STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forrest Oakes Healthcare Center	620 Heathwood Drive Albemarle, NC 28001

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)
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** 46095 Based on record review, observations, resident, resident family, and staff interviews, the facility failed to provide incontinence care in a manner to maintain the residents' dignity for 3 of 5 residents reviewed for dignity (Residents #1, #206 ,and #9). Findings included: 1. Resident #1 was admitted to the facility on [DATE]. Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] indicated her cognition was moderately impaired. She required moderate assistance with toileting hygiene, shower/bath, and dressing. She was occasionally incontinent with bowel and bladder. An observation was conducted on 02/02/25 at 10:54 AM of Resident #1 sitting on the side of her bed with the bedside table in front of her. The surveyor observed her sheet with a very large wet area with a brown ring around it in the center. Resident #1 stated the staff did not put a pull-up on her or check on her last night and she saturated her clothes and bed. She explained that she wore pull-ups at night time and she needed assistance with incontinence care. The surveyor observed a note taped to the closet door that read, I am incontinent and need help going to bathroom!!! (Even at night). She indicated a nurse put the note on the door a while back because the NAs didn't assist her at night. Resident #1 also stated the note on the door did help some but there were still times that night shift didn't come in her room. She further explained that she did use her call bell for assistance, but the night staff would come in and turn it off without assisting her. An interview was conducted on 02/04/25 at 6:10 AM with Nursing Assistant (NA) #1. She verified she did work the night of 02/01/25 and that she was Resident #1's direct care NA. She indicated she checked on Resident #1 at 6:00 AM on the morning of 02/02/25 and she was not soaked. She explained she put a pullup on Resident #1 and checked on her at 3:00 AM and about 6:00 AM. An interview was conducted on 02/02/25 at 11:50 AM with Nursing Assistant (NA) #4. She verified she was the direct care NA for Resident #1. NA #4 stated Resident #1 and her bed were saturated this morning (02/02/25) when she entered the room. She explained she did not have a pull-up or brief on, so she provided incontinence care and removed the linens from her bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 02/03/25 at 8:35 AM of Resident #1's room. A strong smell of urine was present, the bed was without sheets, and the mattress appeared wet. Resident #1 was not in her room. An interview was conducted on 02/03/25 at 8:50 AM with Nursing Assistant (NA) #4. She verified she worked full time on day shift and was normally the direct care NA for Resident #1. She stated Resident #1 did have a pullup on this morning (02/03/25) however, she and her bed were saturated with urine. She explained that she gave Resident #1 a shower and removed the linen from the bed. She then explained this was a reoccurring problem. A follow-up interview was conducted on 02/04/25 at 12:35 PM with Resident #1. She stated she was very embarrassed when her room smelled like urine and to have wet clothes on. She explained that it was not right for the staff on night shift not to assist her. She explained she sometimes reminds them, but they don't listen to her. She had not filed a grievance regarding the concern because she forgot to do it. An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing. She stated she was unaware Resident #1 had not received incontinence care consistently on night shift. She also stated she expected all residents to be provided with incontinence care timely. 2. Resident #206 was admitted to the facility on [DATE]. Baseline care plan, dated 01/30/25, revealed Resident #206 required assistance with activities of daily living. Resident #206's Minimum Data Set (MDS) assessment was in progress. Admission/Readmission Data Collection, dated 01/30/25, revealed Resident #206 was alert and oriented to person, place, and time. She was frequently incontinent with bowel and bladder and wore briefs. She also required assistance from one staff member with activities of daily living. An interview was conducted on 02/02/25 at 6:21 PM with Resident #206's and her family member. The family member stated on 02/01/25 at 5:10 PM when dinner trays were being served, he told the Nursing Assistant (NA) (did not know the NAs name) that the resident needed incontinence care to be provided because Resident #206 was wet. He also stated the NA told him she would be back, however, no one returned to change her. He indicated he turned the call bell on at 5:20 PM and at 5:40 PM a nurse and an NA (did not know their names) were in the hallway, he stopped them and told them Resident #206 needed incontinence care to be provided but they did not come into the room to assist. The family member stated he then put the call bell on again at 5:45 PM but no one responded. He explained that he walked up the hall, looked at the nurses' station and down all the halls but he did not see anyone at all. He stated by this time his mom and the bed were saturated with urine. At 6:30 PM a different NA came by the room, and he stopped her and asked if she could provide incontinent care to Resident #206, which she did. Resident #206 stated that what her son had stated was correct, they didn't come after being asked several times. