STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Creek Center for Nursing and Rehabilitation	4911 Brian Center Lane Winston-Salem, NC 27106

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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** 48916 Based on observations, record reviews, and resident and staff interviews, the facility failed to respect a resident's right to dignity when Resident #212 requested incontinence care and it was not provided until after all the meals trays were passed on the hall for 1 of 1 resident reviewed for dignity (Resident #212). The findings included: Resident #212 was admitted to the facility on [DATE] with diagnoses including bowel and bladder incontinence due to impaired mobility, and osteomyelitis. Resident #212's self-care deficit care plan dated 3/13/25 indicated staff were to aid with bowel and bladder incontinence related to immobility. The admission Minimum Data Set (MDS) dated [DATE] specified that Resident #212 was cognitively intact and dependent on toileting, dressing, bathing, transfers, and mobility care. The MDS also determined that the Resident required a mechanical lift for transfers. There were no indications of behaviors exhibited. The MDS indicated Resident #212 was frequently incontinent of bowel and bladder. An observation was conducted in conjunction with an interview with Resident 212 on 4/1/25 at 8:30 AM. When approaching Resident 212's room a strong odor of feces was noted. Upon entrance to Resident 212's room it was discovered the odor was coming from Resident #212's room. Resident #212 was interviewed, he stated he needed to be changed and had been waiting since before light (outside). The Resident stated they brought him his breakfast tray, but he had them remove it because he could not eat in that mess. Nurse Aide (NA) #1 was notified of Resident #212's request for incontinence care. An observation of incontinence care and an interview occurred with NA #1 and NA #2 on 4/01/25 at 8:40 AM. NA #1 stated they found him like that every time they work, and the 11:00 PM to 7:00 AM shift always leaves him (Resident #212) for us to clean up. When the NAs were asked why they didn't round on the resident earlier in their shift, they stated they were not supposed to do patient care while the trays were out. NA #1 further indicated the residents should be cleaned up by the 11:00 PM to 7:00 AM shift and ready for breakfast. NA #1 also stated the trays came out right after they arrived at 7:00 AM, and Resident #212 always needed cleaning up first thing in the morning, but they could not do patient care while the trays were being passed. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/25 at 9:06 AM, a follow-up interview with Resident #212 revealed that he turned his call light on and had asked the third shift (11:00 PM to 7:00 AM) aide, NA #5, to clean him up. He said NA #5 answered his light, turned it off, said she would return to provide incontinence care, left the room, and did not return. Resident #212 stated this treatment had been going on since his admission. He further said it was still dark outside when he rang for NA #5 but could not recall the exact time. Resident #212 noted the next shift (7:00 AM to 3:00 PM) NA came into his room around 7:00 AM with his breakfast tray, but did not provide care; it was light outside by this time. The resident recalled that NA #1 came in with his breakfast tray and told him she would clean him up after all the trays were passed. Resident #212 stated that he felt disgusted about sitting in this mess and being expected to eat breakfast like that. He asked NA #1 to put the tray back on the cart until he was cleaned up. The tray was removed by NA #1 and placed back on the cart until he was cleaned up. The resident further stated he was left in his soiled brief until after the breakfast trays were passed. He said, I can do bad at home by myself. Attempts were made to interview NA #5 by phone, but she did not return calls. An interview on 4/02/25 at 10:00 AM with Nurse # 4 (Unit Manager) revealed that the 11:00 PM to 7:00 AM shift should have the residents clean and dry for breakfast because the trays came out around 7:00 AM. An interview with the Director of Nursing (DON) on 4/04/25 at 9:45 AM revealed the staff should ensure the residents are clean and dry before breakfast on the first shift. She stated it was unacceptable for the residents to lie in soiled briefs while being expected to eat. She further noted that if a resident needed incontinence care, the staff should leave their tray on the cart and give incontinence care so they will be clean for the meal. The DON indicated the staff should treat the residents with dignity and not allow them to feel sad or like the staff did not care about them.