

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Highland House Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Pamalee Drive Fayetteville, NC 28301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38129</p> <p>Based on record review and interviews of the staff, a family member, and the resident, the facility failed to honor a dependent resident's preference for a shower and provided a bed bath instead (Resident #62). This deficient practice affected 1 of 3 sampled residents.</p> <p>Findings included:</p> <p>Resident #62 was admitted to the facility on [DATE] with the diagnosis of stroke.</p> <p>The quarterly Minimum Data Set, dated dated [DATE] for Resident #23 documented her cognition was moderately impaired. She was able to make herself understood and understands and had not refused care. The resident required substantial assistance for bathing, dressing, and personal care.</p> <p>There was a care plan dated 12/5/24 for Resident #62 that included an activities of daily living (ADL) deficit which required assistance with bathing.</p> <p>Resident #62's Nursing Assistant (NA) Kardex documented she was to receive showers on Wednesday and Saturday on evening shift.</p> <p>A review of Resident 62's ADL sheets for 11/23/24 through 12/20/24 documented the resident had a bed bath every day and had refused 2 showers.</p> <p>The Administrator provided the 11/23/24 through 12/20/24 activities of daily living for showers documented the list of NA signatures for Resident #62's scheduled shower dates which revealed NO, N/A (not applicable) and REFUSED on the Kardex.</p> <p>NA Kardex shower documentation for Resident #62 was as follows:</p> <ul style="list-style-type: none"> <li>o 11/23/24 NA #3 NO</li> <li>o 11/27/24 NA #6 REFUSED</li> <li>o 11/30/24 NA #2 NO</li> <li>o 12/4/24 NA #2 N/A</li> </ul> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>o 12/7/24 NA #1 NO</li> <li>o 12/11/24 NA #8 REFUSED</li> <li>o 12/14 NA #2 N/A</li> <li>o 12/18/24 NA #2 N/A</li> <li>o 12/20/24 NA #2 N/A</li> </ul> <p>On 12/19/24 at 10:53 am Resident #62's bathing and shower record for 11/23/24 through 12/20/24 was reviewed with the Administrator. The NAs documented the showers were not done by response of NO, N/A and two refusals.</p> <p>On 12/16/24 at 3:01 pm an interview was conducted with Resident #62's family member. He stated the resident was mostly non-verbal but could nod her head for yes and no. He stated the resident was not getting showers 2 times a week and she wanted her showers.</p> <p>On 12/16/24 at 2:40 pm Resident #62 was interviewed using yes and no questions. The resident had responded with a head nod of no when asked if she had received her shower.</p> <p>On 12/19/24 at 9:00 am an interview was conducted with Resident #62. She answered yes/no head nod. The resident nodded that she had not received her showers.</p> <p>On 12/19/24 at 9:18 am Nurse #4 was interviewed. Nurse #4 stated she was not aware Resident #62 had not received her showers and she was not informed the resident had refused care.</p> <p>On 12/19/24 at 9:32 an interview was conducted with NA #7. NA #7 stated she was very familiar with Resident #62. The resident was scheduled twice a week Wednesday and Saturday on evening shift for her showers. The NA stated evening shift does not always provide the shower and the NA tried to fit in showers on day shift that were not completed on evening shift. The NA stated there were a couple of residents that had reported to the NA they had not received their showers on evening shift as scheduled.</p> <p>On 12/19/24 at 12:24 PM an interview was unsuccessful with NA #3.</p> <p>On 12/19/24 at 11:58 am NA #1 was interviewed. NA #1 stated she knew the resident well. The resident had already gotten a bed bath on day shift which was received in report and documented NO in the Kardex the shower was not given on evening shift. She was not aware the resident desired showers.</p> <p>On 12/19/24 at 12:29 pm NA #6 was interviewed. NA #6 stated she was assigned to Resident #62 on evening shift a couple of occasions. The NA asked the resident if she wanted a shower and the resident pointed to her leg and nodded her head yes to pain. NA #6 reported the resident's pain to the nurse. The resident refused once due to pain. NA #6 stated a shower would be given even if a resident had a bed bath the same day. NA #6 stated If an NA documented N/A or NO the shower was not given.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/24 at 2:40 pm NA #8 was interviewed. NA #8 stated that Resident #62 refused one shower. He also stated that he would offer a shower even if the resident had received a bed bath on the same day. Staff was required to offer.</p> <p>On 12/19/24 at 5:03 pm an interview was conducted with NA #2. NA #2 stated that she remembered Resident #62. She stated that if her documentation for the resident's Kardex in the kiosk was NO or N/A then the care was not provided.</p>		

