STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bluffs Rehabilitation and Healthcare Center	2850 Porter's Chapel Road Vicksburg, MS 39180

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47157 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to honor a resident 's preferences for (1) one of 23 sampled residents. Resident #195 Findings include: A review of the facility policy titled, Resident Rights, revised 04/2017, revealed, Residents shall: C.) Be assured of choice and share responsibility for decisions . E.) Receive care and services that are adequate and appropriate . An observation on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. In a continued interview with Resident #195, he stated he had been in the facility a little over two weeks, and he had not received a shower, a shave, or had his hair brushed at all. He went on to state he had told someone when he was admitted that he preferred a shower and had asked the staff for one several times, they would say ok but never come back. He then stated, I am unable to get up by myself, or I would try to shower myself. In an interview and observation of Resident #195 on 1/6/24 at 12:10 PM with Certified Nurse Assistant (CNA) #1, she confirmed she had not attempted to give the resident a shower, and stated the facility does not have a set shower schedule for the residents. She then admitted that the resident's hair, beard and nails did not appear clean or that he had had a bath lately. In an interview and record review with the shower CNA #2 on 1/06/24 at 1:00 PM, she confirmed that the facility does not have a set shower schedule for the residents letting us know when they need one. She then revealed that if a resident receives a shower by the shower staff, then it would be documented on the shower schedule forms. After record review she confirmed that Resident #195 had no documented shower since admission. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule in place at this time. She stated, we had one in place for a while, but no one was following up on it and so it was stopped. She confirmed she was aware there was a problem and should have put something in place to ensure residents received their showers. She stated that failing to provide Resident #195 showers per his preference is a failure to honor the residents' right of choice. Record review of the January Shower Record revealed there was no documented shower for Resident #195. Review of the Admission Record revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure. Record review of Resident #195's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section F0400 : Interview for Daily Preferences revealed, C. How important is it to you to choose a bath, shower, bed bath, or sponge bath? Coded: Very Important.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on observations, resident and staff interviews, and facility policy reviews, the facility failed to provide a clean, comfortable, and homelike environment as evidenced by broken blinds or window coverings on three (3) of six (6) hallways observed during survey. Rooms 203, 505, 601, and 607. Findings included: A review of the facility policy titled Homelike Environment with a revision date of 02/2023 revealed under the Policy Statement .Residents are provided with a safe, clean, comfortable environment . During an initial facility tour on 1/6/25, beginning at 7:45 AM, observations revealed broken or missing slats on window blinds in Rooms 203, 505, 601, and 607. This observation revealed there were residents residing in these rooms and the broken blinds allowed the room to be visible from outside the building. An observation of room [ROOM NUMBER] on 1/6/25 at 8:00 AM, revealed four (4) broken slats on the left side of the blinds. An observation of room [ROOM NUMBER] on 1/6/25 at 9:05 AM, revealed four (4) missing slats at the bottom of the blinds. An observation of room [ROOM NUMBER] on 1/6/25 at 3:19 PM revealed ten (10) missing slats on the blinds. In an observation and interview with Certified Nursing Assistant (CNA) #4 on 1/7/25 at 1:00 PM, she confirmed that the window blinds were broken with multiple missing pieces. CNA #4 stated that maintenance needs are typically reported verbally to the Maintenance Director or Administrator, as there is no formal documentation process. She admitted she had noticed the broken blinds but forgot to report the issue due to other responsibilities. During an interview with the Administrator on 1/7/25 at 1:15 PM confirmed that she was aware of the broken blinds because she conducts daily rounds. She stated that she reports maintenance needs to the maintenance director and that replacement blinds had been received but admits they had not been put up yet. She admitted there was no documentation of her rounds or maintenance notifications regarding the blinds. In an interview with the Maintenance Director on 1/7/25 at 1:24 PM, he confirmed that he was aware of the broken blinds in multiple rooms and stated that some replacement blinds had arrived the previous week, but none had been installed yet. He then verified that there was no documentation available to show when the blinds were ordered.