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/04/25 at 2:20 PM with Resident #206. She stated the Nursing Assistant (NA) was good today and had provided incontinence care like she should. She then stated on 01/31/25 she waited 1 hour and 30 minutes for the NA to come and change her and on 02/01/25 she waited 1 hour and 20 minutes to be changed. She explained that her family member timed the occurrences because no one would answer her call bell or respond to her family member's request for assistance needed. Resident #206 further stated she did not like to be left soaking wet like she was on these two occurrences, even her bed and sheets were wet. She then stated, it felt yucky, and I stunk. She also explained that she did not know the NAs name that assisted her, only that it was an African American female. Multiple unsuccessful attempts were made to contact the Nursing Assistant that worked from 4:00 PM until 7:00 PM on 01/31/25 and from 3:00 PM until 7:00 PM on 02/01/25. 50415 3. Resident #9 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #9 was cognitively intact and her vision was assessed as adequate. During an interview and observation with Resident #9 in her room on 2/3/25 at 9:07 AM she reported that she was a heavy wetter and had been wearing a wet brief. She stated that she had to wait for an extended period during the night of 2/2/25 before staff would help change her undergarment. She stated she had pressed her call light, but it was turned off and the staff did not assist her for at least an hour afterward. A clock was observed in the resident's room on the wall in front of her bed. She indicated that she felt ignored when she needed help and had to wait. Resident #9 further stated having to wait so long for help to arrive caused her to feel aggravated. She indicated she was uncomfortable having to wear wet briefs. On 2/3/25 at 6:11 AM Nurse Aide (NA) #1 was interviewed. She stated that she was the only NA who worked 7:00 PM to 7:00 AM on the night shift that day. She stated that it was difficult to get to each resident to provide toileting care throughout the shift. She stated that when she worked alone, she tried to round on everyone at least every 2 hours. She indicated that she had checked on Resident #9 around 5:00 AM, and she didn't need any assistance at that time. NA #1 stated staff calling out was often an issue, leaving the night shift shorthanded. She stated it was difficult to respond to the call lights when multiple residents needed help. The Director of Nursing (DON) was interviewed on 2/6/25 at 10:01 AM. She stated that NAs were supposed to round on residents every two hours and as needed to provide personal care and that Resident #9 should have received incontinence care. The DON stated that an NA had called out the night of 2/3/25 causing the facility to be short staffed.

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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** 40197 Based on observations, record reviews, resident and staff interviews, the facility failed to place a resident's call light within reach for 2 of 2 residents reviewed for accommodation of needs (Residents #6 and #14). The findings included: 1. Resident #6 was admitted to the facility on [DATE] with diagnoses that included history of stroke, chronic pain, and chronic obstructive pulmonary disease (COPD). Resident #6's active care plan, last reviewed 10/3/24, included the following focus areas: - Activities of Daily Living (ADL) self-care performance deficit related to COPD, chronic pain syndrome and left-sided weakness. One of the interventions was to encourage the resident to use the call light for assistance. - Risk for falls related to history of falls, impaired gait/balance problems related to history of a stroke with weakness, potential side effects related to use of psychoactive drug use, poor safety awareness and impulsive behaviors. One of the interventions included to encourage the resident to use the call light for assistance with transfers. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was cognitively intact, displayed no behaviors and required maximum assistance from staff to complete ADLs. On 2/2/25 at 11:30 AM, an observation and interview occurred with Resident #6 while he was lying in bed listening to his radio. The call light was lying on the floor to the left side of the bed out of reach. Resident #6 stated he didn't know how long the call light had been on the floor and couldn't recall it sliding off the bed. He went on to say that normally the call light was fastened to his bed covers so that he could use it, but there were times he would have to ask staff who passed by his room to put the call light where he could reach it. He stated he would have to yell out if he needed something as he was unable to get out of bed on his own to reach it. Another observation was made on 2/2/25 at 12:40 PM. Resident #6 was lying in bed listening to his radio. The call light remained on the floor to the left side of the bed out of reach. When asked how he would request assistance, he stated he would use the call light when he could reach it, otherwise he let staff know when they entered the room, were passing by or yelling out for assistance. Resident #6 stated the nurse had been in to give him his medications that morning but left out of his room before making sure his call light was pinned to him. He recalled asking for it and was told they would be right back. On 2/2/25 at 1:15 PM, an interview occurred with Nurse Aide (NA) #3. She was scheduled to care for Resident #6 from 7:00 AM to 7:00 PM on 2/2/25. She explained she was working with one other NA for the entire building (the census on the day of the interview was 54) and had three other hallways to care for. This was the first time she had been over to Resident #6's hall, she was unaware the call light was not within reach and would fix it immediately. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/2/25 at 2:45 PM, an interview was completed with Medication Aide (MA) #1 who was assigned to care for Resident #6 on the 7:00 AM to 7:00 PM shift for the day of the interview. She couldn't recall if his call light was within reach when she provided him with his morning medications. On 2/5/25 at 9:12 AM, Resident #6 was observed lying in his bed listening to the radio. The head of the bed was elevated, and the call light was noted to be hanging between the headboard and the wall behind Resident #6, out of his reach. NA #6 was interviewed on 2/5/25 at 10:00 AM. She observed Resident #6's call light hanging on the back of headboard out of reach. NA #6 explained she was assigned to care for Resident #6 from 7:00 AM to 3:00 PM and thought she had clipped it to his covers after personal care had been rendered that morning. She retrieved the call light and hooked it to Resident #6's blankets within reach. The Director of Nursing was interviewed on 2/6/25 at 9:32 AM and stated Resident #6's call light could have fallen off the bed if he reached for a snack, but staff should be ensuring the call lights are clipped within reach, so they don't fall off the bed. 46095 2. Resident #14 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc degeneration and repeated falls. Resident #14's active care plan, dated 01/16/25, indicated she was at risk for falls related to intervertebral disc degeneration and repeated falls. The interventions included ensuring her call light was within reach and encouraging Resident #14 to use it for assistance as needed. Resident #14's admission Minimum Data Set (MDS) dated [DATE] indicated her cognition was intact. Resident #14 required maximal assistance with toileting hygiene, shower/bathe self, dressing, bed mobility, transfers, and personal hygiene. She was occasionally incontinent with bladder and always incontinent with bowels. An observation was conducted on 02/02/25 at 11:00 AM of Resident #14. She was observed asleep lying on her bed. Her call light was on the floor under the left side of her bed. An observation was conducted on 02/02/25 at 12:10 PM of Resident #14. She was sitting in her wheelchair about an arm's length from the left side of the bed. Her call light remained out of reach on the floor under the left side of her bed. An observation and interview were conducted on 02/02/25 at 1:01 PM with Resident #14. She was sitting in her wheelchair on the left side of the bed. Her call light was on top and in the center of her bed. She indicated that after the Nursing Assistant (NA) got her out of bed she made the bed and put the call bell in the center of it before exiting the room. Resident #14 propelled herself to the left side of her bed and stated if she attempted to reach for the call bell, she would fall face first out of her wheelchair. She then stated she would have to yell for assistance if she needed anything and hope that someone would hear her. She explained when the NA was in a hurry, they didn't pay attention to where they put the call bell and whether it was in her reach. She then indicated it was frustrating if she couldn't reach the call bell because she could not get the staff's attention. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview were conducted with Nursing Assistant (NA) #3 on 02/02/25 at 1:15 PM. She verified she was the direct care NA for Resident #14. She verified she did put Resident #3's call bell in the center of her bed and that Resident #3 could not reach the call bell from where the wheelchair was positioned. She indicated that Resident #3 would propel herself in the wheelchair and she figured if she needed it, she would move over to get it. An interview was conducted on 02/04/23 at 10:00 AM with the Director of Nursing (DON), she stated the call light device should always be in the resident's reach.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40197 Based on observations, record reviews, and staff interviews, the facility failed to ensure a safe environment as evidenced by exposed wires to the bed control cord (room [ROOM NUMBER]) and to clean the vents of the Packaged Terminal Air Conditioner (PTAC-room [ROOM NUMBER]). The facility also failed to ensure resident rooms were clean and in good repair (Rooms #112, 128, 144, 120, 122, 126, and 129). This was for 8 of 18 resident rooms reviewed for comfortable, clean and homelike environment. The findings included: 1a. On 2/3/25 at 11:33 AM, room [ROOM NUMBER]'s bed control was observed lying on the mattress to the right of the resident's pillow. The bed control cord was noted with approximately 1 inch of yellow electrical tape below the control box. Beyond the yellow electrical tape was approximately 1/4 inch of exposed wires showing. On 2/5/25 at 9:00 AM, the Maintenance Director observed the bed control unit for room [ROOM NUMBER]. He explained that the outer casing protecting the wires tore very easily. He acknowledged that he had wrapped the yellow electrical tape to the bed control cord when exposed wires were first seen but was unable to state when that was. He went onto say the bed control used low voltage so wouldn't hurt a resident if wires were exposed and he would need to rewrap the bed control cord for the exposed wires. When asked if the bed controls could be replaced, he stated yes, but I try to tape them first. The Maintenance Director stated he tried to do frequent checks of the controls for any exposed wires on the cords but had lost his assistant in December 2024 and was doing the best he could. The Administrator was interviewed on 2/6/25 at 9:25 AM and stated that she expected bed control units not to have exposed wires. b. On 2/2/25 at 11:10 AM, room [ROOM NUMBER]'s PTAC vent