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<p>F 0567</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38129</p> <p>Based on record review and interviews of the resident, staff, and Department of Social Services, the facility failed to manage a resident's facility trust fund account when a billing discrepancy was discovered regarding the resident's patient monthly liability (PML) for February 2024. This deficient practice affected 1 of 1 resident reviewed for personal funds (Resident #24).</p> <p>Findings included:</p> <p>Resident #24 was admitted on [DATE].</p> <p>Resident #24's RTF statement documented Resident #24 had a deduction from his Resident Trust Fund (RTF) for his February 2024 PML.</p> <p>A document from the Department of Social Services (DSS), clarified the amount due to the facility for February 2024 skilled nursing was for the full month and was not prorated, as it should have been for 2 days, starting 2/27/24.</p> <p>On 12/16/24 at 11:05 am Resident #24 was interviewed. He stated the facility charged over \$600 from his skilled nursing facility (SNF) resident trust fund (RTF) account without notifying him back in April 2024. He noticed on his April 2024 RTF statement the money was withdrawn. The resident stated he notified the business office sometime in April 2024 of the error and he still had not been reimbursed. According to the resident, the business office member's answer repeatedly was they were working on it.</p> <p>On 12/17/24 at 10:32 am an interview was conducted with the Business Office Manager. The Business Office Manager stated when Resident #24 moved from adult care to SNF care nursing on 2/27/24, he was billed for the entire month of February 2024 for skilled nursing PML instead of 2 days prorated. This mistake was not identified until April 2024 when the Business Officer Manager first started the position. The corporate business office was working on correcting the mistake since it was first identified in April. The resident complained to the Business Office Manager a couple of months after April that he was due money. The resident believed he was due approximately \$600 from the mistake. The error had not been corrected and the resident had still not been refunded. The Business Office Manager stated the Administrator was not made aware.</p> <p>The Business Officer Manager provided a copy of an email to DSS staff dated 7/18/24 requesting an answer whether the facility should take the entire month's PML for February for the SNF stay from Resident #24 starting 2/27/24 for that time or partial? The DSS staff responded the facility could bill for the SNF stay from 2/27/24 to 5/31/24.</p> <p>The Business Office Manager provided a copy of an email to the corporate billing office, dated 7/31/24, informing the office Resident #24's DSS case correction was completed. The corporate office could bill PML for 2/27/24 through 5/31/24 for his SNF stay.</p> <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 12/17/24 at 11:53 am the Administrator was interviewed. The Administrator stated she spoke to Resident #24 (on 12/17/24). The resident informed her money was owed to him and he had reported the concern to the Business Office Manager months ago. The Administrator stated she spoke to the Business Office Manager and corporate today (12/17/24). The facility was communicating via email regarding the billing discrepancy and money due to the resident but had not acted upon the reimbursement. The Administrator stated she was not aware the resident was owed money.</p> <p>On 12/17/24 at 1:08 pm a second interview was conducted with the Business Office Manager. The Business Office Manager stated after review of the documentation of Resident #24's billing discrepancy, it was identified the resident had 2 days in skilled nursing February 2024 and DSS allowed charges for an entire month, not prorated. DSS provided documentation for the facility to charge for the entire month of February which was not discovered until 5/24/24. DSS was asked to correct their documentation for the facility to bill correctly for February on 12/17/24. The resident was owed approximately \$700. The Business Office Manager stated she had not remembered the last date she had spoken to DSS to correct the billing so the facility could release the funds they were holding before today (12/17/24).