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff and resident interviews, record review, and facility policy review the facility failed to send a written transfer/discharge notice to a resident or resident representative for a hospital transfer for three (3) of 3 residents reviewed. Residents #8, # 27, and #45 Findings include: Record review of the facility policy, titled Transfer or Discharge Documentation and Notice with a review date of 5/17/24 revealed under Policy Interpretation and Implementation .5. The residents and representatives are notified in writing the following information: a. the specific reason for the transfer . Resident #8 Record review of the Discharge Minimum Data Set (MDS) for Resident #8 with an Assessment Reference Date (ARD) of 8/22/24 revealed, Section A-2000: discharge date : 8/22/24 . Section A-2105: Discharge Status: coded Short-Term General Hospital. During an interview on 1/7/25 at 12:45 PM, the Social Services Director revealed that she had not sent a written discharge/transfer notification form to any resident or resident representative and was unaware that she needed to provide the notifications when they went to the hospital. Record review of the Admission Record revealed that Resident #8 was admitted to the facility on [DATE], and her most recent hospital stay was from 08/22/2024 to 08/30/2024. Resident #8 was admitted with medical diagnoses that included End Stage Renal Disease, and Diastolic (Congestive) Heart Failure. 47158 Resident #27 Record review of Resident #27's electronic Census status revealed that the resident was transferred to the hospital on 5/9/24, 5/26/24, 7/3/24 and 7/13/24. Record review of Resident #27's electronic Contacts list revealed that Resident #27 was his own Responsible Party (RP). An interview with Resident #27 on 1/6/24 at 11:30 AM, he stated he had not received a written transfer notification for any of his hospitalization s. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 1/7/24 at 2:45 PM stated that it was important to provide the resident or responsible party with a written transfer notification so that they could understand why they were transferred. The Administrator stated that it was her expectation that the Social Services Director would have provided the Resident/Resident Representative with a written transfer notification. Record review of the Admission Record revealed the facility admitted Resident # 27 on 3/15/21 with diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of the Quarterly MDS with an ARD of 12/5/24 revealed Resident # 27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates he is cognitively intact. 47157 Resident #45 Record review of the Discharge MDS for Resident #45 with an ARD of 11/28/24 revealed, Section A-2000: discharge date : 11/28/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review of the Discharge MDS for Resident #45 with an ARD of 12/06/24 revealed, Section A-2000: discharge date : 12/06/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review Discharge MDS for Resident #45 with an ARD of 12/27/24 revealed, Section A-2000: discharge date : 12/27/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Review of the Admission Record revealed Resident #45 was admitted by the facility on 11/12/24 with a diagnosis of Malignant Neoplasm of Glottis.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff and resident interview, record review, and facility policy review the facility failed to send a bed hold notice to a resident or resident representative following a transfer for three (3) of 3 resident hospitalization s reviewed. Residents #8, # 27, and #45 Findings Include Record review of the facility policy, titled Transfer or Discharge Documentation and Notice with a review date of 5/17/24 revealed under Policy Interpretation and Implementation .5. The resident and representative are notified in writing the following information .e. the facility bed hold policy . Resident #8 Record review Discharge Minimum Data Set (MDS) for Resident #8 with an Assessment Reference Date of 8/22/24 revealed, Section A-2000: discharge date : 8/22/24 . Section A-2105: Discharge Status: coded Short-Term General Hospital. Record review of the Admission Record revealed that Resident #8 was admitted to the facility on [DATE], and her most recent hospital stay was from 08/22/2024 to 08/30/2024. Resident #8 was admitted with medical diagnoses that included End Stage Renal Disease, and Diastolic (Congestive) heart failure. 47158 Resident #27 Record review of Resident #27's electronic Census status revealed that the resident was transferred to the hospital on 5/9/24, 5/26/24, 7/3/24 and 7/13/24. Record review of Resident #27's electronic Contacts list revealed that Resident #27 was his own Responsible Party (RP). An interview with Resident #27 on 1/6/24 at 11:30 AM, he stated that he had not received a written notification of the facility bed-hold policy for any of his hospitalization s. Record review of the Admission Record revealed the facility admitted Resident # 27 on 3/15/21 with diagnosis that included Chronic Obstructive Pulmonary Disease. Record review of the Quarterly MDS with an ARD of 12/5/24 revealed Resident # 27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates he is cognitively intact. 