had a large amount of grey dust particles and dried white material throughout the vent area. The room was occupied and the PTAC was running at the time of the observation. The Housekeeping Manager was interviewed on 2/4/25 at 2:53 PM and explained that the housekeepers cleaned the outside of the PTAC units but anything inside the vents would be taken care of by the Maintenance department. On 2/5/25 at 9:00 AM, an observation of room [ROOM NUMBER] was conducted with the Maintenance Director. He explained that housekeeping cleaned the outside of the PTAC and anything inside the vents would be cleaned by the Maintenance department. The Maintenance Director added that PTAC's were to be cleaned monthly and confirmed the vents to room [ROOM NUMBER]'s PTAC was dirty with various particles in it and required cleaning. The Administrator was interviewed on 2/6/25 at 9:25 AM and stated that she would expect the PTAC's to be clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 2/2/25 at 12:38 PM, in room [ROOM NUMBER], there were multiple areas of the wall under both of the overbed lights with exposed dry wall. This room was occupied by a resident. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM and observed the walls of room [ROOM NUMBER] with exposed sheetrock under both of the overbed lights. He explained that as a room became unoccupied, he was fixing walls and installing back splashes to these areas. He was unable to state if this room was scheduled to be repaired. On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike. 46095 3a. On 02/03/25 at 8:35 AM, in room [ROOM NUMBER], there were multiple areas of the wall on the right side of the headboard and on the wall to the right when entering the room with exposed dry wall. This room was occupied by a resident. An interview was conducted on 02/05/25 at 03:07 PM with the Maintenance Director. He indicated that he observed the walls of room [ROOM NUMBER] with exposed dry wall on the right side of the headboard and on the wall to the right when entering the room. He explained that as a room became unoccupied, he would fix the walls and install back splashes into these areas. He then stated this room was not scheduled to be repaired. On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike. b. On 02/03/25 at 8:35 AM, in room [ROOM NUMBER], there were multiple areas of the wall on the right side of the PTAC with exposed dry wall. This room was occupied by a resident. An interview was conducted on 02/05/25 at 03:07 PM with the Maintenance Director. He indicated that he observed the walls of room [ROOM NUMBER] with areas of the wall on the right side of the PTAC with exposed dry wall. He explained that as a room became unoccupied, he would fix the walls and install back splashes into these areas. He then stated this room was not scheduled to be repaired. On 2/6/25 at 9:21 AM, the Administrator was interviewed and stated it was important for the environment to be well maintained and homelike. 4. On 02/03/25 at 8:35 AM, in room [ROOM NUMBER], the floor under the bed had a brown coffee cup, food crumbs, 3 pencils, and a clear plastic cup on it. The floor beside the bed had a brownish dried liquid (like water was spilled on dirty floor) spot. This room was occupied by a resident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview were conducted on 02/03/25 at 12:15 PM with the Housekeeping Manager in room [ROOM NUMBER]. The floor appeared to have been mopped, the food crumbs, brownish dried liquid (like water was spilled on dirty floor, and water cup were removed from floor. However, the brown coffee cup and pencils were still located on the floor under the bed but were pushed up towards the headboard. The Housekeeping Manager stated that the housekeepers don't touch the residents' personal belongings due to residents accusing them of taking their items, but the coffee cup and other trash should have been removed. She expected the rooms to be neat, clean, and free of debris. She removed the coffee cup and other items from under the bed. An interview was conducted on 02/03/25 at 3:15 PM with the Housekeeping District Manager. He stated he was not aware the housekeeping staff were not touching the residents' belongings when cleaning the rooms. He stated he expected the rooms to be clean, neat, and free of trash and debris. The items should be removed and/or swept up prior to mopping. An interview was conducted on 02/05/25 at 11:52 AM Housekeeper #2. She verified she worked 02/03/25 and was assigned room [ROOM NUMBER]. She stated she did clean room [ROOM NUMBER] and that she thought she got all the stuff from under bed A. She explained that she had a bad back and she didn't bend all the way over to see under the beds, she just took the mop and tried to blindly sweep under the bed. She verified there was trash and a brown coffee cup under the bed that she did not get out because she could not reach it. 50415 5. On 2/2/25 at 11:46 AM room [ROOM NUMBER] was observed to have multiple areas of black scuff marks on the window wall as well as the wall at the head of the bed. This room was occupied by a resident. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. He was unable to state if room [ROOM NUMBER] was scheduled to be repaired. Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned. At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping had a list of areas to be cleaned every day. She stated staff was supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls. The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He also indicated that maintenance was responsible for repairing damaged walls. On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the environment to be well maintained and homelike for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 02/02/25 at11:53 AM room [ROOM NUMBER] was noted to have black scuffs and a partially painted wall by the closet where the television was placed. Paint streaks were also noted on the 3 walls that surrounded the bed. Blue paint was streaked on the white wall at the head of the resident's bed, and white paint streaks were noted on the blue wall on the door wall. The white ceiling also had blue paint streaks on it over the blue wall. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. The Maintenance Director stated room [ROOM NUMBER] was due to be painted as the walls were partially painted from a prior repair. He presented a piece of paper with multiple rooms highlighted for repairs, but room [ROOM NUMBER] was not on the list. He was unable to state if room [ROOM NUMBER] was scheduled to be repaired. Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned. At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping has a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls. The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He also indicated that maintenance was responsible for repairing damaged walls as this was beyond the scope of housekeeping. On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the residents' rooms to be clean, well maintained, and homelike for the residents. 7. On 02/02/25 at 12:11 PM room [ROOM NUMBER] was noted to have black scuff marks on the walls at the right and head of the resident's bed. This room was occupied by a resident. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls and installed backsplashes at the head of the beds. room [ROOM NUMBER] was not on the highlighted list of rooms to be repaired at the time of the interview. He was unable to state when the room would be scheduled for repair. He stated that he lost his assistant in December 2024 and was doing the best that he could. Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned, but that housekeeping was not responsible for fixing scuff marks or damaged walls. At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping had a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forrest Oakes Healthcare Center	620 Heathwood Drive Albemarle, NC 28001

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty. He stated that housekeeping is responsible for cleaning vertical and horizontal surfaces, removing trash, and dust mopping followed by wet mopping of the residents' rooms. He also indicated that maintenance was responsible for repairing damaged walls since this was beyond the scope of housekeeping. On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the residents' rooms to be well maintained and homelike for the residents. 8. On 02/03/25 09:07 AM room [ROOM NUMBER] was observed to have peeling paint on the wall by the window. The wall also had brown marks beside the resident's bed. The Maintenance Director was interviewed on 2/5/25 at 10:15 AM. He indicated that as rooms became vacant, he repaired the walls, painted walls as needed, and installed backsplashes at the head of the beds to reduce damage from beds and wheelchairs hitting the walls. The Maintenance Director stated that he checked the condition of the rooms as he walked the halls and kept a paper of what rooms needed repairing. He was unable to state if room [ROOM NUMBER] was on the list as scheduled to be repaired. Housekeeping staff #1 was interviewed on 2/6/25 at 9:01 AM. She stated housekeeping was responsible for wiping down the walls from visible dirt when the rooms were cleaned. She stated that housekeeping could wipe the brown marks off the wall, but the peeling paint was the responsibility of maintenance to repair. At 9:08 AM on 2/6/25 the Housekeeping Manager was interviewed. She stated that housekeeping has a list of areas to be cleaned every day. She stated they're supposed to wipe down visibly dirty areas in the residents' rooms, but that it was the responsibility of maintenance to repair damaged walls. She stated that she would have housekeeping staff #1 wash the brown marks off the wall in room [ROOM NUMBER]. The Housekeeping Manager stated once the staff turned in their completed task sheets for the day that she inspected the rooms for the areas reported to have been cleaned. The District Manager for housekeeping was interviewed on 2/6/25 at 9:23 AM. He stated that housekeeping was responsible for cleaning walls if they were visibly dirty such as the brown marks on Resident #129's wall. He stated that housekeeping is responsible for cleaning vertical and horizontal surfaces, removing trash, and dust mopping followed by wet mopping of the residents' rooms. He also indicated that maintenance was responsible for repairing damaged walls since this was beyond the scope of housekeeping. On 2/6/25 at 9:21 AM, the Administrator was interviewed. She stated that it was important for the environment to be well maintained and homelike for the residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415 Based on record reviews, observations, and family, resident, and staff interviews, the facility failed to provide nail care and/or incontinence care for 8 of 13 residents dependent on staff for activities of daily living (ADL) (Residents #9, #32, #35, #51, #205, #1, #206, and #33). The findings included: 1a. Resident #9 was admitted to the facility on [DATE] with diagnoses that included a history of a fractured right femur, history of a stroke, Alzheimer's disease, and diabetes. The care plan updated 7/18/24 indicated Resident #9 required one person staff assist for bathing and personal hygiene. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #9 was cognitively intact. There were no mood concerns, but it was noted that the resident was coded for rejection of care. Resident #9 was dependent on staff for toileting, bathing, and personal care and was incontinent of bowel and bladder. A review of the shower sheets for Resident #9 indicated that on 2/3/25 the resident was given a shower, but nail care was marked as not done. An observation on 2/3/25 at 9:07 AM revealed that Resident #9 had jagged fingernails on both hands that extended beyond the fingertips. The fingernails had a yellow-brown substance underneath all of them. Resident #9 stated at the time of the observation she was not offered nail cleaning during her shower that day. Subsequent observations on 2/4/25 at 11:40 AM and on 2/5/25 at 9:30 AM revealed the resident had jagged fingernails with a yellow-brown substance underneath. On 2/6/25 at 8:50 AM NA #4 was interviewed and confirmed she was the NA assigned to Resident #9 that day. NA #4 stated she was regularly assigned to the E hall where Resident #9 lived. She stated that nail care was completed during showers unless the resident refused. She indicated that Resident #9 had a nail care pouch that sat on her table, and she would try to do her own nail care. She stated Resident #9 refused nail care on her shower day on 2/3/25. She further stated that Resident #9 refused showers and nail care a lot. On 2/3/25 at 12:59 PM the Treatment Nurse was interviewed. She stated at the end of the day she brought the Nurse's Aides (NA) to her office to review if the residents received their shower and if nail care was completed at that time. She stated that she knew the residents were getting their showers because she saw the NAs taking the residents to the shower room. The Infection Control (IC) nurse was interviewed on 2/4/25 at 10:33 AM. She stated that she randomly went through the facility checking the residents' fingernails. She stated that the NAs were ultimately responsible for nail care, but that it was lacking lately. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on 2/6/25 at 10:01 and stated the Nurse Aides normally do nail care during showers and morning care. She indicated that the Infection Control nurse would assist with nail care sometimes as well. She stated that nail care should be done on shower days and residents should be checked daily for as needed care. 1b. An observation and interview with Resident #9 occurred on 2/3/25 at 9:07 AM. The room had a strong odor of urine. Resident #9 reported that she was a heavy wetter and had been wearing a wet brief for a long time last night. She stated that she had pushed her call light, but it was turned off. Resident #9 stated she had to wait an extended period before staff helped change her undergarment after the light was turned off. She stated it was about 5:00 AM when the NA helped her. There was a clock noted on the wall located at the end of the resident's bed within her line of vision. On 2/3/25 at 6:11 AM NA #1 was interviewed. She stated that she was the only NA who worked 7:00 PM to 7:00 AM on the night shift that day and that she was assigned all the halls in the facility. She stated that it was difficult to get to each resident to check on them throughout the shift. She stated the last time she changed Resident #9 was around 5:00 AM when she did rounds on the E hall. The Director of Nursing was interviewed on 2/6/25 at 10:01 AM and stated that NAs were supposed to round on residents every two hours to assist with toileting and as needed to provide personal care. 2. Resident #32 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbances, diabetes type II, and major depressive disorder. A review of the care plan revised on 9/13/24 revealed Resident #32 required two person staff assistance with bathing/showering. Staff were to check nail length and trim and clean on bath day and as necessary. The care plan also indicated the resident had a history of refusing showers and should be offered a sponge bath if she refused. The quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #32 was cognitively intact without mood or behavioral concerns. She was coded as requiring substantial/maximal assistance with bathing/showering and setup assistance for personal hygiene. An observation and interview was conducted with Resident #32 on 2/2/25 at 12:54 PM. The resident was noted to have long jagged fingernails that extended beyond the fingertips on both hands. She had chipped nail polish on the nails and there was a black substance noted underneath. Resident #32 stated that she liked having her nails long and pretty. She stated that the Activities Director would paint her nails for her sometimes as part of activities. Resident #32 stated she had never refused to have her fingernails cleaned when she was given a shower because the NA never asked her if she wanted to have the care done. Subsequent observations were completed on 2/3/25 at 3:10 PM and 2/4/25 at 10:18 and continued to reveal the fingernails were long and jagged with a black substance underneath the nails. The shower sheets were reviewed and indicated on 2/3/25 Resident #32 refused a shower but received a bed bath. The shower sheet also indicated she refused nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 8:50 AM, NA #4 was interviewed. She stated that nail care was completed during showers unless the resident refused. She indicated that Resident #35 refused her shower on 2/3/25 and said she did not want to be touched. NA #4 stated Resident #35 would often refuse showers and request not to be touched. She stated the family would assist her at times when they visited. On 2/3/25 at 12:59 PM the Treatment Nurse was interviewed. She stated that at the end of the day she brought the NAs to her office to review the care provided to the residents during showers. She stated that she was unsure why the