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007 Based on record review, observations, and resident and staff interviews, the facility failed to assess and document the ability of a resident to self-administer medications for 1 of 2 residents (Resident #38) reviewed for medication self-administration. Findings included: Resident #38 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #38 was cognitively intact. On 4/1/25 at 9:53 am, an observation was made of fluticasone propionate nasal spray (a steroid nasal spray to treat allergic rhinitis) sitting on Resident #38's bedside table. During an interview with Resident #38 on 4/1/25 at 10:35 am he stated that he used the nasal spray a couple times a day when he needed to for his stuffy nose. Resident #38 reported he couldn't remember who gave the nasal spray to him but he had been using it for a month or two. A care plan last revised on 2/18/25 revealed Resident #38 did not have a care plan to address self-administration of medications. A review of physician orders for Resident #38 there was no order for fluticasone propionate nasal spray. During an interview with Nurse #2 on 4/1/25 at 10:40 am, she stated she was assigned to Resident #38 often but had never noticed the nasal spray on his bedside table before. She reported she was unsure if he had been assessed to self-administer any medications. During an interview on 4/1/25 at 11:00 am with the Director of Nursing (DON), she stated Resident #38 had never been assessed for self-administration of any medication. The DON reported if a resident wanted to have medications at their bedside there should be an order and an assessment for self-administration of medications.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observations, record review, and resident and staff interviews, the facility failed to ensure the accessibility of a wheelchair for 1 of 1 resident (Resident #1) reviewed for reasonable accommodations of needs. Findings included: Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: osteomyelitis, cerebral infarction, and diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #1 was cognitively intact; and was totally dependent on staff and a mechanical lift for transfers. During an observation and interview on 3/31/25 at 1:20 p.m., Resident #1 revealed he had not attended the out of room group activities because he had not seen his wheelchair since his return from the hospital (2/18/25). The resident stated that prior to his hospitalization he would use the wheelchair to propel himself to the group activities. An observation of the resident's room and bathroom revealed there was no wheelchair in Resident #1's room or bathroom. On 4/3/25 at 1:50 p.m., Resident#1 was observed awake, lying in his bed. There was no wheelchair in the resident's room or bathroom. An interview was conducted on 4/3/25 at 3:00 p.m. with Nursing Assistant (NA) #8 who stated she had been working at the facility approximately 2 to 3 months during second shift (3:00 PM to 11:00 PM). NA #8 stated Resident #1 had never requested to get out of bed but acknowledged she never asked the resident if he wanted to get out of his bed to his wheelchair. The NA #8 indicated she was not aware there was no wheelchair in the resident's room or bathroom. During an interview on 4/3/25 at 3:05 p.m., NA #9 stated the resident currently required the use of the mechanical lift and two nursing assistants for transfers in and out of bed. Resident #1 did not like the use of the mechanical lift and would refuse to get out of bed. She recalled the resident's wheelchair had not been in his room for approximately three weeks, when the resident's room was deep cleaned. On 4/3/25 at 3:46 p.m., NA #7 stated that she worked every other weekend and whenever needed during second shift. NA#7 stated that she last worked with Resident #1 approximately two months ago. She revealed the resident used to get out of bed and was able to propel himself in his wheelchair. NA #7 indicated Resident #1 never requested to get out of bed since his return from the hospital. NA #7 acknowledged she never asked the resident if he wanted to get out of the bed and was not aware there was not a wheelchair in the resident's room or bathroom. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/25 at 10:07 a.m., the Interim Rehabilitation Director stated that on 4/1/25 she attempted to work with Resident #1 for out of bed tolerance for sitting on the side of his bed for activities of daily living and unsupported sitting balance on the side of his bed but the resident refused. The Interim Rehabilitation Director did not recall observing the resident's wheelchair in his room. On 4/4/25 at 10:12 a.m., during a follow-up interview, the Interim Rehabilitation Director stated that after the interview with this Surveyor, she was able to locate Resident#1's bariatric wheelchair on the second floor, in the empty therapy room which was used by the facility as a storage room. She revealed the bariatric wheelchair was labeled with the resident's name. The Interim Rehabilitation Director further stated she went to Resident#1's room and asked if he wanted to get out of his bed to his wheelchair. The resident replied yes, after his meal. She stated she informed the nursing staff.