STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Ripley	101 Cunningham Dr Ripley, MS 38663

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide dignity to residents, as evidenced by leaving indwelling urinary catheter bags and tubing uncovered for three (3) of eleven residents with a catheter reviewed. Resident #58, #99 and #103. Findings include: A review of the facility policy, Rights of Nursing Facility Residents dated May 1, 2012, revealed By law, every nursing facility resident has the right .To be treated with dignity, respect, courtesy and consideration . Resident #58 An observation on 12/15/24 at 3:43 PM, revealed Resident #58 lying in his bed in his room. A urinary catheter bag containing 100 milliliters of yellow urine was hanging on his bed and visible from the hall with no privacy bag in place. An interview on 12/16/24 at 2:30 PM, with Certified Nursing Assistant (CNA) #5, confirmed that Resident #58's catheter bag was hanging on his bed and there was no privacy bag. She revealed that the catheter bags were supposed to be placed inside a privacy bag. CNA #5 confirmed that not having a privacy bag was a dignity issue. An interview on 12/17/24 at 8:45 AM, with the Assistant Director of Nursing (ADON) confirmed that Resident #58's urinary catheter bag should have been in a privacy bag out of sight. She confirmed that it was a dignity issue for a resident not to be provided with a privacy bag for a urinary catheter. Record review of Resident #58's Admission Record revealed the facility admitted the resident on 07/18/22 and that he had diagnoses that included Obstructive and Reflux Uropathy. Record review of Resident #58's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 04 which indicated that the resident had severe cognitive deficits. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #99 An observation on 12/15/24 at 3:20 PM, revealed Resident #99 sitting in his room with a urinary catheter bag containing 300 milliliters of urine hanging on his wheelchair visible from the hall with no privacy bag in place. He revealed that sometimes they placed the catheter bag in a black satchel to keep it covered but most of the time they did not. He revealed that it made him feel bad when he went out of his room to see people when his catheter bag was exposed for everyone to see, and he would rather it be covered. An observation on 12/15/24 at 5:25 PM, revealed Resident #99 sitting in his wheelchair. The urinary catheter bag was hanging on the right side of the wheelchair with amber colored urine visible from the hallway. There was no privacy bag in place. An interview on 12/16/24 at 8:15 AM, with CNA #6, confirmed that Resident #99's catheter bag was hooked to his wheelchair this morning and was not in a privacy bag. She revealed that they were supposed to always keep the urinary catheter bags covered and she agreed that this was a dignity issue. An interview on 12/17/24 at 8:40 AM, with the ADON confirmed that resident's urinary catheter bags should always be placed in a privacy bag and out of sight to promote the residents dignity. Record review of Resident #99's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Obstructive and Reflux Uropathy and Retention of Urine. Record review of Resident #99's MDS with an ARD of 09/20/24 under Section C revealed a BIMS score of 11 which indicated that the resident had moderate cognitive deficits. 46013 Resident #103 An observation on 12/15/24 at 5:30 PM, and again on 12/16/24 at 9:30 AM, revealed Resident #103 lying in bed with a urinary catheter bag and tubing exposed with approximately 100 cc (cubic centimeters) of a brown substance in the catheter bag and no privacy covering. The catheter bag and tubing were exposed and visible to anyone entering the room. An interview and observation on 12/16/24 at 12:30 PM, Resident #103 revealed he has stomach cancer, and his tubing connects to his stomach. He stated, I don't even know what kind of stuff is in that bag, but it sure looks nasty. He revealed he doesn't like that people can see what's in the bag because it's kind of disgusting. During an observation and interview on 12/16/24 at 2:25 PM, Licensed Practical Nurse (LPN) #1 revealed all catheter bags are to always be in a privacy bag. She confirmed that the uncovered catheter bag was a dignity issue for the resident and revealed it should have a privacy covering over the tubing and bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/16/24 at 3:00 PM, with the Director of Nurses (DON) confirmed Resident #103's dignity was not honored by leaving his catheter bag exposed. She revealed all catheter bags are supposed to have a covering over them. A record review of Resident #103's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Stomach, Obstructive and Reflux Uropathy, and Acquired Absence of Other Specified Parts of Digestive Tract. Record review of the MDS with an ARD of 12/5/24, under Section C revealed a BIMS score of 15 which indicated that the resident was cognitively intact.