47157 Resident #45 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review Discharge MDS for Resident #45 with an ARD of 11/28/24 revealed, Section A-2000: discharge date : 11/28/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review Discharge MDS for Resident #45 with an ARD of 12/06/24 revealed, Section A-2000: discharge date : 12/06/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Record review Discharge MDS for Resident #45 with an ARD of 12/27/24 revealed, Section A-2000: discharge date : 12/27/24 . Section A-2105: Discharge Status : coded Short-Term General Hospital. Review of the Admission Record revealed Resident #45 was admitted by the facility on 11/12/24 with a diagnosis of Malignant Neoplasm of Glottis. An interview with Social Services on 1/7/25 at 12:50 PM, she stated that she did not provide a written notification of the bed-hold policy to Resident #8, #27,or #45 for any of their hospital transfers. She stated that she did not realize that she needed to provide the residents or resident representative this notification. An interview with the Administrator on 1/7/24 at 2: 45 PM she stated that the importance of providing the resident or resident representative with a bed-hold notification was to give them an opportunity to decide if they want to hold their bed at the facility. The Administrator stated that her expectations were that Social Services would have provided the Resident/Resident Representative with a written bed-hold policy notification.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46013 Based on staff interviews, record review, and facility policy review the facility failed to accurately complete Section N of the Minimum Data Set (MDS) assessment for a Resident, as evidenced by incorrectly coding anticoagulant medication usage during the 7-day observation look-back period for 1 (one) of three (3) residents reviewed for anticoagulant use. Resident # 17 Findings include: Review of the facility policy titled, Certifying Accuracy of the Resident Assessment with a revision date of November 2019 revealed Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 3 .The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Record review of the MDS with an Assessment Reference Date (ARD) of October 29, 2024, revealed under section N that Resident #17 received seven (7) days of anticoagulant medication for the observation look-back period of 10/23/24 through 10/29/24. Record review of the Electronic Medication Administration Record (eMAR) for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #17 did not receive anticoagulant medication between 10/23/24 and 10/29/24. An interview with the MDS Coordinator on 1/07/25 at 2:50 PM confirmed that Resident #17 was coded on the 7-day look-back period of 10/23/24 through 10/29/24 for receiving an anticoagulant medication. She revealed that the resident was not on an anticoagulant medication and that it was coded in error. Record review of the Admission Record for Resident #17 revealed the facility admitted the resident on 11/19/2019 with diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47157 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to implement a baseline care plan related to preferences and personal hygiene care for (1) one of 29 resident care plans reviewed. (Resident #195) Findings include: Review of the facility policy titled, Care Plans-Baseline, with a revision date of March 2022 revealed under Policy Interpretation and Implementation .the baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality and must include the minimum healthcare information necessary to properly care for the resident . Review of the Baseline care plan for Resident #195 dated 12/21/24, revealed, Daily preferences that a resident prefers: receiving showers checked. Functional Abilities and Goals-Self Care: Shower/bathe care: coded requires partial/moderate assistance. I.) Personal Hygiene: coded requires setup or clean-up assistance. An observation and interview with Resident #195 on 1/6/25 at 9:00 AM revealed his hair appeared mated and his fingernails were approximately one-half (1/2) inch past the tips of the fingers with a brown substance underneath. He stated that he had been in the facility a couple of weeks and had not had a shower, shave or brushed his hair. He stated that he told the staff during admission that he preferred showers and had asked for one several times. In an interview with the Minimum Data Set (MDS) Coordinator #2 on 1/07/25 at 10:50 AM, she revealed after reviewing the baseline care plan for Resident #195, that the care plan reflected that it was the resident's preference to receive showers and required assistance with bathing and personal hygiene. She then confirmed if staff did not shower the resident, they did not implement his care plan for his preferences. She also confirmed if staff did not assist the resident with bathing and personal hygiene needs, staff did not implement his care plan related to self-care performance. The MDS Coordinator also revealed the purpose of any type of care plan is to direct resident specific care