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48916 Based on observation, a Resident Council Meeting, and staff interviews, the facility failed to post the survey results in a location accessible to the residents. The findings included: While entering the facility on 04/02/25 at 8:00 AM, an observation revealed the survey results binder was in the lobby on a table. The facility's lobby area was enclosed and secured by a door requiring a code to be entered for staff and residents to access. The Resident Council meeting was held on 04/02/25 at 1:30 PM. During the meeting, Resident #9, Resident #28, Resident #35, and Resident #12 stated they were unaware that survey results were posted in the facility or where the results were located. The Resident Council President, Resident #18, attended the meeting and stated she was aware that survey results could be reviewed and that they were in the lobby. They all stated they were not able to access the lobby to review the survey binder. An interview with the Administrator on 04/02/25 at 2:39 PM indicated that the survey results binder was available to the residents in the lobby; they just needed to let someone know they would like to look at the survey results binder. The interview further revealed the door leading to the lobby was always locked and required a staff member to enter a code to unlock it.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on record review and staff interview, the facility failed to provide information to residents regarding the residents' right to accept or refuse medical/surgical treatment when formulating an advanced directive for 4 of 6 sampled residents reviewed for advanced directives (Residents #15, #25, #29, #39). Findings included: 1. Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE]. The most recent Minimum Data Set assessment dated [DATE] indicated Resident #15 was cognitively intact. Review of the physician's order dated 2/4/25 documented Resident #15's Advance Directive status as Full Code. There was no documentation in Resident #15's medical record indicating the resident was provided information about his right to accept or decline medical or surgical treatment prior to making a Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #15 had the right to accept or decline medical or surgical treatment. 2. Resident #25 was admitted to the facility on [DATE]. The most recent Minimum Data Set assessment dated [DATE] indicated Resident #25 was severely cognitively impaired. Review of the physician's order dated 2/27/24 documented Resident #25's Advance Directive status as Full Code. There was no documentation in Resident #25's medical record indicating the resident or the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #25 had the right to accept or decline medical or surgical treatment. 3. Resident #29 was admitted to the facility on [DATE]. The most recent minimum data set assessment dated [DATE] indicated Resident #29 was (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's order dated 1/23/25 documented Resident #29's Advance Directive status as Full Code. There was no documentation in Resident #29's medical record indicating the resident and the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #29 had the right to accept or decline medical or surgical treatment. 4. Resident #39 was admitted to the facility on [DATE]. The most recent Minimum Data Set assessment dated [DATE] indicated Resident #39 was severely cognitively impaired. Review of the physician's order dated 12/24/24 documented Resident #39's Advance Directive status as Do Not Resuscitate. There was no documentation in Resident #39's medical record indicating the resident and the resident's responsible party were provided information about the right to accept or decline medical or surgical treatment prior to making an Advance Directive decision. During an interview on 4/2/25 at 8:40 a.m., the Social Worker acknowledged the facility did not inform or have any documentation indicating Resident #39 had the right to accept or decline medical or surgical treatment.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 20670 Based on observation and staff interviews, the facility failed to protect the private health information for 3 of 3 sampled residents by posting confidential medical information in an area accessible to the public (Resident #11, Resident #22, and Resident #158). Findings included: During observations on the 100 and 200 halls on 4/1/25 at 9:51 a.m. and 9:52 a.m., one 8.5 inch x 11-inch white sheet of paper with the updated date of 3/12/25 was posted on the wall with tape located behind and next to 2 of 2 nurses' stations. The signs were documented with Resident #11, Resident #22, and Resident #158's names and medical information concerning the residents' dialysis treatments. The documentation on the signs was in large print, typed and had additional handwritten notes about each dialysis resident. The signs included the residents' names, days of the week each resident was scheduled for dialysis treatment, departure times from the facility, and dialysis procedure times. The posted signs on the walls were visible and readable to residents and visitors from the front of each of the nurses' station countertops. During an interview on 4/1/25 at 10:02 a.m., the Director of Nursing acknowledged and stated residents' medical information was displayed on the signs posted on the wall next to the nurses' stations on the 100 and 200 halls in full view of residents and visitors to the facility. She indicated the signs should not have been posted in areas for anyone other than nursing staff to view due to Health Information Portability and Accountability Act (HIPAA) violations.

