STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Rehabilitation and Healthcare Center	214 Lanefield Road Warsaw, NC 28398

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of indwelling urinary catheter,hospice care, smoking and prescribed medication, for 4 of 18 residents reviewed for MDS accuracy (Resident #10, #71, #43 and #8). 1. Resident #10 was admitted to the facility on [DATE]. Resident #10 did not have a diagnosis for the use of an indwelling urinary catheter. Review of Resident #10's physician orders did not reveal an order for an indwelling urinary catheter. Resident #10's significant change Minimum Data Set (MDS), dated [DATE], revealed the resident was coded as having an indwelling urinary catheter. A telephone interview was conducted with MDS Coordinator #1 on 6/3/26 at 2:05 PM. MDS Coordinator #1 explained that she worked at a sister facility and around the time of this MDS assessment was when she had first started helping the facility with their MDS assessments and did not know the residents. She stated she coded Resident #10 as having an indwelling urinary catheter in error. An interview was conducted with the Administrator on 6/4/26 at 1:43 PM. The Administrator stated it was her expectation that the coding on MDS assessments to be accurate. 2. Resident #71 was admitted to the facility on [DATE] with diagnoses which included quadriplegia and adult failure to thrive. Review of Resident #71's Physician Orders revealed an order dated 1/14/26 to admit to hospice. Resident #71's quarterly Minimum Data Set (MDS), dated [DATE], was not coded for receiving hospice care. A telephone interview was conducted with MDS Coordinator #1 on 6/3/26 at 2:05 PM. MDS Coordinator #1 explained that she worked at a sister facility and around the time of Resident #71's 4/21/26 MDS was when she had first started helping the facility with their MDS assessments and did not know the residents. She stated she did not code Resident #71 as receiving hospice care and felt it was an oversight. An interview was conducted with the Administrator on 6/4/26 at 1:43 PM. The Administrator stated it was her expectation that the coding on MDS assessments be accurate. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #43 was admitted into the facility on 1/2/24 with a diagnosis of end stage renal disease. Resident #43's annual Minimum Data Set (MDS) dated [DATE] revealed he was coded for current tobacco use. Resident #43's safe smoking screening dated 1/28/26 indicated he required supervision while smoking. Resident #43's annual Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and was not a current tobacco user. A telephone interview was conducted with the MDS Coordinator on 6/2/26 at 3:41 PM who confirmed she completed Resident #43's annual MDS dated [DATE]. She revealed she was aware that Resident #43 smoked and it was an oversight that current tobacco use was marked incorrectly. An interview with the Administrator on 6/2/26 at 12:15 PM indicated she expected all MDS assessments to be completed accurately. 4. Resident #8 was admitted to the facility on [DATE] with diagnoses that included encounter for orthopedic aftercare following surgical amputation, congestive heart failure and chronic obstructive pulmonary disease. His diagnoses did not include diabetes. Resident #8's medication orders did not include a prescription of any hypoglycemics. A review of Resident #8's medication administration record (MAR) from 3/12/26 through 5/9/26 revealed hypoglycemic medication had not been administered to Resident #8 during that period. A quarterly MDS dated [DATE] coded Resident #8 as cognitively intact. He was coded as having received a hypoglycemic (including insulin) during the last 7 days look back period. He did not have a diagnosis of diabetes. During an interview on 6/3/26 at 2:16 PM with the MDS Nurse she revealed that she had completed Resident #8's quarterly MDS dated [DATE]. She stated that she had incorrectly indicated in the 5/9/26 MDS that Resident #8 had received a hypoglycemic during that look back period and that it was an oversight since Resident #8 did not have a diagnosis of diabetes or any hypoglycemic medication. During an interview on 6/3/26 at 10:49 AM with the Director of Nursing (DON), she indicated that she expected the MDS Nurse to accurately code the MDS to reflect the resident's status. An interview was conducted on 6/3/26 at 11:44 AM with the Administrator. She stated that she expected the MDS to be coded accurately and that the MDS Nurse should not have included a hypoglycemic in Resident #8's MDS since he did not have a prescription for a hypoglycemic.