required to meet their needs. Review of the Admission Record revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure. Record review of Resident #195's Admission MDS with an Assessment Reference Date (ARD) of 12/27/24, revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section GG0130: Self Care, revealed, E.) Shower/bathe: coded requires substantial/maximal assistance and I.) Personal Hygiene: coded requires supervision or touching assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interviews, record reviews, and facility policy reviews, the facility failed to implement a comprehensive care plan for personal hygiene for three (3) of 23 resident care plans reviewed. Residents #17, #49, and #57 Findings include: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered dated 10-2022 revealed under Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident #17 Record review of Resident #17's Care Plans, undated revealed Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) decreased mobility and generalize weakness . Interventions .Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. The resident is totally dependent on one (1) staff with personal hygiene. On 1/06/25 at 9:30 AM, an observation and interview with Resident #17 revealed long and jagged fingernails with a brown substance under the nails on bilateral hands that measured approximately one (1) inch long. Facial hair measured approximately three-fourths (3/4) inch long to sporadic areas of her chin. Resident #17 stated, I don't like these whiskers. They are very long, and they need to be cut. She revealed it's been a while since I've had my fingernails cut, and I would like them cleaned and trimmed. On 1/07/25 at 1:00 PM, an observation and interview the Director of Nurses (DON) confirmed Resident #17's fingernails were long, jagged, and had a substance under them. The DON revealed that the nurses are responsible for trimming her fingernails since she is diabetic, and trimming her facial hair is part of her daily grooming when she gets a bed bath or shower. She revealed that with her fingernails, long and jagged, she could scratch herself and cause skin concerns. The DON confirmed that Resident #17 had long facial hair in her chin area and revealed that she had not been properly groomed. A review of the Admission Record revealed the facility admitted Resident #17 on 11/19/2019 with medical diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-29-2024 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates the resident is cognitively intact. Resident #49 (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 #49's Care Plans, date initiated: 08/19/2024, revealed Focus: The resident has an ADL self-care performance deficit r/t Activity Intolerance, Dementia, Limited Mobility . Interventions: The resident is totally dependent on 1 staff with personal hygiene and oral care. The resident requires extensive assistance by two (2) staff for toileting. An observation on 1/06/25 at 08:15 AM, revealed a strong urine smell when standing by Resident #49's bed and with approximately 3/4 inch of facial hair growth on his chin, above his lip, and on the sides of his cheeks. CNA #7 entered the room upon the State Agent's (SA) request and pulled back the blanket covering the resident. The resident was lying on a sheet that was saturated with urine extending from the right side of the resident's waist up to his torso and extending out approximately eight (8) inches towards the edge of the bed. The saturated urine area had a brown ring around the outer edges. CNA #7 confirmed that Resident #49 was lying in a large amount of urine and revealed that it looked like the night shift did not change him. On 1/6/25 at 8:55 AM, during an interview the DON confirmed that Resident #49 had long facial hair and revealed she wasn't sure when he was last properly groomed. She revealed the plan of care regarding his hygiene was not being followed, and it should have been. Record review of the Admission Record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis. Resident #57 Record review of Resident #57's Care Plans, date initiated: 10/20/2021, revealed Focus: The resident has an ADL self-care performance deficit r/t Confusion, Impaired balance . Interventions . Personal Hygiene: The resident is totally dependent on two (2) staff members for personal hygiene. On 1/06/25 at 8:00 AM, an observation revealed Resident #57 lying in bed with approximately 1-inch long facial hair growth on his chin, above his lip, and on the sides of his cheeks. Resident #57's fingernails on bilateral hands were approximately one-half (1/2) inch long and jagged with a brown substance under his fingernails. On 1/06/25 at 8:30 AM, during an observation and interview the DON confirmed that Resident #57 was unshaven, and his fingernails were long, jagged, and dirty. The DON revealed that it is the CNAs' responsibility to ensure the resident is shaven and adequately groomed, and the nurses are responsible for his nail care since he is a diabetic. During an interview on 1/07/25 at 2:40 PM, the Minimum Data Set (MDS) Nurse #1 revealed both MDS Coordinators are responsible for developing the resident's care plans. She revealed that it is patient-centered and addresses all areas of care that the resident is to receive. She revealed that the comprehensive care plans for Residents #17, #47, and #59 were not followed if the residents were not adequately groomed. She revealed that personal hygiene and bathing also covered nail care, perineal care, and shaving. MDS Coordinator #1 revealed there is no excuse for a resident not to have the care specified in their care plan. (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 the Admission Record for Resident #57 revealed he was admitted to the facility on [DATE] with diagnoses that included Need for Assistance with Personal Care and Type 2 Diabetes Mellitus.