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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** 20670 Based on observations, and staff interviews, the facility failed to ensure an electrical outlet was securely covered in room [ROOM NUMBER] and failed to ensure resident's clothing was clean and stored neatly in sufficient storage spaces for two residents on the 200 hall. The deficient practice occurred on 1 of 2 halls observed for a clean and homelike environment (200 hall). Findings included: 1. An observation in room [ROOM NUMBER] and interview of Resident #1 was conducted on 3/31/25 at 1:23 p.m. An electrical outlet cover located behind and to the left side of the head of Resident #1's bed was observed partially separated from the wall. There were two electrical cords inserted in the electrical outlet (attached to the bed and the air mattress on the bed) and both attached devices were functioning. The resident revealed he had not been out of his room since his return from the hospital (2/18/25). He indicated he was not aware of the condition of the electrical outlet. During a follow-up observation in room [ROOM NUMBER] on 4/03/25 at 1:50 p.m., the electrical outlet cover located behind and to the left side of the head of Resident #1's bed continued to be partially separated from the wall. On 4/03/25 at 1:50 p.m. during an observation of the electrical outlet cover in room [ROOM NUMBER] and an interview, the Environmental Services Director stated it appeared as if the electrical outlet cover was missing screws and should have been reported by the nursing staff and/or housekeeping staff when observed while cleaning the room An interview was conducted on 4/03/25 at 2:30 p.m. with the facility's Maintenance Director. He revealed none of the facility staff reported the outlet's condition in room [ROOM NUMBER] to the maintenance department. He explained that the facility's protocol for reporting maintenance repair needs was for them to be communicated to him via the Tels Program (an application on the facility's computers as well as the nursing assistants' automatic tasks and service access machine). The Maintenance Director indicated all facility staff were trained to input maintenance work order requests into the program in the computer. During an interview on 4/03/25 at 3:05 p.m., Nursing Assistant (NA) #9 revealed she was aware the outlet next to Resident #1's bed was partially pulled out from the socket and reported this to the staff nurse (no longer worked at the facility) in February 2025. 2.a. During an observation of room [ROOM NUMBER] on 4/01/25 at 10:51 a.m., there was an overflowing large, clear plastic bag of clothes on the floor, beneath the vanity which was visible from the room's open doorway. Resident #29 revealed there were dirty clothes in the plastic bag and she would prefer the dirty clothes to be placed in some sort of container/laundry bag. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/25 at 1:51 p.m., a follow-up observation of room [ROOM NUMBER] was conducted with the Environmental Services Director. The large clear, plastic bag of clothing remained on the floor beneath the vanity. The Environmental Services Director revealed residents' clothes were washed and dried in the facility's laundry room twice each week (Tuesdays and Saturdays) and whenever needed. He further stated that if the nursing assistants brought residents' dirty clothes to the laundry room, there would not be dirty clothes piled in overflowing bags and stored on the floor beneath the vanity. During a third observation on 4/04/25 at 12:43 p.m. room [ROOM NUMBER] a large, clear, plastic bag of clothing continued on the floor beneath the vanity. b. On 4/3/25 at 1:55 p.m., an observation of room [ROOM NUMBER] from the opened doorway revealed multiple large, clear, plastic bags of clothing on the floor beneath the vanity and piles of clothing scattered on top of the vanity. Resident #15 resided in room [ROOM NUMBER] was in the hospital at the time of the observation. discharged to the hospital prior to the observation. On 4/4/25 at 1:55 p.m., during a follow-up observation of room [ROOM NUMBER] clear, a large plastic bag of clothing continued on the floor beneath the vanity and piles of clothing continued to be on top of the vanity. During an interview on 4/4/25 at 1:25 p.m., Nursing Assistant (NA) #10 revealed the nursing assistants were required to sign up for the shower assistant team which included taking residents' dirty laundry to the laundry room.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on record review and staff interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 2 sampled residents (Resident #39) reviewed for hospice services. Findings included: Resident #39 was admitted to the facility on [DATE] with diagnoses which included: dementia and chronic obstructive pulmonary disorder. Resident #39 was admitted to Hospice Services on 2/22/25 with the diagnosis of Alzheimer's disease with late onset. A review of the MDS assessments revealed a Significant Change in Status MDS Assessment was not completed after Resident #39 was admitted to hospice services. During an interview on 4/4/25 at 9:54 a.m., the facility's Administrator revealed the MDS Coordinator was not available. The Administrator acknowledged that a Significant Change MDS should have been completed within fourteen days of Resident #39's admission to Hospice Services.

