one of the first trays on the second cart, going to the second floor. At 12:15 PM on 4/14/25, the meal cart made it to the 2nd floor and staff started to deliver resident trays. At 12:22 PM on 4/14/25, all of the hall trays on the cart had been delivered and the test tray was in the conference room with the following temperatures found: Carrots and Peas 116F, Ham and Potato casserole 108F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38905 Based on observation, interview, and record review, the facility failed to maintain best practices in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During a tour of the kitchen, starting at 9:27 AM on 4/14/25, an interview with Certified Dietary Manager (CDM) D found that most potentially hazardous foods are held for three to seven days. At this time, observation inside of the walk-in cooler, found the following items: hot dogs dated 4/12 to 5/11, sliced ham dated 4/14 to 4/27, and a large chunk of ham dated 4/14 to 4/22. A follow up of the walk-in cooler, at 2:57 PM on 4/14/25, found a new container of hot dogs in the walk-in cooler dated 4/14 to 5/11. An interview with CDM D stated she is still training some new staff on proper date marking. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . During the initial tour of the kitchen, at 9:36 AM on 4/14/25, an interview with CDM D found that the facility does not cool food down to save leftovers and tries to only make what they need for service. At this time, a tour of the walk-in cooler found the following items saved from breakfast, covered, with condensation on the inside of the containers: chunks of ham, scrambled eggs, and sausage links. At this time, a temperature of the ham chunks was found to be 88F and no logging of cooling times and temperatures by staff was present. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During the initial tour of the kitchen, at 9:42 AM on 4/14/25, observation of the two-door arctic air unit found an increased accumulation of crumb debris on the bottom floor of the unit. During the initial tour of the kitchen, at 9:45 AM on 4/14/25, it was observed that the inside of the clean utensil drawer was found with an accumulation of cake breading among utensils in the drawer. When asked how often staff clean this area, CDM D stated weekly. During a tour of the kitchen, at 9:48 AM on 4/14/25, observation found the underside of the coffee spouts showed an accumulation of debris. During a tour of the kitchen, at 9:52 AM on 4/14/25, it was observed that the can opener was found with an increased accumulation of debris around the blade. During the initial tour of the kitchen, at 10:23 AM on 4/14/25, it was observed that a plate drying on the clean side of the dish machine was found to have an accumulation of dried scrambled eggs. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During the initial tour of the kitchen, at 9:49 AM on 4/14/25, it was observed that the air gap on the ice machine was found sunken down the drain. Air gaps require a physical gap from the drain leaving a food contact piece of equipment. During a tour of the three-compartment sink, at 9:54 AM on 4/14/25, it was observed that no air gap was present on the sanitizer drain line. The sanitizer compartment is required to be air gapped as its considered a clean and sanitary piece of equipment. At this time, the sanitizer compartment was found directly connected to the wastewater drain. When asked if she knew anything about the direct connection, CDM D stated she was new and unsure. During a tour of the third-floor pantry, at 11:00 AM on 4/14/25, it was observed that the drain coming from the ice machine was found sunken into the wastewater drain, no longer ensuring an air gap from the ice machine. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . During a tour of the kitchen, at 9:50 AM on 4/14/25, a half full spray bottle was found with a yellow solution. No common name was labeled on the bottle and CDM D was unsure what was in the container. According to the 2022 FDA Food Code section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material. During a tour of the dish machine area, at 10:25 AM on 4/14/25, it was observed that the low temperature dish machine was not able to produce a residual of chlorine sanitizer when the load was complete. A review of the machines data plate found that it needs chlorine over 50 parts per million (ppm). At this time staff was cleaning the machine, and the surveyor stated he would come back to check on the machine. During a revisit to the kitchen, at 11:15 AM on 4/14/25, observation of the dish machine found that after three loads were run, neither load was able to provide indication of a chlorine residual while using the facility provided test strips. According to the 2022 FDA Food Code section 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart . A chlorine solution ranging from 50 - 100 parts per million. According to the 2022 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. (B) A WAREWASHING machine's conveyor speed or automatic cycle times shall be maintained accurately timed in accordance with manufacturer's specifications. During a tour of the Second and Third floor pantries, starting at 10:55 AM on 4/14/25, it was observed that large openings were present in the walls under the sinks where access to the plumbing is located. Holes and crevices should be filled and covered to reduce the risks of pests in the facility. According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38905 Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During a tour of the facility with Maintenance Director (MD) J, at 1:29 PM on 4/14/25, observation of the third-floor soiled utility room found the facility had removed the hopper basin but still had active water lines. When asked if these lines get flushed, MD J was unsure. During a tour of the facility with MD J, at 1:49 PM on 4/14/25, observation of the second-floor tub room found it full of equipment and the tub removed. On the far wall water lines that used to be connected to the tub were found protruding from the wall with shut of valves. When asked if the old tub lines were flushed, MD J stated he believed they were not active anymore. After moving some equipment out of the way, the surveyor was able to access the shut off valves and find the lines were active and still connected to the domestic water supply. During an interview with MD J, at 2:05 PM on 4/14/25, it was found that the facility does regularly flush vacant rooms once a week. When asked about taking free chlorine samples, MD J stated that he only takes a couple samples a year. When asked if there was a facility control limit in place for free chlorine, MD J was unsure. A record review of the facility policy entitled, Water Management Program, revised 2/1/24, found that The general principles of an effective water management program include: .Preventing water stagnation . Ensuring adequate disinfection. The document went on to state that The Facility will implement measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems . Control measures may include visible inspections, use of disinfectant, and temperature .Monitoring such controls include testing protocols for control measures, acceptable ranges, and documenting the results of testing.