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bluffs Rehabilitation and Healthcare Center	2850 Porter's Chapel Road Vicksburg, MS 39180

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide personal hygiene for four (4) of 29 sampled residents. Residents #17, #49, #57, and #195 Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting with a revision date of March 2018 revealed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Resident #17 An observation and interview with Resident #17 on 1/06/25 at 9:30 AM revealed long and jagged fingernails measuring approximately one (1) inch long past the tip of the fingers with a brown substance under the nails on bilateral hands, facial hair approximately three-fourths (3/4) inch long to sporadic areas of her chin. Resident #17 stated, I don't like these whiskers. They are very long, and they need to be cut. She revealed it's been a while since she had her fingernails cut and wanted them cleaned and trimmed. An observation on 1/06/25 at 2:45 PM revealed Resident #17 sitting in the hallway with no change in appearance. An observation on 1/07/25 at 8:25 AM revealed Resident #17 with no change in appearance regarding long, jagged nails and long facial hair to the chin area. An observation and interview on 1/07/25 at 12:50 PM Certified Nurse Aide (CNA) #6 revealed she was assigned to Resident #17 today and confirmed the resident had a lot of facial hair to her chin area and the resident's fingernails were long and jagged with a brown substance under them. She revealed she couldn't cut the resident's fingernails but could have ensured they were cleaned up. Resident #13 told CNA #6 she wanted her nails trimmed and her facial hair removed. An observation and interview on 1/07/25 at 1:00 PM, the Director of Nurses (DON) confirmed Resident #17's fingernails were long, jagged, and had a substance under them. The DON revealed that the nurses are responsible for trimming her fingernails since she is diabetic, and trimming her facial hair is part of her daily grooming when she gets a bed bath or shower. She revealed that with her fingernails, long and jagged, she could scratch herself and cause skin concerns. The DON confirmed that Resident #17 had long facial hair in her chin area and revealed that she had not been properly groomed. During an interview on 1/07/25 at 1:47 PM, Licensed Practical Nurse (LPN) #1 revealed she cleaned and trimmed Resident #17's fingernails about a month ago. She revealed there is no set day to do nail care and there is not a reminder in the documenting system; she stated, We just do nail care when we notice that it needs to be done. I take full responsibility for not doing her nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record revealed the facility admitted Resident #17 on 11/19/2019 with medical diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-29-2024 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates the resident is cognitively intact. Resident #49 On 1/06/25 at 08:15 AM, an observation revealed a strong urine smell when standing by Resident #49's bed. CNA #7 entered the room upon the State Agent's (SA) request and pulled back the blanket covering the resident. The resident was lying on a sheet that was saturated with urine extending from the right side of the resident's waist up to his torso and extending out approximately eight (8) inches towards the edge of the bed. The saturated urine area had a brown ring around the outer edges. CNA #7 confirmed that Resident #49 was lying in a large amount of urine and stated, You can tell he has not been changed in a while because of that brown ring around the outer edge. This observation also revealed Resident #49 with approx. 