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interviews, the facility failed to protect private health information of Resident #37 leaving confidential medical information visible and accessible to the public on an unattended medication cart for 1 of 4 medication carts (unit 4 hall medication cart). The findings included:A continuous observation of an unattended medication cart on unit 4 hall was made on 06/04/2026 at 9:01 AM to 9:25 AM. Nurse #1 left the medication cart with the computer screen visible while she retrieved vital signs and administered medications to Resident #37 in the resident's room. Resident #37's Face Sheet (a summary sheet containing medical information) was visible on the screen. Visitors, residents and staff were present in the hallway during the observation. During an interview on 06/04/2026 at 9:25 AM with Nurse #1, she indicated she had left the computer screen unattended in the hallway while she went to retrieve vital signs and administer medications to Resident #37. Nurse #1 explained she forgot to close the electronic medical record prior to walking away from the cart. Nurse #1 explained she should have locked the screen and not left Resident #37's medical information visible to others in the hallway.An interview was conducted on 06/03/2026 at 12:18 PM with the Director of Nursing (DON). She indicated Nurse #1 should not have left the computer screen visible when she went into Resident #37's room to retrieve vital signs and administer medications. She also stated nurses were responsible for protecting residents' medical information from others' visibility.During an interview on 06/03/2026 at 12:12 PM with the facility Administrator, she indicated Nurse #1 should not have left the computer screen visible while she went into residents' rooms. The Administrator further stated private health information should never be left on the computer screen where it was visible to the public.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete the annual Minimum Data Set (MDS) to address the preferences of 1 of 18 residents reviewed for MDS accuracy (Resident #45).The findings included:Resident #45 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE] noted Resident #45 was cognitively intact. The Preferences for Customary Routine and Activities sections were not complete and did not include any information. The MDS nurse who completed the annual MDS dated [DATE] was not available for an interview. An interview with the Regional Clinical Reimbursement Consultant was conducted on 6/2/2026 at 1:20 PM. She stated the annual MDS dated [DATE] for Resident #45 was coded incorrectly. She explained because the assessment had incorrectly noted that the facility was not Medicare or Medicaid certified, this caused the Preferences for Customary Routine and Activities section to not be opened for completion. She stated all MDS assessments must be coded accurately. An interview with the Administrator was conducted on 6/3/2026 at 12:12 PM. She stated she expected the staff to code the MDS assessments accurately.

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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** Based on record review, resident and staff interviews, the facility failed to assist a resident with a bath (Resident #45) and failed to provide showers as scheduled and failed to wash the hair of a resident who was totally dependent on staff assistance for showers and bathing (Resident #4). Resident #4 was observed on 6/1/26 with matted hair on the back of her head and knotted ends of sections that were standing up on the top and sides of her head. This was found for 2 of 26 residents reviewed for activities of daily living (ADL). 1. Resident #4 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, persistent vegetative state, other disorders of the autonomic nervous system, and contracture of muscles, multiple sites. Resident #4's annual Minimum Data Set (MDS), dated [DATE], indicated Resident #4 was in a persistent vegetative state and had no behaviors. The assessment indicated the resident had impairment on both of her upper and lower extremities and was totally dependent on staff for her activities of daily living (ADLs) which included oral hygiene, toileting hygiene, showers/bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident #4 was dependent on staff for tub/shower transfers, had an indwelling catheter and was always incontinent of her bowels. It indicated she was 60 in height and weighed 182 pounds. Resident #4's care plan, last revised 5/9/26, indicated the resident required assistance with her ADLs related to being in a persistent vegetative state. The care plan indicated Resident #4 required a 1-person assist with bed mobility, toileting, and/or repositioning as needed. It directed the staff that Resident #4 required a total mechanical lift with 2 staff assisting. Review of the master shower schedule indicated Resident #4 was to receive two showers a week on Mondays and Thursdays during the hours of 3:00 PM to 11:00 PM. Review of the Nurse Aide documentation report for May 