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement a care plan for Activities of Daily Living) (ADL) care plan (Resident #8, #58, and #104) and for respiratory care (Resident #73) for (4) four of twenty-four care plans reviewed. Findings Include: Review of the facility policy titled, Care Area Assessment (CAA) Process and Care Planning, dated October 2024, revealed, under The RAI (Resident Assessment Instrument) and Care Planning: the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives, and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident#8 A record review of Resident #8's care plan titled; Self-care deficit related to mobility impairment . His deficits make it hard for him to perform his ADLs without assistance . Interventions: Nail, hair, and oral care daily and as needed. Date initiated 10/25/23. On 12/15/24 at 4:00 PM, an observation and interview revealed Resident #8's fingernails to be 1/2 inch long, jagged in appearance, with a thick brown substance under the nail beds, his facial hair/beard was unkept. Resident #8 stated that he would love his nails cut, and his beard trimmed, but he can't get anyone to do it. In an interview with the Minimum Data Set (MDS) nurse on 12/17/24 at 10:50 AM, she revealed the purpose of the care plan is to identify the needs of each resident for the staff to know how specifically to care for each resident. She then stated if staff did not trim and clean Resident #8's beard /facial hair or clean and trim his nails per the care plan interventions, staff did not follow the care plan. Record review of the Admission Record revealed the facility admitted Resident #8 on 8/24/19 with medical diagnosis that included Need for Assistance with Personal Care and Contracture, Left Hand. Record review of Resident #8's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/24 revealed on a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. 45598 Resident #58 Record review of Resident #58's Care Plan revealed that he had self-care deficit related to mobility impairment with interventions that included nail, hair, and oral care daily and as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/15/24 at 3:42 PM an observation revealed Resident #58's fingernails on his right hand had a brown substance underneath them. On 12/16/24 at 2:15 PM, observation revealed Resident #58 lying in bed with no change in the resident's fingernails. On 12/16/24 at 2:25 PM, an observation in Resident #58's room and an interview with Certified Nursing Assistant (CNA) #5 confirmed that Resident #58 had dirty fingernails with gunk underneath the fingernails on his right hand. An interview on 12/17/24 at 3:20 PM with the MDS Coordinator revealed that nail care was included in Resident #58's Care Plan to be completed daily and as needed and since his nails were observed to be dirty, the care plan was not followed. Record review of Resident #58's Admission Record revealed the facility admitted the resident on 07/18/22 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #58's MDS with an ARD of 11/08/24 under Section C a BIMS Score of 04 which indicated that he had Severe Cognitive Deficits. Resident #104 On 12/15/24 at 4:00 PM, an interview with Resident #104 revealed that she hadn't had a shower since Wednesday night, 12/11/24. She stated, I sure need one. She revealed that they were so busy, they did not give her a shower last night, 12/14/24, and that she had missed one other bath last week. She stated, The aide never came in to offer me a shower. Record review of Resident #104's Care Plan revealed that she had a self-care deficit and had interventions in place that included to assist with bathing as needed and nail, hair, and oral care daily and as needed. On 12/16/24 at 2:10 PM, an observation and interview with Resident #104 revealed her hair was greasy with a mild odor observed while standing next to the resident. She stated, I'm fat, I sweat underneath my boobs and if I don't get proper care, I smell. Resident #104 also revealed that it had been several days since she had her hair washed and her head had started itching. During an interview with CNA #5 on 12/16/24 at 2:17 PM, she confirmed that Resident #104's hair was greasy and needed to be washed. On 12/17/24 at 9:00 AM, an interview with the MDS Coordinator confirmed that Resident #104's Care Plan included interventions to assist with bathing as needed and to complete nail, hair, and oral care daily and as needed. She confirmed that since Resident #104 did not receive her scheduled shower and hair care, her care plan was not followed. Record review of Resident #104's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Difficulty in Walking, Need for Assistance with Personal Care, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #104's MDS with ARD of 12/11/24 under Section C revealed a BIMS Score of 15 which indicated that she was cognitively intact. 