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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** 48916 Based on observations, record review, and resident and staff interviews, the facility failed to provide incontinence care to a resident upon request for 1 of 1 dependent resident reviewed for activities of daily living (ADL) (Resident #212). The findings included: Resident #212 was admitted to the facility on [DATE] with a diagnosis that included osteomyelitis (bone infection) and bowel and bladder incontinence due to impaired mobility. The admission Minimum Data Set, dated dated dated [DATE] specified that Resident # 212 was cognitively intact and dependent for toileting, dressing, bathing, transfers, and mobility care. The MDS also determined that the Resident required a mechanical lift for transfers. There were no indications of behaviors exhibited. The MDS indicated Resident #212 was frequently incontinent of bowel and bladder. Resident #212's self-care deficit care plan dated 3/13/25 indicated staff were to provide assistance with bowel and bladder incontinence related to immobility. An observation was conducted in conjunction with an interview with Resident 212 on 4/1/25 at 8:30 AM. When approaching Resident 212's room a strong odor of feces was noted. Upon entrance to Resident 212's room it was discovered the odor was coming from Resident #212's room. Resident #212 was interviewed, he stated he needed to be changed and had been waiting since before light (outside). Nurse Aide (NA) #1 was notified of Resident #212's request for incontinence care. An observation of incontinence care and an interview occurred with NA #1 and NA #2 on 4/01/25 at 8:40 AM. The Resident had a saturated brief with a large amount of soft stool from the front to the back and upwards. The stool was not dry and was not stuck to Resident #212's skin and the skin in his sacral area was pink and intact. The bottom sheet had stool on it, but it was not observed that the bottom sheet was wet with urine. NA #1 stated that they find him like this every time they work, and that the 11:00 PM to 7:00 AM shift always leaves him for us to clean up. When the NAs were asked why they didn't round on the resident earlier in their shift, they stated they were not supposed to do patient care while the trays were out. NA #1 further indicated that the residents should be cleaned up and ready for breakfast by the 11:00 PM to 7:00 AM shift. She also stated the trays came out right after they got there at 7:00 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/01/25 at 9:06 AM, a follow-up interview with Resident #212 revealed that he turned his call light on and had asked the third shift (11:00 PM to 7:00 AM) aide, NA #5, to clean him up. He said NA #5 answered his light, turned it off, said she would return to provide incontinence care, left the room, and did not return. He said that this treatment had been going on since his admission. He further stated it was still dark outside when he rang for NA #5 but could not recall the exact time. The resident noted that the next shift (7:00 AM to 3:00 PM) came in his room but did not change him; instead, they passed out his breakfast tray around 7:00 AM, and it was light outside by this time. The resident said that NA #1 came in and told him she would get him cleaned up as soon as all the trays were passed. The resident stated he was left in his soiled brief until after the breakfast trays were passed. He said, I can do bad at home by myself. NA# 5 was unable to be interviewed and did not return phone calls. An interview with the Director of Nursing (DON) on 04/04/25 at 09:45 AM revealed the staff should ensure the residents were clean and dry before the first shift. She stated that it was unacceptable for the residents to lie in soiled briefs for long periods. The DON further stated she felt the staff members understanding was to pass all trays no matter what and not to stop and clean up a resident who had not had a meal served and needed a brief change.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42007 Based on observations, record review and staff interviews, facility failed to secure a spray cleaner and spray deodorizer inside a housekeeping cart with a working lock for 1 of 2 housekeeping carts (the 2nd floor housekeeping cart) observed for accidents hazards. The findings included: An observation of the housekeeping cart occurred on 3/31/25 at 1:17 PM on the second floor of the facility outside of a resident's room. The side door of the cart was partially ajar. The cart did not have a lock. There were three residents seen nearby the cart. There were no staff members near the cart at the time of observation. During an observation and interview with Housekeeper #1 on 3/31/25 at 1:25 PM, she stated she had a spray cleaner, and a spray deodorizer inside the cart. Houskeeper #1 reported the cart used to have a lock but it broke sometime over the weekend (3/28/25-3/30/25). She explained she reported it to the Environmental Manager but it had not been fixed yet. Housekeeper #1 stated she was aware the cart should have a working lock, but it was the only cart on the floor. Housekeeper #1 stated she was keeping it close to her as she was going from one resident's room to another. Review of the Safety Data Sheet issued 10/26/18 for the spray cleaner read, in part, all components are considered non-hazardous and proprietary in their quantities. The SDS indicated the cleaner could cause eye irritation and to wash any contacted parts of the body after handling with soap and water thoroughly. Review of the Safety Data Sheet issued 3/6/18 for the spray deodorizer revealed it contained propanol (a colorless alcohol) and was flammable. The SDS also indicated it could cause irritation to the eyes, nose, and throat and to wash any contacted parts of the body after handling with soap and water thoroughly. During an interview with the Housekeeping Manager on 3/31/25 at 3:40 PM, he stated he had been at the facility for two weeks. The Housekeeping Manager stated he had been made aware by Housekeeper #1 that the lock had broken off over the weekend but he had not had a chance to let maintenance know yet. During an interview with the Administrator on 4/4/25 at 4:10 PM, she verbalized the importance of having a working lock on all housekeeping carts due to the cleaning chemicals stored inside.