2026 revealed no evidence Resident #4 received her showers on Mondays and Thursdays. In addition, there was no evidence that the resident received a shower on any day or shift during the month of May 2026. Review of Resident #4's Nurse Progress Notes for the month of May 2026 did not reveal any notes written about showers not being administered. During an observation of Resident #4 on 6/1/26 at 12:26 PM and accompanied by Nursing Assistant (NA) #3, the resident was observed lying on her back in her bed with the head of her bed elevated approximately 35 degrees. Her eyes were open, but she did not respond when spoken to. A pole that held a tube feeding pump and bag of enteral nutrition (a nutrient-rich liquid designed to replace regular food) were positioned to the right of her bed. Resident #4 had a gastrostomy tube (a soft medical tube inserted directly into her stomach through a small opening in her stomach) and her liquid nutrition was administered continuously. On the lower part of the pole and around the base of the pole on the floor, was a dried light brownish substance. A urinary collection bag from the resident's urinary catheter (a tube connected to her bladder that allows urine to flow into the collection bag) was observed hanging off the frame of the bed on the right side of the bed. The resident was dressed in a hospital gown which was not completely snapped shut, which allowed her arms to be exposed. A palm guard had been placed in her left hand but was not positioned under her contracted fingers. She was covered with a white flat sheet to her chest area. The sheet had light brownish stains observed in the area near the right of her waist. The resident was African-American, and her hair was pushed straight up (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the top part and sides of her head in sections with the remnants of what might have once been braids observed on the ends of some of the sections. NA #3 lifted the resident's head, and the back of her hair was matted flat. NA #3 attempted to position the palm guard under her fingers correctly. Approximately 10 or more flies were observed flying around the room and landing on the pole, feeding pump and bag of liquid nutrition. The flies were also observed landing on the resident's face and arms. NA #3 was observed waving her arms, trying to shoo the flies away from the resident. When the flies would land on Resident #4's face, she would jerk her head and make a loud groan. An interview was conducted with NA #3 on 6/1/26 at 12:40 PM. NA #3 had been assigned to Resident #4's care on 6/1/26 from 7:00 AM to 3:00 PM. NA #3 stated she had not bathed Resident #4 that morning and stated the resident got her showers during the second shift, from 3:00 PM to 11:00 PM. NA #3 explained residents are supposed to receive showers twice a week and explained she did not know which days Resident #4 was supposed to get her showers, nor when her last shower had been given. NA #3 picked through Resident #4's hair while she talked and tried to unknot the hair in one of the sections. As she did this, she made a pile of whitish lint and/or debris and hair that she picked out from that section of the resident's hair. NA #3 agreed her hair was dirty and said she thought it had not been washed in a long time. She said that she heard the resident's family had given permission to have her hair cut and thought that might have been about a month or so ago. NA #3 said she and another NA had planned to stay over that afternoon to give her a good shower and wash her hair. A second interview was conducted with NA #3 via telephone on 6/16/26 a 10:04 AM. When asked if they had given Resident #4 a shower and washed her hair after their day shift hours of 7:00 AM to 3:00 pm on 6/1/26, she said they had. When asked why she and the other NA decided to give the shower that particular day, she said she was going to be honest and said she knew the State had been in the building and were questioning why the resident appeared so dirty and why her hair looked like it did that on 6/1/26. An observation of Resident #4 was conducted on 6/2/26 at 8:43 AM. The resident was lying in her bed on her back, the head of the bed was elevated. She was awake but again did not speak or groan. The hospital gown she wore was correctly snapped and her bed linens were free of any stains, and there were no odors noticed in the room. She had a set of palm guards in both of her hands, different from the one she had worn on her left hand the day prior. Her hair was brushed and sections of hair were put into a pom-pom style using hair elastics. The tube feeding pump, pole and floor was free of any dried substance. There were still flies in her room, though not as many noted as the day prior. They landed about the room as well as on the resident. An observation of Resident #4 was conducted on 6/2/26 