46013 Resident #73 A record review of the Care plan revealed Resident #73 has an alteration in Respiratory Status due to Asthma, Chronic Obstructive Pulmonary Disease, and Sleep Apnea with interventions initiated on 11/18/2024 that included Change oxygen tubing and humidifier bottle weekly. An observation on 12/15/24 at 3:55 PM, revealed Resident #73's oxygen concentrator with an undated, empty humidifier water bottle. The oxygen tubing connected to the humidifier water bottle was dated 11/29. An observation on 12/16/24 at 12:39 PM, revealed no change in the oxygen tubing. During an interview and observation on 12/16/24 at 2:10 PM, Licensed Practical Nurse (LPN) #1 confirmed that the oxygen tubing was dated 11/29 and revealed that it is important for the tubing to be changed as ordered to prevent the possibility of infections. In an interview on 12/16/24 at 2:30 PM, the Director of Nurses (DON) confirmed that Resident #73's care plan was not followed since the oxygen tubing and the water bottle were not changed as the physician had ordered. In an interview on 12/17/24 at 02:35 PM, the MDS Coordinator revealed that the care plan is developed so that the staff knows the individual needs of the residents. She revealed that the plan of care is patient-centered, and if the oxygen tubing and humidifier bottles were not changed out weekly, then the plan of care was not being followed as it should have been. A record review of Resident #73's Admission Record revealed the facility admitted the resident on 11/11/2024 with medical diagnoses that included Acute Respiratory Failure with Hypoxia, Unspecified Asthma, and Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 11/19/24, revealed Resident #73 had a BIMS score of 15, which indicated the resident is cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 47157 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide needed services for residents who were unable to carry out their Activities of Daily Living (ADL's) for three (3) of 23 sampled residents. (Resident #8, Resident # 58, and Resident #104) This was cited as a pattern due to a previous citation with the last Annual Recertification Survey 8/31/23. Findings Include: (Cross-reference F725) Review of the facility policy titled, ADL's (Activities of Daily Living) with effective date of August 2021 revealed Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences. Resident #8 An observation and interview on 12/15/24 at 4:00 PM revealed Resident #8's fingernails to be one-half (1/2) inch long past the tip of the fingers, jagged in appearance, with a thick brown substance under the nail beds, his facial hair/beard was unkempt. He stated that he would love his nails cut, and his beard trimmed, but he can't get anyone to do it. In an interview with Certified Nurse Assistant (CNA) #4 on 12/16/24 at 2:10 PM, confirmed Resident #8 's nails were long and jagged with a thick brown substance underneath. She stated that they appeared to have not been trimmed and cleaned in a while. She also confirmed his beard and facial hair was unkempt, long, and needed to be shaved. In an interview with Licensed Practical Nurse (LPN) #2 on 12/16/24 at 3:21 PM, she revealed that concerns from residents not having their dirty jagged nails cut included scratching themselves possibly leading to a skin infection from the dirty nails. She then revealed that not shaving a resident could be irritating to the resident. In an interview with the Director of Nursing (DON) on 12/17/24 at 9:48 AM, she revealed she was unable to find any documentation of recent refusals of ADL care for Resident #8 and confirmed the resident should have been shaved and nail care provided. Record review of the Admission Record revealed the facility admitted Resident #8 on 8/24/19 with a diagnosis that included Need for Assistance with Personal Care and Contracture, Left Hand. Record review of Resident #8's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/24 revealed a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. 45598 Resident #58 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/15/24 at 3:42 PM, revealed Resident #58's fingernails on his right hand had a brown substance underneath them. An observation on 12/16/24 at 2:15 PM, revealed Resident #58 continued to have a brown substance underneath his fingernails on his right hand. An observation in Resident #58's room and an interview on 12/16/24 at 2:25 PM with CNA #5, revealed that ADL included nail care. She confirmed that Resident #58's fingernails were dirty with gunk underneath them on his right hand. CNA #5 revealed that dirty fingernails could cause issues like spreading germs, sickness or infection. She revealed that it was their (CNA's) responsibility to clean out from under resident fingernails during their bath or shower and as needed. She revealed that Resident #58 is a two-person assist with ADLs. Record review of Resident #58's Admission Record revealed the facility admitted the resident on 07/18/22 and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia, and Chronic Obstructive Pulmonary Disease. Record review of Resident #58's MDS with an ARD of 11/08/24 under Section C revealed a BIMS Score