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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 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** 42007 Based on observations, record review, and resident and staff interviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen (O2) was in use and to obtain a physician order for oxygen therapy for 1 of 1 resident reviewed for respiratory care (Resident #6). The findings included: Resident #6 was admitted to the facility 7/15/24 with diagnoses including chronic lung disease and hypertension. Resident #6's care plan last revised on 1/18/25 addressed potential for breathing issues related to his lung disease and specified to administer oxygen at 3 liters per minute by nasal canula. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated he was cognitively intact and used oxygen therapy. Review of Resident #6's physician orders showed there was no active order for continuous oxygen therapy. Observation of Resident #6 in his room on 4/1/25 at 9:45 AM revealed he had an oxygen concentrator by his bedside delivering 3 liters of continuous oxygen via nasal canula. There was no cautionary signage outside of Resident #6's room indicating there was oxygen in use inside. During an interview with Resident #6 on 4/1/25 at 9:45 AM, he stated that he had been on oxygen continuously for a while. He reported he had seen his lung specialist last week with no changes. Resident #6 reported that he saw a specialist outside of the facility who takes care of his oxygen needs. During an interview with Nurse #2 on 4/1/25 at 10:55 AM she stated Resident #6 moved to a new room the day before (3/31/25) and the oxygen in use sign was inadvertently not moved with him. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:35 PM, she stated that she was unaware Resident #6 did not have an active order for oxygen use. She stated he previously had one for as needed use but that was discontinued at the end of last year. The DON reported Resident #6 should have had a physician order entered into the facility system for continuous oxygen and that would also include instructions for the flowrate. The DON explained that initiating continuous oxygen therapy based on orders from an outside physician was appropriate, but the facility physician also needed to be notified to write an order. The DON also explained that there should be a cautionary sign on the outside of each resident's room who was on oxygen indicating there was oxygen in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007 Based on record review and staff interviews, the facility failed to maintain ongoing communication with the dialysis treatment center for 2 of 3 residents reviewed for dialysis (Resident #22 and Resident #11). The findings included: 1. Resident #22 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD) and dependence on dialysis (treatment to filter wastes and water from the blood). Resident #22 had an active physician order dated 8/21/23 for dialysis on Monday, Wednesday, and Friday. Review of Resident #22's care plan last reviewed 1/13/25 revealed the need for dialysis related to renal failure with an intervention to communicate with the dialysis center by the dialysis communication form. Review of Resident #22's electronic medical record showed completed dialysis communication forms last scanned into her chart on 11/20/24. Review of Resident #22's dialysis communication forms, located in medical records dated 11/13/24 through 3/28/25 revealed the facility was only able to locate 23 dialysis communications forms. Of the 23 forms located, 5 were incomplete with no documentation by the dialysis facility. There were no communication forms located for the month of December 2024. During an interview with Nurse #3 on 4/3/25 at 1:30 PM, she stated that she fills out the top part of the dialysis sheets, which included vital signs, and sends that form with the resident to her dialysis appointments. Nurse #3 then stated, she would assess the resident when she returned (vital signs and site assessment) and document the information on the resident's medication administration record. Nurse #3 reported that the dialysis center sends their own printed copy of post dialysis information instead of filling out the bottom portion of the facility provided form. Nurse #3 stated both dialysis communication papers (the partial facility and the dialysis center) go to medical records. Nurse #3 reported no dialysis sheets were kept on the floor that she was aware of. The Medical Records staff member was unavailable for interview. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:08 pm she stated the facility was responsible for completing the dialysis communication form prior to the resident being sent to dialysis center and for making sure the dialysis center provides post dialysis information either by completing the bottom portion of the facility form or by providing their own printout. The DON stated she did not know why the facility had been unable to locate complete dialysis communication sheets or why they were not scanned into the chart. The DON explained it was the responsibility of medical records staff to scan completed dialysis communication forms into the electronic medical record. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #11 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease and dependence on dialysis. Resident #11 had an active physician order dated 8/21/23 for dialysis on Monday, Wednesday, and Friday. Review of Resident #11's care plan last reviewed 12/18/24 revealed the need for dialysis related to renal failure with an intervention to communicate with the dialysis center by the dialysis communication form. Review of Resident #11's electronic medical record showed completed dialysis communication forms last scanned into his chart on 11/22/24. Review of Resident #11's dialysis communication forms, located in medical records dated 11/8/24 through 3/28/25 revealed the facility was only able to locate 3 completed forms for the month of January 2025 and only 4 completed forms for the month of February 2025. During an interview with Nurse #3 on 4/3/25 at 1:30 PM, she stated that she fills out the top part of the dialysis sheets, which included vital signs, and sends that form with the resident to her dialysis appointments. Nurse #3 then stated, she would assess the resident when she returned (vital signs and site assessment) and document the information on the resident's medication administration record. Nurse #3 reported that the dialysis center sends their own printed copy of post dialysis information instead of filling out the bottom portion of the facility provided form. Nurse #3 stated both dialysis communication papers (the partial facility and the dialysis center) go to medical records. Nurse #3 reported no dialysis sheets were kept on the floor that she was aware of. The Medical Records staff member was unavailable for interview. During an interview with the Director of Nursing (DON) on 4/4/25 at 2:08 pm she stated the facility was responsible for completing the dialysis communication form prior to the resident being sent to dialysis center and for making sure the dialysis center provides post dialysis information either by completing the bottom portion of the facility form or by providing their own printout. The DON stated she did not know why the facility had been unable to locate complete dialysis communication sheets or why they were not scanned into the chart. The DON explained it was the responsibility of medical records staff to scan completed dialysis communication forms into the electronic medical record.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observation, record reviews, and resident and staff interview, the facility failed to provide dental services as ordered by the physician for 1 of 2 sampled residents (Resident #18). Findings included: Resident #18 was admitted to the facility on [DATE] diagnoses which included: COPD (chronic obstructive pulmonary disease), adult failure to thrive, diabetes mellitus, and Crohn's disease (chronic inflammatory bowel disease). Resident #18's most recent periodic oral evaluation was on 11/30/23. The oral exam showed the resident's oral tissue was red and inflamed, with heavy plaque buildup. The resident had no dental pain. The Dentist's recommendation included: dental cleaning and for the facility staff to remind/assist Resident #18 to brush her teeth twice daily, focusing at gum line. Also, dental follow-up, when needed. The review of the physician's order dated 1/29/24 documented a dental referral for Resident #18 due to a diagnosis of cavities. Review of the clinical record revealed Resident #18 was examined by the Nurse Practitioner (NP) on 3/15/24 due to a reported toothache. The examination showed the resident had cavities to several of her molars, several cracked/broken teeth, and excessive plaque. The resident's upper and lower posterior gingiva (gums) were mildly inflamed. The resulting diagnosis was oral cavity pain and poor oral hygiene. The treatment plan included: continue with (11/30/22) Tylenol (acetaminophen) as prescribed; continue (1/30/24) chlorhexidine (antiseptic) 0.12% swish and swallow; continue to (2/2/24) brush teeth twice daily and as needed; (3/15/24) Cefdinir (antibiotic) 300 mg (milligram) twice a day for seven days, refer to dentist. The review of Resident #18's March 2024 physician's orders included a dental referral for a toothache dated 3/15/24. The follow-up NP's note dated 3/19/24 revealed the cavity on the lower left side of Resident #18's mouth caused the resident to complain of pain when attempting to touch the gum area around that tooth. The dental referral was discussed along with the antibiotics for possible abscessed tooth. There was no documentation in Resident #18's clinical record indicating the resident was referred to or seen by a dentist as re-ordered on 3/15/24. It was originally ordered on 1/29/24. The quarterly minimum data set assessment dated [DATE] indicated Resident #18 was cognitively intact. During an interview on 3/31/25 at 11:38 a.m., Resident #18 revealed she had two cavities. She stated last year, during her last dental visit, she was informed the teeth required extraction. The resident recalled that x-rays of her teeth and gums were completed but she had not received any follow-up. Resident #18 acknowledged she had no oral pain and was able to chew her food without discomfort. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 4/14/25 at 10:01 a.m. with Nurse #4 who revealed she worked as the Unit Manager on the first floor but was familiar with Resident #18 who resided on the second floor in the facility. She indicated she would often see and speak with the resident, but Resident #18 did not complain of tooth or gum pain. Nurse #4 explained the facility's practice was for the physician to document the medication or referral order in the que (standby) of the electronic health record for signed confirmation by a facility nurse (including a unit manager). If the physician's order was a referral order, the nurse was required to print the order then deliver the order to the Appointment Scheduler via the Scheduler's mailbox or in person. She revealed during the time period of the referral order dated 3/15/24, the physician placed the order for Resident #18 