at 2:38 PM. The resident was sitting up in her bed and had her hair tied up in a poof on top of her head. Her hospital gown and bed linens were free of any stains. The pole, tube feeding pump, bag of enteral nutrition and floor did not have any dried fluids on them. There were several flies observed in her room, flying about and landing on her upper body and arms. When the flies would land on the resident she would make a jerking motion and groan. A telephone interview was conducted with NA #9 on 6/4/26 at 11:22 AM. NA #9 stated she had taken care of Resident #4 on many occasions. She explained that the resident is a 2-person assist and they only have 3 nursing assistants (NAs) scheduled on 2nd shift (3:00 PM to 11:00 PM). She explained that one of the reasons Resident #4 had not been getting her showers was because of lack of help. She further explained that on 2nd shift, one of the NAs had to go to the dining room for the supper meal, which left 2 NAs on the floor with all the residents. NA #9 said that between passing out and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then picking up meal trays, doing rounds on the residents, and answering call lights, they did not have time to do the scheduled showers. She said it is impossible to do everything they are supposed to do if there is only 3 NAs assigned to the back (part of the facility). When asked if she had reported her concerns to administration, NA #9 said it had been mentioned at their monthly meetings and that the Director of Nursing (DON) was present at those meetings. NA #9 agreed that Resident #4's hair was dirty and matted and that she had not had a shower for a while. She could not recall when the resident's last shower had been. NA #9 said that she had heard the resident was supposed to have her hair cut but did not know how long ago she heard that. She stated that she attempted to wash the resident's hair using one of those shampoo caps about 2 weeks prior, but it just did not work on the resident's air. She explained that she had seen all the flies on Resident #4 the day before (6/3/26) and she thought if she washed her, that might help. NA #9 said she also turned the air conditioning on trying to get rid of the flies in the room and it didn't help. A telephone interview was conducted with NA #4 on 6/15/26 at 2:08 PM. NA #4 confirmed she worked the 3:00 PM to 11:00 PM shift. She explained that Resident #4 required a total mechanical lift which required 2 staff to operate. She then said they work short-staffed, which made it hard to give Resident #4 and other residents a shower. She stated that Resident #4 is very heavy and that she and other nursing assistants try to do the best they can for her. NA #4 stated administration had been made aware of the issues, but stated nothing ever changed. NA #4 stated she could not recall the last time Resident #4 had a shower. A telephone interview was conducted with NA #5 on 6/15/26 at 2:42 PM. NA #5 confirmed she has been assigned to care for Resident #4 on her usual 11:00 PM to 7:00 AM shifts but also when she occasionally works from 3:00 PM to 11:00 PM. She explained the main reason Resident #4 does not get her scheduled showers on second shift is because she is a 2-person assist. She further explained that on the 3:00 PM to 11:00 PM shift, they are allowed to have 3 NAs in the back (part of the facility). When 1 NA has to go to the dining room at supper, that leaves only 2 NAs working on the floor. She said that during survey when State was in the building they got a 4th nursing assistant but as soon as State left, that staffing returned to usual with just 3. NA #5 said it was not fair for the residents because many of them require total mechanical lifts and it was nearly impossible to get Resident #4, or any resident for that matter, to the shower. As far as Resident #4's hair, NA #5 that with her type of hair, it has to be brushed or combed every day, and that it is not consistently being brushed or taken care of. She said they tried using the shampoo cap, but it did not work. She wondered if the Resident is what attracted all the flies because she sometimes has a foul odor. She recalled a time when she gave her a bed bath and the washcloths she used on her were filthy afterwards. She did not recall how long ago that had been. After seeing how dirty those washcloths had been, she wondered if she had been getting her bed baths like she was supposed to. NA #5 stated that she and other nursing assistants had informed the Administrator that they cannot get Resident #4 to the shower without the help of 4 NAs in the back, but nothing ever changed except when State came in for their survey. She said that as soon as the State left, it went back to how it always was with just 3 nursing assistants in the back. NA #5 said she could guarantee that Resident #4 would get her shower if they