of 04 which indicated that the resident had severe cognitive deficits. Resident #104 An interview on 12/15/24 at 4:00 PM, with Resident #104 revealed that she hadn't had a shower since Wednesday night, 12/11/24 and stated, I sure need one. She revealed that they were so busy, they did not give her a shower last night, 12/14/24. She stated, The aide never came in to offer me a shower. An observation and interview with Resident #104 on 12/16/24 at 2:10 PM, revealed her sitting up in her wheelchair in her room with her hair pulled up on her head appearing greasy with a mild odor observed while standing next to the resident. She stated, I'm fat, I sweat underneath my boobs and if I don't get proper care, I smell. Resident #104 also revealed that it had been several days since she had her hair washed and her head had started itching. An interview with CNA #5 on 12/16/24 at 2:17 PM, CNA #5 confirmed that Resident #104's hair was greasy and that it had not been washed in a few days. She revealed that Resident #104 was scheduled to get her showers on the 3PM-11AM shifts on Tuesdays, Thursdays, and Saturdays and that Resident #104 reported to her this morning that she missed her shower on Saturday night. She also revealed that Resident #104 should have had a shower, and her hair washed on her scheduled days to make sure she was clean and to prevent body odor. An observation and interview with the Assistant Director of Nursing (ADON) on 12/17/24 at 8:30 AM, confirmed that Resident #104 and all residents should receive their scheduled showers and that residents' hair should be washed during that time. She confirmed that Resident #104's hair was oily and that she should have received her shower as scheduled on Saturday night. Resident #104 reported to the ADON that she had not had a shower since Wednesday night, 12/11/24. She revealed that on Saturday night, the aide never came in to get her for her shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #104's Admission Record revealed the facility admitted the resident on 06/03/24 and that she had diagnoses that included Difficulty in Walking, Need for Assistance with Personal Care, and Type 2 Diabetes Mellitus. Record review of Resident #104's MDS with an ARD of 12/11/24 under Section C revealed a BIMS Score of 15 which indicated that she was cognitively intact.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure that oxygen tubing and an oxygen concentrator humidifier water bottle was changed as ordered for one (1) of eight (8) residents with oxygen observed. Resident #73 Findings include: Review of the facility policy titled, Oxygen Guideline updated 8/1/2024 revealed, Policy .Medical oxygen is classified by the food and drug Administration as a drug and therefore it is provided in accordance with a health care provider's order and in accordance with acceptable standards of practice. Procedure: Oxygen with humidification will be provided in accordance to a physician's order . Record review of Resident #73's Order Summary Report revealed an order dated 12/6/24 to change oxygen tubing and humidifier bottle weekly. Cleanse any external filters one time a day every Friday. On 12/15/24 at 3:55 PM, Resident #73's oxygen concentrator was observed with an undated, empty humidifier water bottle. The oxygen tubing connected to the humidifier water bottle was dated 11/29. An observation on 12/16/24 at 12:39 PM, revealed the oxygen tubing connected to the humidifier water bottle remained dated 11/29. During an interview and observation on 12/16/24 at 2:10 PM, Licensed Practical Nurse (LPN) #1 revealed that the nightshift nurses are to change out the oxygen tubing and water humidification bottles weekly. She confirmed that the oxygen tubing was dated 11/29 and revealed that it is important for the tubing to be changed as ordered to possibly prevent any infections. In an interview on 12/16/24 at 2:30 PM, the Director of Nurses (DON) revealed that the nurses on Friday nights are responsible for changing the oxygen tubing and water humidification bottles. She revealed she put a new water bottle on this morning when she noticed the humidifier bottle had no water and was unsure why the oxygen tubing and water bottle had not been changed since 11/29. She confirmed the facility failed to follow the physician's order by not changing out the oxygen tubing and water humidifier bottle as ordered. She revealed it's important for the tubing and humidification bottle to be changed weekly to prevent infection. A record review of Resident #73's Admission Record revealed she was admitted to the facility on [DATE] with medical diagnoses that included Acute Respiratory Failure with Hypoxia, Unspecified Asthma, and Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/24 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide sufficient nursing staff to meet the resident's activities of daily living (ADL) needs for for three (3) of five (5) residents reviewed for ADLs. (Resident # 8, #55 and #104) Findings included: Cross-reference with F677 Record