into the que of Resident #18's electronic health, then confirmed the order, herself. Nurse #4 stated that because the physician did the confirmation process, the nurses were not aware of the Resident #18's dental referral and it would not appear on the medication administration record as the medications would. An interview with the Administrator on 4/2/25 at 3:06 p.m. revealed the facility had not had onsite dental services in six months. She further explained that if or when a resident had dental requests/needs, the resident's nurse would notify the physician who would write a referral order for dental services. The approved order would then be given to the Appointment Scheduler/Receptionist to schedule the dental appointment to an offsite dental service. During an interview on 4/03/25 at 10:24 a.m., the Appointment Scheduler stated she maintained documentation of all referrals and scheduled appointments for three years. The nurse would inform her and give her a copy of the physician's order. She revealed Resident #18 had been seen by the dentist during previous onsite facility visits. After she reviewed documentation of Resident #18's referrals, the Appointment Scheduler acknowledged there were no dental referrals for this resident throughout 2024. During an interview on 4/03/25 at 10:55 a.m., the Administrator stated the nurse failed to follow through on giving the physician's dental referral order to the Appointment Scheduler. During follow-up telephone interview on 4/14/25 at 9:36 a.m., the Administrator revealed Resident #18's most recent routine on-site dental examination was on 11/30/23. She stated that after reviewing the resident's medical record, there was no documentation indicating Resident #18 complained of oral pain prior to her visit with the nurse practitioner on 3/15/24, and the resident did not complain of tooth pain during or after completion of her antibiotic treatment. The Administrator stated the routine dental on-site visit on 11/30/23 was the most recent dental examination prior to 3/15/24. The Administrator revealed the facility's practice for physician's referral orders was that once the physician entered the order for the dental referral for Resident #18 into the electronic health record, the staff nurse was to confirm the order, print the order and submit it to the Appointment Scheduler.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007 Based on staff interviews and record reviews, the facility failed to offer the opportunity to be vaccinated with the Prevnar 20 (pneumococcal conjugate vaccine (PCV20) in accordance with nationally recognized standards for 4 of 5 residents reviewed for pneumococcal immunizations (Resident #16, #10, #15, and #36). Findings include: The Center for Disease Control and the Advisory Committee on Immunization Practices (ACIP), last reviewed on 10/26/24, now recommends routine vaccination against pneumococcal infection for all adults aged [AGE] years or older and 19-64 with certain underlying medical conditions. Beginning June 8, 2021, for persons aged [AGE] years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, they should receive 1 dose of PCV15 or 1 dose of PCV20. Review of the facility's immunization policy last revised in 2019 stated that all residents would be offered a pneumococcal vaccine upon admission; brand unspecified. A. Record review revealed Resident #16 was admitted to the facility on [DATE] and was over [AGE] years of age at the time of admission. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #16 received a pneumococcal PPSV23 vaccine on 10/28/24. There was no documentation that the resident received a PCV20 vaccine prior to admission or since the last recertification on 11/16/2023. B. Record review revealed Resident #10 was admitted to the facility on [DATE] and was over [AGE] years of age at the time of admission. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #10 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine. There was no documentation that the resident received a PCV20 vaccine prior to admission or since the last recertification on 11/16/2023. C. Record review revealed Resident #15 was admitted to the facility on [DATE] and was over the age of 65. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #15 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine since the last recertification on 11/16/2023. There was no documentation that the resident received a PCV20 vaccine prior to admission. D. Record review revealed Resident #36 was admitted to the facility on [DATE] and was over [AGE] years of age at the time of admission. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pneumococcal immunizations, provided by the facility, indicated Resident #36 declined to receive a pneumococcal PPSV23 vaccine. There was no documentation on the declination form that the resident had specifically been offered a PCV20 vaccine since the last recertification on 11/16/2023. There was no documentation that the resident received a PCV20 vaccine prior to admission. During an interview with the Staff Development Coordinator/Infection Preventionist (IP) on 4/4/2025 at 10:05 AM, she stated that the facility offers PPSV23 (Pneumovax 23) to all residents. The IP stated that, as far as she was aware of, the facility had never offered the Prevnar 20 vaccine. The IP reported she was not aware of the regulation that stated the facility should follow the ACIP recommendations. During an interview with the Director of Nursing on 4/4/2025 at 3:00 PM, she reported the facility offered the pneumococcal PPSV23 vaccine to all residents upon admission and she was unaware that the facility also needed to offer the Prevnar 20 vaccine.