had that 4th NA because they work together to get care done. A telephone interview was conducted with NA #6 on 6/15/26 at 3:15 PM. NA #6 states that she works PRN (as needed) at the facility, maybe 1 or 2 times a week. She explained that they are supposed to give showers on 2nd shift (3:00 PM to 11:00 PM) but when they are short-staffed, they cannot get the residents to the showers. When asked what short-staffed meant, NA #6 said they are short if they have 3 NAs assigned to the back. She said between meals and lights going off, and everything else they had to do, they just could not find time to do the residents' showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second interview was conducted with the DON on 6/4/26 at 1:56 PM. The DON stated she expected the nursing staff to perform daily bed baths and hair care on the residents. The DON stated she could not provide any additional staff, however, she stated she could re-evaluate the needs of the residents and possibly move some of the resident baths to day shift where there is more manpower. An interview was conducted with the Administrator on 6/4/26 at 1:43 PM. The Administrator stated it was her expectation that staff keep Resident #4 kempt, her hair unmatted and for staff to keep the residents clean as per the standards of nursing care. 2. Resident #45 was admitted to the facility on [DATE] with diagnoses including coronary artery disease (CAD). The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #45 coded as cognitively intact and was dependent on ADL care. A review of the concern form from Resident #45 dated 2/15/2026 revealed she was not bathed on Sunday 2/15/2026. The resolution for the concern included the staff member being disciplined and an apology was made to the resident. An interview with Resident #45 was conducted on 6/1/2026 at 12:00 PM. The Resident stated she had completed a concern form because on 2/15/20256 she did not receive a bath of any kind. She also stated she does not refuse baths or showers. An interview with Nurse Aide (NA) #3 was conducted on 6/4/2026 at 12:12:40 PM. She stated she was Resident #45's aide on 7:00 to 3:00 PM shift on 2/15/2026. She stated she asked Resident #45 if she wanted a bath or shower and she refused. The nurse aide also stated if a resident refused activities of daily living (ADL) care then she must report it to the nurse. NA #3 did not recall if she reported this to the nurse. A telephone interview with Nurse #2 was conducted on 6/3/2026 at 12:40 PM. She stated she worked with Resident #45 on 7:00 to 3:00 PM shift on 2/15/2026 and did not recall a nurse aide coming to report a refusal for a bath or shower on that day for Resident #45. Nurse #2 indicated if there was a refusal, then it would be in her notes. A review of nursing notes for 2/15/2026 revealed no documentation of Resident #45 refusing care. An interview with the Administrator was conducted on 6/3/2026 at 12:12 PM. The Administrator stated on 2/15/2026 there was a written concern about missing ADL care for Resident #45. The concern was investigated and it was substantiated. The staff member was written up, and an apology was offered to Resident #45.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warsaw Rehabilitation and Healthcare Center	214 Lanefield Road Warsaw, NC 28398

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to ensure a dependent resident's toenails were trimmed and podiatry services were arranged for 1 of 3 residents reviewed for foot care (Resident #9).The findings included:Resident #9 was admitted to the facility on [DATE] with diagnoses that included demyelinating disease (a condition that affects the nerve signals) of the central nervous system, flaccid hemiplegia (paralysis of one side of the body) affecting the right dominant right side, generalized muscle weakness and lack of coordination.A physician order dated 4/21/26 indicated dentist/podiatrist/psychiatrist/ophthalmologist/ counseling/wound services as indicated.An admission head to toe/skin assessment completed by the Wound Treatment Nurse on 4/22/26 indicated that Resident #9's toenails were long. The assessment did not indicate Resident #9 was referred for podiatry services.Resident #9's care plan had a care focus area initiated 4/22/26 that indicated that Resident #9 had an activity of daily living (ADL) self-care performance related to demyelinating disease of nervous system with right flaccid hemiplegia, lack of coordination, and muscle weakness. Interventions included provide one (1) person assistance with bathing/showers, check nail length, trim and clean on bath day and as necessary and report any changes to the nurse.An admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #9 as having moderately impaired cognition and functional limitation in range of motion on one side of the upper and lower extremities. She required