review of facility policy titled, Staffing, revealed, It is the practice of (proper name of facility) to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Resident #8 During an observation and interview on 12/15/24 at 4:00 PM revealed Resident #8's fingernails were 1/2 inch long, jagged in appearance, with a thick brown substance under the nails, facial hair/beard were unkempt. During the interview, Resident #8 stated that he would love to have his nails cut and his beard trimmed but cannot get anyone to do it. During an interview on 12/16/24 at 2:10 PM, Certified Nurse Assistant (CNA) #4 revealed that when she arrived at work, she observed that Resident #8's nails were long and jagged with a thick brown substance under them and appeared to have not been trimmed and cleaned in a while. She also confirmed his beard, and facial hair were long and unkempt and needed to be shaved. She revealed she felt that staffing was a big issue with residents not getting the care they needed, due to staff calling in, this lead to the staff working short-staffed all the time. Review of the Admission Record revealed the facility admitted Resident #8 on 8/24/19 with a diagnosis of Need for Assistance with Personal Care and Contracture, Left Hand. Record review of Resident #8's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #58 During an observation on 12/15/24 at 3:42 PM, it was revealed that Resident #58 was lying in bed and his fingernails on his right hand were noted to have a brown substance underneath them. During an observation on 12/16/24 at 2:15 PM revealed Resident #58 lying in bed. He continued to have a brown substance underneath the fingernails on his right hand. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 2:25 PM, in an observation of Resident #58 nails with CNA #5, she confirmed that Resident #58 had long fingernails and had gunk underneath the fingernails on his right hand. She revealed that it was the CNAs responsibility to clean the resident's fingernails during their bath or shower and as needed. An interview on 12/17/24 at 8:40 AM, with CNA # 1, she confirmed that they run low on staffing due to people calling in and being absent. Record review of Resident #58's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia, and Chronic Obstructive Pulmonary Disease. Record review of Resident #58's MDS with an ARD of 11/08/24 under Section C revealed a BIMS Score of 04, which indicated that he had severe cognitive deficits. Resident #104 In an interview on 12/15/24 at 4:00 PM with Resident #104, she revealed that the staff were so busy, they did not give her a shower last night, and they never came in to offer her a bath. She stated that she missed her bath last night because they did not have time and had missed a couple of baths, including this past Tuesday night. She revealed that her scheduled bath times were Tuesday, Thursday, and Saturday on night shifts. She revealed that on Tuesday night, the CNA said it was too late by the time they got to her and gave an excuse that they really didn't have time. During an observation and interview with Resident #104 on 12/16/24 at 2:10 PM, revealed her sitting up in her wheelchair in her room. The resident's hair appeared greasy and was pulled up into a ponytail. A mild odor was noted while standing next to the resident. Resident #104 revealed that it had been so long since she had had her hair washed, her head had started itching. CNA #5 confirmed during an interview on 12/16/24 at 2:17 PM, that Resident #104 hair was greasy when she brushed it for her that morning and it should have been washed on her scheduled bath days, but it was not. Record review of Resident #104's Admission Record revealed the resident was admitted to the facility on [DATE] and that she had diagnoses that included Difficulty in Walking, Need for Assistance with Personal Care, and Type 2 Diabetes Mellitus. Record review of Resident #104's MDS with an ARD of 12/11/24 revealed under Section C a BIMS Score of 15 which indicated the resident was cognitively intact. During an interview on 12/18/24 at 9:33 AM, the Director of Nursing (DON) confirmed that the facility did have a staffing concern regarding aides. She stated they may have 10 or 15 aides on the schedule and five (5) may call in and not show up for their shift. She revealed the scheduler will get on the phone and start trying to get aides to come in and work, and at times, the aides that are already at the facility will work a double shift. She revealed the facility gave incentives and bonuses to try to get the staff to work and if they could not get any aides to come in, the nurses on the floor would help. She confirmed that this had been an ongoing issue, especially on the 3 PM-11 PM shift. (continued on next page)

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	255102	A. Building B. Wing	12/18/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record reviews of a list provided by the facility revealed there were 46 residents that required two people to assist with care.