3/4 inch of facial hair growth on his chin, above his lip, and on the sides of his cheeks. During an observation and interview on 1/06/25 at 8:20 AM, LPN #1 confirmed she could smell a strong urine smell and that the urine-saturated sheet had a dried brown ring. She revealed that the urine looked like it had been there for a while and confirmed the resident was unshaven and unkempt. During an observation and interview on 1/06/25 at 8:30 AM, the Administrator (ADM) confirmed that Resident #49 was lying on a urine-saturated sheet with a brown ring around the outer edges of the stain. She revealed that this is not acceptable and confirmed that he doesn't look like he has been groomed in quite some time and has been left wet for a while. An observation and interview on 1/6/25 at 8:35 AM CNA #7 revealed she is assigned to the resident today and made quick rounds when she came on her shift at 7 AM, just glancing in at her residents, and Resident #49 was asleep; she revealed she hadn't changed his brief this morning because she got busy assisting with breakfast. She stated the resident had not been shaved in quite some time, and with his sheets being wet, I can tell you that the night shift did not change him like they were supposed to. During an interview on 1/6/25 at 8:55 AM, the DON confirmed that Resident #49 had long facial hair and revealed she wasn't sure when he was last properly groomed. She revealed there was no excuse for the resident to be found lying in urine and stated, We obviously have an issue with care not being done. Record review of the Admission Record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis. Resident #57 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 1/06/25 at 8:00 AM revealed Resident #57 lying in bed with facial hair growth on his chin, above his lip, and on the sides of his cheeks that was approximately 1 inch long. Resident #57's fingernails were approximately one-half (1/2) inch long, jagged and had a brown substance underneath them on both hands. During an observation and interview on 1/06/25 at 8:10 AM, LPN #1 confirmed Resident #57 was unshaven with fingernails that were long and jagged, with a brown substance under them. She revealed she wasn't sure when the resident was shaven, but it looks like it has been a while. She revealed it is the nurses' responsibility to do his nail care since he is diabetic and revealed we do it whenever we notice they are getting long. She confirmed it had been about a month since the resident's nails were trimmed. During an observation and interview on 1/06/25 at 8:20 AM, CNA #8 revealed she was assigned to the resident today and wasn't sure what day the resident was supposed to get his showers. She revealed we take them when they need to be cleaned up or give them a bed bath. She revealed that it looked like the resident hadn't been shaven in a long time, and his nails were very long and dirty. During an observation and interview on 1/06/25 at 8:30 AM, the DON confirmed that Resident #57 was unshaven, and his fingernails were long, jagged, and dirty. She revealed that the resident could scratch himself and possibly cause an infection. The DON stated, The CNA's are responsible for making sure residents are properly groomed, and it honestly looks like it's been a while since that has happened. Record review of the Admission Record for Resident #57 revealed he was admitted to the facility on [DATE] with diagnoses that included Need for Assistance with Personal Care and Type 2 Diabetes Mellitus. 47157 Resident #195 An observation and interview on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. Resident #195 stated he had been in the facility for a little over two weeks and had not received a shower, a shave, or even had his hair brushed. He then stated that his nails had also not been trimmed or cleaned since he was admitted . Resident #195 stated he had asked for a shower several times and the staff would say ok but would never come back to give him a shower, and stated, I am unable to get up by myself, or I would try to do it myself. In an observation of Resident #195 on 1/6/24 at 12:10 PM with CNA #1 assigned to the resident, she confirmed that the resident's hair and beard were unkept and did not appear clean. She then stated he did not appear that he had received a shower lately and confirmed the resident's nails were dirty, long, and jagged with some type of brown substance under his nail beds. She then confirmed she had not attempted to do nail care on the resident or give him a shower. CNA #1 then revealed the facility did not have a shower schedule in place letting the staff know when the residents are to be bathed and stated that nail care should be provided as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the shower CNA #2 and record review on 1/06/24 at 1:00 PM, she confirmed the facility did not have a set shower schedule for the residents. CNA #2 then revealed that when a resident receives a shower by the shower team that it would be documented on the shower schedule. She then confirmed she was unable to find any documentation of showers for Resident #195. During an interview with the DON on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule at this time. She stated The facility had one in place for a while, but no one was following up on it, so it was stopped. She confirmed she was aware there was a problem with residents not receiving showers and confirmed she should have put something in place before now. She then stated concerns from failing to provide a resident with their showers and personal hygiene, is it could cause skin irritation, infection control issues, and dignity concerns. Review of the Admission Record revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure. Record review of Resident #195's Admission MDS with an ARD of 12/27/24, revealed the BIMS score was 13, indicating the resident was cognitively intact. Section GG0130: Self Care, revealed, E.) Shower/bathe: coded requires substantial/maximal assistance . I.) Personal Hygiene: coded requires supervision or touching assistance.