</p> <p>On 12/17/24 at 3:20 pm a phone interview was conducted with DSS Staff. DSS staff stated she was called today (12/17/24) by the facility Business Office Manager regarding Resident #24's PML for 2 days in February 2024 that he was charged for an entire month. The DSS staff member did not remember communicating on 7/31/24 with the facility Business Officer Manager regarding the PML that was coded for the full month when the timeframe was for 2 days. The DSS staff stated she reviewed her records and found that the State Office decided the PML to be billed for the full month amount. The DSS staff stated normally the amount would be prorated to the actual number of days. The DSS staff had not known why the PML came back as a full month and commented that her supervisor reviewed her work and approved of this amount before it was submitted to the facility. She further stated she could not pro-rate the days on her end, the supervisor would need to address this.</p> <p>On 12/17/24 at 3:30 pm an interview was conducted with the DSS Supervisor. She stated today (12/17/24) was the first time she was made aware by her staff that Resident #24 was charged PML for a full month instead of 2 days for February 2024. She further stated she was not aware and had not remembered the 7/31/24 email to her staff regarding the question from the facility Business Office Manager about the PML charges and that DSS staff was made aware of the mistake. The DSS Supervisor stated she would submit to zero out the PML for 2 days and if the system would not allow the change due to the age of several months, a correction by the State Office would be requested. She stated the paperwork was initiated today (12/17/24) and would be provided to the facility to reimburse the resident.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38129</p> <p>Based on record review and interview of the resident and staff, the facility failed to complete and provide a written grievance when a resident reported an error on his facility trust fund account statement. This deficient practice affected 1 of 4 residents reviewed for grievances (Resident #24).</p> <p>Findings included:</p> <p>Resident #24 was admitted on [DATE] with the diagnosis of chronic obstructive pulmonary disease.</p> <p>On 12/16/24 at 11:05 am Resident #24 was interviewed. He stated that the facility took over \$600 from his facility trust fund account without notifying him way back in April 2024. He noticed on his April 2024 statement the money was taken. The resident stated he notified the business office sometime in April 2024 of the error and he had not been reimbursed. The business office member had not completed a grievance and there was no resolution.</p> <p>On 12/17/24 at 10:32 am an interview was conducted with the Business Office Manager. She stated that back in April 2024 Resident #24 was billed for a second patient monthly liability for February 2024 in error. She also stated the resident reported this to the business office and a grievance was not completed and the Administrator was not notified.</p> <p>On 12/17/24 at 11:53 am the Administrator was interviewed. The Administrator stated she spoke to Resident #24 (12/17/24). The resident informed her money was owed to him and that he had reported the concern to the Business Office Manager months ago. The Administrator stated she spoke to the Business Office Manager and corporate to resolve the concern (12/17/24). The Administrator stated the Business Officer Manager had not completed a written grievance form when the concern was reported.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35930</p> <p>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessment in the area of feeding tubes for 1 of 23 residents reviewed for MDS accuracy (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease.</p> <p>The quarterly MDS, dated [DATE], indicated Resident #6 was moderately cognitively impaired and had a feeding tube while at the facility.</p> <p>An interview was conducted with Nurse #5 on 12/17/24 at 12:12 P.M. Nurse #5 stated that Resident #6 did not have a feeding tube and had never had one while he was at the facility that she was aware of.</p> <p>An interview was conducted with the MDS Coordinator on 12/17/24 at 3:01 P.M. The MDS Coordinator explained Resident #6 did not have a feeding tube. She further explained the nutrition section of Resident #6's 10/15/24 quarterly MDS assessment had been completed by the Assistant Dietary Manager.</p> <p>An interview was conducted with the Assistant Dietary Manager on 12/18/24 at 12:15 P.M. The Assistant Dietary Manager explained she had mistakenly marked Resident #6 as having had a feeding tube on his 10/15/24 quarterly MDS assessment due to human error.