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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** 46013 Based on observation, resident and staff interview, and record review the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 23 sampled residents. Resident #68 Findings include: A review of the statement on facility letterhead, signed by the Administrator and dated 12/20/24, revealed, (Proper Name) does not have a specific policy for medication storage. The center utilizes the medication administration competencies that refers to returning medications back to medication cart as well as standards of practice. An observation and interview on 12/16/24 at 9:35 AM revealed Resident #68 had two (2) inhalers lying on his bedside table. The inhalers were labeled 1. Spiriva Respimat Inhalation Aerosol Solution 2.5 MCG/ACT(micrograms/actuation) and 2. Symbicort Inhalation Aerosol 80-4.5 MCG/ACT. A nebulizer machine was observed on the bedside table with two (2) unopened Ipratropium-Albuterol Inhalation Solution 0.5-2.5 packages. Resident #68 stated those are my emergency inhalers. During an observation and interview on 12/16/24 at 2:00 PM, Licensed Practical Nurse (LPN) #1 confirmed that the medications were left unattended on the bedside table and should have been locked in the medication cart. She revealed that the medicines are supposed to be given as the physician ordered, and with the inhalers being in the resident's room then they don't know if she is using them or how much she is taking. During an interview on 12/16/24 at 2:25 PM, the Director of Nurses (DON) confirmed that medications should not be left at the bedside unattended but should always be kept locked up in the medication cart. Otherwise, a wandering resident could enter a resident's room and take the medicines. A record review of Resident #68's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Respiratory Failure, Pulmonary Fibrosis, and Atelectasis. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #68 was cognitively intact.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a resident with alternative food items (Resident #59) and failed to honor a resident's food preferences (Resident #83) for two (2) of nine (9) residents sampled for dining services. Findings include: A review of the facility policy titled, Dining and Food Preferences, revealed , revised 9/2017 revealed Policy Statement: Individual dining, food and beverage preferences are identified for all residents .Procedures: 7. The individual tray assembly ticket will identify all food items appropriate for the resident based on diet order, and preferences . 8. Upon meal service, any resident with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value . 9. The alternate meal and/or beverage will be provided in a timely manner . Resident # 59 An interview with Resident #59 on 12/16/24 at 5:00 PM, she revealed that she was unhappy with the food, stating that if she does not like something it does not help to ask for something else because you won't get it. She stated that the dietary staff tell her they have to wait until all residents in the facility have been served to make sure they have enough food. An observation of the evening meal for Resident #59 on 12/15/24 at 5:45 PM, revealed the resident to have a ground turkey patty, green beans, cornbread dressing, a wet roll, and iced tea. Resident #59 asked Certified Nurse Assistant (CNA) #2 if she would ask the kitchen for another helping of the cornbread dressing because that is all she liked on the tray. CNA # 2 returned from the kitchen and stated the Dietary Manager told her she could not give her anymore dressing until all the meal trays were made for all the residents. In an interview with CNA #2 on 12/15/24 at 5:55 PM, she revealed this is a problem every day and when we ask for an alternative, or something different, the dietary staff state they cannot do that, or they don't have the food items. In an interview with the Dietary Manager (DM) on 12/16/24 at 12:10 PM, she revealed she was trained that all residents had to be served before giving any resident any other food to ensure they don't run out of food. In an interview with the District Dietary Manager on 12/18/24 at 8:10 AM, stated there was no reason someone should be told to wait until everybody else is served because they always have plenty of food and alternates they can provide the residents with. An interview with CNA #3 on 12/16/24 at 3:00 PM revealed that if a resident does not like what they get from the kitchen the dietary staff will not give them any extra servings or alternates because they say they may run out of food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record revealed the facility admitted Resident #59 on 11/1/22. Record review of Resident #59's Section C of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. 