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44804 Based on staff interviews, record review and facility policy review, the facility failed to provide a Registered Nurse (RN) eight (8) hours a day for one (1) of 14 staffing days reviewed. Findings Include Record review of the facility policy titled, Staffing, Sufficient and Competent Nursing with a review date of 3-2023 revealed under Policy Interpretation and Implementation: Sufficient Staffing .A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week . Record review of the Staffing Grid for the dates of 12/24/24 through 1/6/25 revealed there was no RN coverage on 12/25/24. An interview on 1/6/25 at 11:15 AM with the Director of Nurses (DON) confirmed there was no RN coverage on 12/25/24. She stated that the RN that was scheduled did not call in or show up and no one notified her. She stated that she figured it out around noon on Christmas Day when she looked through the computer at the time clock ins. She admitted that she did not come to cover it, everyone else was on vacation and they are not allowed to use agency RN for coverage. She confirmed that the purpose of having an RN on duty is for supervision to handle emergencies or intravenous medications (IV). She admitted there were no incidents or IV therapy on 12/25/24. An interview on 1/6/25 at 2:45 PM with the Administrator confirmed there was no RN coverage on 12/25/24. She stated that the DON put an RN on the schedule that had already requested off for that day and is not sure if the DON just forgot or was not aware. She confirmed that they need an RN for at least 8 hours a day to handle emergencies and IV's. She verifies that the DON was the person that should have covered it. A follow up interview on 1/6/25 at 3:00 PM with the DON confirmed that she does the schedule, and she put an RN on the schedule that had requested off, but she was not aware of her request. She stated that after she put the schedule out that the RN called and told her that she had already requested off for that day. When asked if she expected her to come to work after that phone conversation she stated, she never said she wasn't. When asked if she should have come in and covered, she stated, Yes but I was not coming in to cover someone else's responsibility and miss my family.

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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. 46013 Based on staff interviews, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of the four quarters reviewed. Fourth quarter 2024 Findings include: Record review of the facility policy titled, Reporting Direct-Care Staffing Information (Payroll-Based Journal) Dated October 2022, revealed, . 10 .Staffing data includes the number of hours worked each day by each staff member. Record review of PBJ Staffing Data Report CASPER (Certification and Survey Provider Enhanced Reporting) Report 1705D FY (Fiscal Year) Quarter 4 2024 (July 1-September 30) revealed Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low. During an interview on 1/09/25 at 8:27 AM with the Administrator and the Director of Nurses (DON), they confirmed that the data entered for the fourth quarter PBJ was entered incorrectly and did not capture the full direct care on the PBJ. The DON revealed they had an issue with employees failing to clock out and in for weekend mealtimes, affecting their overall weekend hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff interviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene for one (1) of five (5) resident direct care observations. Resident #37 Findings include: Review of the facility policy titled, Handwashing-Hand Hygiene Policy and Procedures with a revised date of 10-2020 revealed, This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .g. Before handling clean or soiled dressings, gauze pads, etc .; k. After handling used dressings . An observation and interview on 1/8/25 at 9:50 AM with Registered Nurse (RN) #1 providing wound care for Resident #37 with the Director of Nurses (DON) present revealed RN #1 washed her hands, applied clean gloves after removing the residents wound bandage. RN#1 then cleaned Resident #37's sacral wound, patted the wound bed with a dry gauze and then applied Santyl ointment to the wound without changing her soiled gloves, washing her hands, and applying clean gloves. RN #1 confirmed she had not washed her hands and changed her gloves between the dirty and clean procedures and acknowledged that not practicing proper infection control measures could potentially cause an infection in the wound. An interview on 1/08/25 at 2:34 PM with the DON confirmed proper hand hygiene was not performed during the wound treatment for Resident #37 and confirmed their policy is to make sure to change gloves and wash hands between dirty and clean wound treatment. She revealed that not doing so is an infection control issue and could delay healing. A record review of Resident #37's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included a Pressure Ulcer of the Sacral Region, Stage 4.