partial to moderate assistance with personal hygiene, showers/bathing and rolling left to right in bed, substantial to maximal assistance with transfers and was dependent with toileting and putting on/taking off footwear. She was not coded for rejection of care during the assessment period.Resident #9's head-to-toe skin assessments dated 4/30/26 and 5/12/26 did not indicate that Resident #9's nails were long.A review of the facility's podiatry clinic schedule dated 5/18/26 revealed Resident #9 was not seen by the podiatrist and was not on the list to be seen on that day.An observation of Resident #9 and interview was conducted on 6/2/26 at 10:58 AM in the company of the Wound Treatment Nurse. All of Resident #9's toenails on both feet were observed to be thick and long. When Resident #9 was asked if she wanted her toenails trimmed, she stated that she was not able to take care of her feet or toenails herself and that she would like her toenails trimmed. The Wound Treatment Nurse stated that normally the nurse aides would notify the primary nurses if a resident required podiatry services and the nurses would notify the Social Worker to add the resident to the list to be seen by the podiatrist who came to the facility on a quarterly basis.During a follow up interview on 6/4/26 at 10:18 AM with Wound Treatment Nurse she stated that she had completed Resident #9's admission skin assessment on 4/22/26 and noted her toenails to be long but she could not recall if she had told the Social Worker to add her to the podiatry list to be seen during the podiatry clinic on 5/18/26. She stated that she should have followed through and ensured that Resident #9 was added to the podiatry list so that she could have been seen on 5/18/26.An interview was conducted on 6/2/26 at 11:30 AM with the Social Worker who stated that he added residents to the podiatry list when he received the referrals from nurses that a resident needed podiatry services. He stated that the podiatrist came to the facility on a quarterly basis and that he was last at the facility on 5/18/26 but Resident #9 was not seen by the podiatrist during that visit because he (the Social Worker) was not aware that Resident #9 needed podiatry services since no one had asked him to add Resident #9 to the podiatry list. During an interview with Nursing Assistant (NA) #1 on 6/3/26 at 2:00 PM she revealed that she frequently cared for Resident #9 during the first shift (7:00 AM to 3:00 PM). NA #1 explained that she had noticed that Resident #8's toenails were long and thick from when she was admitted to the facility in April 2026 and that she had attempted to trim them without success. NA #1 stated that she had mentioned this to an agency nurse about 2 weeks ago, but she could not recall the name of the agency nurse.During an interview with the Unit Manager (UM) on 6/4/26 at 10:00 AM she indicated that nurses were supposed to inform the (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker to add the residents to the podiatry list or request podiatry referral from the physician if the resident required podiatry services. She stated that nurses would know that a resident required podiatry services when they completed the admission head-to-toe skin assessment, weekly skin assessments or when they were notified by the nursing assistants of their observations during ADL care. The UM explained that normally the Wound Treatment Nurse completed the admission skin assessment and weekly skin assessments when Wound Treatment Nurse was at the facility and if she was not at the facility the primary nurses completed the skin assessments. The UM reported that the Wound Treatment Nurse had completed Resident #9's admission head to toe skin assessment on 4/22/26 and noted long toenails and the Wound Treatment Nurse should have referred Resident #9 to the Social Worker to be added to the podiatry list so that she could have been seen during the 5/18/26 podiatry clinic at the facility.An interview was conducted with the Director of Nursing (DON) and the Administrator on 6/4/26 at 11:46 AM. The DON stated that the Wound Treatment Nurse should have informed the Social Worker to add Resident #9 to the podiatry list after she completed her admission skin assessment on 4/22/26 so that Resident #9 could have been in house by the podiatrist on 5/18/26. The Administrator stated that she was not aware that Resident #9's toenails were long and that after she was made aware on 6/3/26, Resident #9 had been scheduled to be seen at an offsite podiatry clinic on 6/17/26. The Administrator explained that the Wound Treatment Nurse should have ensured that Resident #8 was added to the podiatry list to be seen at the facility on 5/18/26 to ensure that she received appropriate foot care. The Administrator further stated that she expected all residents to receive podiatry services when needed.