45598 Resident #83 An observation and interview on 12/16/24 at 8:27 AM revealed Resident #83 was sitting up in her bed eating breakfast. She had oatmeal, eggs, toast, and two slices of bacon on her plate. She stated that she could not eat the bacon because she did not have bottom dentures to chew it. She revealed that she had told nurses, aides, and the Dietary Manager but they continued to put bacon on her plate. She stated, They won't fix it. She admitted that she had told the Dietary Manager several times and she was supposed to change it in the computer then stated, You can't get anything done around here. An observation of the meal ticket on the resident's tray indicated that she preferred bacon in place of sausage. An interview on 12/17/24 at 8:50 AM with the Dietary Manager (DM) confirmed that Resident #83 had talked to her about her preference for sausage instead of bacon and she had changed it in the computer. The DM revealed that they had completed a food preference interview with Resident #83 on 09/16/24 and Resident #83 had voiced that she wanted no bacon and that she preferred sausage. She revealed that the meal ticket continued to print off as a preference for bacon instead of sausage, so it had to be a glitch in the computer system. The DM confirmed that Resident #83 had told her that she continued to receive bacon instead of sausage on her plate. She also confirmed that she had not followed up with Resident #83 like she should have to make sure it was resolved. The Dietary Manager revealed that the residents should be able to make their own food choices and receive what they requested. Record review of Resident #83's Food Preference Interview form dated 09/16/24 revealed under Dining Preferences that she preferred no bacon!!! for breakfast. She also had marked an x beside bacon under food dislikes. Record review of Resident #83's Meal Ticket dated for Monday, 12/16/24 revealed that she prefers bacon in place of sausage. Record review of Resident #83's Admission Record revealed an admitted [DATE]. Record review of Resident #83's MDS with ARD of 09/12/24 under Section C revealed a BIMS Score of 15 which indicated that she was cognitively intact.

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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. 47874 Based on observation, staff interview, and facility policy review, the facility failed to prevent the possibility of the spread of foodborne illness as evidenced by thawing meat at room temperature and using unsafe food handling practices for food preparation for one (1) of two (2) kitchen tours. Findings include: Record review of the facility policy titled, Food: Preparation with a revision date of 9/2017 revealed under, Procedures: . 2. Dining Services will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination . 5. The Cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: Thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross-contamination; . Completely submerging the item under cold water (at a temperature of 70 [degrees] F [Fahrenheit] or below) that is running fast enough to agitate and float off loose particles . During the initial kitchen tour, on 12/15/24 at 3:10 PM, an observation of the two (2)-compartment sink revealed, five (5) packs of kielbasa sausages that were placed in the sink to thaw at room temperature with no running water. Dietary Staff #1 confirmed that meat should not be left out to thaw at room temperature and should have been placed in the cooler to prevent the potential for bacteria growth during the thawing process. Further observation revealed, a brown box placed on the kitchen floor that contained raw chicken skin inside the box and resting on the outer edges. Dietary Staff #1 confirmed the box contained raw chicken skin that had been removed during preparation of the chicken for the upcoming dinner meal. Dietary Staff #1 picked up the box to remove it and the box dripped a pink tinged watery drainage onto the floor and onto the drainboard of the 2-compartment sink. An interview with Dietary Staff #1 revealed the chicken skin should have been disposed of in the garbage during the preparation of the chicken. She revealed the raw chicken skin and drainage could contaminate surfaces and spread salmonella and potentially make someone sick. An interview with the Regional Dietary Manager on 12/18/24 at 8:10 AM confirmed that frozen meat should be thawed under running water or placed in a bin and into a cooler to thaw. He revealed the purpose was to prevent the growth of bacteria on the meat. He confirmed that raw chicken skin should be disposed of in the trash to prevent the possibility of contamination. The Regional Dietary Manager confirmed unsafe food handling practices could make someone sick.