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/19/24 at 11:55 A.M. The DON stated it was her expectation that the MDS assessment was coded accurately.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38702</p> <p>Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) application for a resident with newly evident mental health diagnosis for 1 of 2 sampled residents reviewed for PASRR. (Resident #3)</p> <p>The findings included:</p> <p>The North Carolina Department of Health and Human Services (NCDHHS) PASRR determination letter dated 02/01/2023 revealed a level I screen and a PASRR number that remained valid for the individual's stay and no further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness.</p> <p>Resident #3 was readmitted to the facility on [DATE] with diagnoses including vascular dementia, with psychotic disturbance.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #3 coded as cognitively intact.</p> <p>A review of the diagnosis list revealed a diagnosis of bipolar II disorder, 04/11/2024.</p> <p>An interview with the Social Worker (SW) was conducted on 12/17/2024 at 10:10 AM. The SW stated he oversaw submitting PASRRs for determinations and when a resident had a new mental health diagnosis the facility submitted a PASRR application for a level II screen. Resident #3 had a new mental health diagnosis since her first determination letter and a new PASRR application was supposed to be submitted when she was diagnosed with bipolar II disorder on 04/11/2024. A PASRR level II screen should have been submitted after the new diagnosis but wasn't due to an oversight.</p> <p>An interview with the Administrator was conducted on 12/17/2024 at 10:38 AM. The Administrator stated Resident #3 did have a negative PASRR level I and did have new mental health diagnoses. The SW who oversaw the PASRRs should have submitted a new PASRR application at the time of a new mental health diagnoses, but it was not done. The Administrator also stated the SW will work with psych closer to get the new diagnoses as it happens so he will not miss any PASRR screenings.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38129</p> <p>Based on observation, record review, and interview of the resident and staff, the facility failed to provide a dependent resident nail care (Resident #23). This deficient practice affected 1 of 3 sampled residents.</p> <p>Findings included:</p> <p>Resident #23 was admitted to the facility on [DATE] with the diagnosis of adult failure to thrive.</p> <p>The care plan for Resident #23 included an activity of daily living deficit. The intervention was for staff to provide bathing, dressing, and all personal care.</p> <p>The quarterly Minimum Data Set, dated dated [DATE] for Resident #23 documented her cognition was moderately impaired. She was able to make herself understood and understands. The resident required substantial assistance for bathing, dressing, and personal care.</p> <p>On 12/16/24 at 12:30 pm Resident #23 was observed and interviewed. The resident was alert and able to clearly make her needs known. The resident stated she wanted her nails cleaned and trimmed; she could not do this by herself. The resident's nails were long, uneven, jagged, and had black soil underneath with more on the right hand than the left. The staff had not offered nail care, and she had not thought to ask. She has a bed bath each morning during weekdays.</p> <p>On 12/16/24 at 1:22 pm an observation of incontinence care with Resident #23 and NA #5 was completed. The resident had long, uneven and jagged nails with black soil underneath. A concurrent interview was completed with NA #5. She stated she was the assigned NA and was only providing incontinent care and meal set up. The NA commented that the resident's nails were cut during bathing, and the hospice NA was providing the bathing and would provide nail care. The NA observed the long, dirty nails and stated she had not offered the resident nail care today and had not known why. The NA stated she was aware the facility staff were responsible for cleaning and/or cutting the resident's nails.</p> <p>On 12/16/24 at 1:22 pm an interview was conducted with Nurse #2. He stated the facility NAs were responsible for nail care if the hospice NA had not provided nail care during bathing.</p> <p>On 12/19/24 at 11:50 am an interview was conducted with NA #7. She stated that the NAs were responsible for nail care which was completed during bathing or showers and when requested.</p> <p>On 12/19/24 at 1:40 pm an interview was conducted with the Administrator. The Administrator stated she was not aware Resident #23's nails needed care. The facility was responsible for nail care if not completed by hospice staff during bathing.</p>		