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47874 Based on observation, staff interview, and facility policy review, the facility failed to keep kitchen trash properly contained and disposed of safely for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled Dispose of Garbage and Refuse unrevised, revealed under, Policy Statement: All garbage and refuse will be collected and disposed of in a safe and efficient manner . Procedures: 2. The dining service director will ensure that: Garbage and refuse is removed from the kitchen area routinely during the day and at the end of the work day . An observation during the initial kitchen tour on 12/15/24 at 3:10 PM revealed 2 trash barrels that were full and overflowing with trash and uncovered. Multiple empty boxes were stacked on top of both garbage barrels. An interview with Dietary Staff #1 on 12/15/24 at 3:16 PM confirmed that the overflowing garbage in the kitchen was unsanitary. She revealed they (the Dietary Staff) had not had time to empty the garbage today and were in the middle of shift change while preparing for the dinner meal. An interview with the Regional Dietary Manager on 12/18/24 at 8:10 AM confirmed the kitchen trash should be emptied once a shift and when needed and the trash lid should remain intact to ensure safe waste disposal.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41878 Based on staff interviews, record review, and facility policy review, the facility failed to submit accurate data into the Payroll Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Fiscal Year Quater 2024 (July 1-September 30) Findings include: Record review of the facility policy titled, Payroll Based Journal Entry Submission, dated 2022, revealed, CMS (Centers for Medicare and Medicaid Services) regulations for Payroll Based Journal (PBJ) entries submission are adhered to. The policy also revealed, Procedure: 1. Collaboration with Human Resources and Payroll must occur to capture payroll hours for clinical team in centers and submission. 2. CMS allows manual input data or through the use of automatic reports generated by time-tracking or payroll software. If necessary, you may use both types of submissions for your facility. 7. Hours that each team member works each day must be submitted. Per CMS training hours and corporate team member hours may be included if the team member is providing direct care or performing direct care duties. On 12/16/24 at 2:00PM, an interview with the Workforce Management Coordinator confirmed that the facility did not accurately report to PBJ. She stated that there were salary employees that worked the weekends sometimes and their work hours had to be put in manually instead of by the time clock. She revealed that she thinks the numbers entered into PBJ were not accurate. During an interview on 12/16/24 at 2:30 PM, the Human Resource Coordinator confirmed she was responsible for submitting the information for any staff schedule changes into the computer system. She stated this was generally done on Monday or Tuesday after each weekend, and if the report was sent out prior to that, then it was not accurate since it did not reflect all of the staff that worked during the weekend. An interview with the Administrator on 12/18/24 at 8:20 AM confirmed that he felt this was an inaccurate submission concern for PBJ showing they were having low weekend staffing. He stated he pulled the salary employees' time and validation report, and it was noted that these employees were not entered manually into the computer system timely. He stated the PBJ information was submitted to the corporate staff on Monday morning and if the weekend changes were not entered at that time, the information submitted was inaccurate. He confirmed the facility was responsible for submitting PBJ information accurately to reflect the staffing in the facility and the facility failed to do this. Record review of the PBJ for the fourth quarter of 2024 revealed the facility triggered for low weekend staffing. Record review of the facility's staffing validation computer printout revealed the additional staff that worked had not been entered. Verification by the State Agency was conducted through documentation that those staff members were in the facility and performing resident care.