shower sheets for Resident #35 were left blank, but she stated that she knew the residents were getting their showers because she saw the NAs taking the residents to the shower room. The Infection Control nurse was interviewed on 2/4/25 at 10:33 AM and stated that she randomly went through the facility checking the residents' fingernails. She also stated that she would cut the nails of the residents who had diabetes if it was reported to her that it was needed since NAs could not cut their nails. She stated that the NAs were ultimately responsible for nail care, but that it was lacking lately. The Director of Nursing was interviewed on 2/6/25 at 10:01 AM and stated the Nurse Aides normally do nail care during showers and AM care. She indicated that the IC nurse would assist with nail care sometimes as well for those residents diagnosed with diabetes. She stated that nail care should be done on shower days, and the residents should be checked daily for as needed care. She stated the NAs should report refusals of showers to the floor nurse. 46095 4. Resident #51 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness or paralysis on one side of the body), and aphasia (loss of ability to understand or speak). Baseline care plan, dated 01/13/25, revealed Resident #51 required assistance with activities of daily living. He was dependent on staff for incontinence care, toileting hygiene, personal hygiene, shower/bath, and transfers. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #51's cognition was severely impaired. He had no behavior and no rejection of care. He was dependent on staff for personal hygiene and shower/baths. A review of Resident #51's nursing progress notes from 01/13/23 to 02/04/23 did not reveal refusals for showers or nail care. An observation of Resident #51 was conducted on 02/02/25 at 11:20 AM. The observation revealed Resident #51's fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his fingertips and were jagged. Under the fingernails on the left and right hands was a brown/black substance. An observation of Resident #51 was conducted on 02/03/25 at 11:08 AM. He was observed on a shower stretcher being taken to the shower room. The observation revealed Resident #51's fingernails were still long, jagged, and dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #51 was conducted on 02/03/25 at 12:08 PM. Resident #51 was observed sitting in his wheelchair with his family member rubbing his legs. The Resident's fingernails were still long, jagged, and dirty. An observation and interview were conducted on 02/03/25 at 12:09 PM with Resident #51's family member. She stated she tried to keep Resident #51's nails clean and cut because they were long, and he had been scratching himself. She stated the staff had not cut or cleaned them since he was admitted to the facility, and she did not realize that was their responsibility. An observation of Resident #51 was conducted on 02/04/25 at 9:14 AM. Resident #51's fingernails were still long, jagged, and dirty. A phone interview was conducted on 02/04/25 at 1:12 PM with Nursing Assistant (NA) #7 which stated she provided showers to the residents that were scheduled for 02/03/25. She verified she gave Resident #51's shower on 02/03/25. She stated she did clean Resident #51's nails on 02/03/25 after his shower, however she did not cut or file them. She indicated she did not know why she did not cut or filed his nails. An interview was conducted on 02/05/25 at 11:22 AM with Nursing Assistant (NA) #2. She verified she was the direct care NA for Resident #51 on 02/03/25. She stated she did not perform nail care to the residents on F Hall because she did not know the residents and did not know if they were diabetic. She also stated she did not think to ask the nurse. She explained that she normally performed nail care when she gave showers. An observation and interview were conducted on 02/04/25 at 10:00 AM with the Director of Nursing (DON). She stated nail care was to be done any time it was needed. The Nursing Assistants normally did nail care during showers, morning care, and as needed. She observed Resident #51's nails and stated his nails needed to be cut and cleaned. She then stated there was no reason his nails had not been tended to. An interview was conducted on 02/04/25 at 10:33 AM with the Infection Control (IC) Nurse. She stated that she randomly went through the facility checking fingernails. She also stated that Nursing Assistants were ultimately responsible for nail care, but it's been lacking lately. 5. Resident #205 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of vertebra and type 2 diabetes mellitus. Baseline care plan, dated 01/20/25, revealed Resident #205 required assistance with activities of daily living. He was dependent on staff for toileting hygiene, shower/bath, and transfers and required moderate assistance with personal hygiene. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #205's cognition was intact. He had no behavior and no rejection of care. He was dependent on staff for shower/baths and required moderate assistance with personal hygiene. A review of Resident #205's nursing progress notes from 01/20/23 to 02/04/23 did not reveal refusals for showers or nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #205 was conducted on 02/02/25 at 11:30 AM. The observation revealed Resident #205's fingernails on his left and right hands extended approximately 1/4 of an inch beyond his fingertips and were jagged. Under the fingernails on the left and right hands was a brown/black substance. An observation of Resident #205 was conducted on 02/03/25 at 2:19 PM. His fingernails were still noted to be long, jagged, and dirty. An observation and interview were conducted on 02/04/25 at 9:40 AM with Resident #205. He was observed lying in bed watching television. Resident #205's fingernails were observed to still be long, jagged, and dirty. He stated he asked a staff member to cut and clean his fingernail a week ago, the staff member said they would be back to do them but never returned. An interview was conducted on 02/05/25 at 11:22 AM with Nursing Assistant (NA) #2. She verified she was the direct care NA for Resident #205 on 02/03/25. She stated she did not perform nail care to the residents on F Hall because she did not know the residents and did not know if they were diabetic. She also stated she did not think to ask the nurse. She explained that she normally performed nail care when she gave showers. An interview was conducted on 02/05/25 at 12:48 PM Nurse #1/Wound Nurse. She verified she was Resident 205's direct care nurse on day shift for 02/02/25 and 02/03/25. She stated the Nursing Assistants should be performing nail care when they did showers and when they performed morning care. She stated she had not noticed that Resident 205's fingernails needed to be cut or cleaned, and NA #2 did not report to her that the nails were long and needed to be cut. An observation and interview were conducted on 02/04/25 at 9:55 AM with the Director of Nursing (DON). She stated nail care was to be done any time it was needed. The Nursing Assistants (NAs) normally did nail care during showers, morning care, and as needed unless they were diabetic. If the resident was diabetic the NAs could clean the nails, but the nurse would have to cut the nails. She observed Resident #205's nails and stated his nails needed to be cut and cleaned. She then stated there was no reason his nails had not been tended to. An interview was conducted on 02/04/25 at 10:33 AM with the Infection Control (IC) Nurse. She stated that she randomly went through the facility checking fingernails. She also stated that Nursing Assistants were ultimately responsible for nail care, but it's been lacking lately. 6. Resident #1 was admitted to the facility on [DATE]. Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] indicated her cognition was moderately impaired. She required moderate assistance with toileting hygiene, shower/bath, and dressing. She was occasionally incontinent with bowel and bladder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted on 02/02/25 at 10:54 AM of Resident #1 sitting on the side of her bed with the bedside table in front of her. The surveyor observed her sheet with a very large wet area with a brown ring around it in the center. Resident #1 stated the staff did not put a pull-up on her or check on her last night and she saturated her clothes and bed. She explained that she wore pull-ups at night time and she needed assistance with incontinence care. The surveyor observed a note taped to the closet door that read, I am incontinent and need help going to bathroom!!! (Even at night). She indicated a nurse put the note on the door a while back because the NAs didn't assist her at night. Resident #1 also stated the note on the door did help some but there were still times that night shift didn't come in her room. She further explained that she did use her call bell for assistance, but the night staff would come in and turn it off without assisting her. An interview was conducted on 02/04/25 at 6:10 AM with Nursing Assistant (NA) #1. She verified she did work the night of 02/01/25 and that she was Resident #1's direct care NA. She indicated she checked on Resident #1 at 6:00 AM on the morning of 02/02/25 and she was not soaked. She explained she put a pullup on Resident #1 and checked on her at 3:00 AM and about 6:00 AM. An interview was conducted on 02/02/25 at 11:50 AM with Nursing Assistant (NA) #4. She verified she was the direct care NA for Resident #1. NA #4 stated Resident #1 and her bed were saturated this morning (02/02/25) when she entered the room. She explained she did not have a pull-up or brief on, so she provided incontinent care and removed the linens from her bed. An observation was conducted on 02/03/25 at 8:35 AM of Resident #1's room. A strong smell of urine was present, the bed was without sheets, and the mattress appeared wet. Resident #1 was not in her room. An interview was conducted on 02/03/25 at 8:50 AM with Nursing Assistant (NA) #4. She verified she worked full time on day shift and was normally the direct care NA for Resident #1. She stated Resident #1 did have a pullup on this morning (02/03/25) however, she and her bed were saturated with urine. She explained that she gave Resident #1 a shower and removed the linen from the bed. She then explained this was a reoccurring problem. A follow-up interview was conducted on 02/04/25 at 12:35 PM with Resident #1. She stated that the staff on night shift do not assist her with putting on a pullup or incontinent care throughout the night. She explained she sometimes she reminds them, but they don't listen to her. She had not filed a grievance regarding the concern because she forgot to do it. An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing. She stated she was unaware Resident #1 had not received incontinent care consistently on night shift. She also stated she expected all residents to be provided with incontinent care timely. 7. Resident #206 was admitted to the facility on [DATE]. Baseline care plan, dated 01/30/25, revealed Resident #206 required assistance with activities of daily living. Resident #206's Minimum Data Set (MDS) assessment was in progress. (continued on next page)

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	345442	A. Building B. Wing	02/06/2025

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Forrest Oakes Healthcare Center	620 Heathwood Drive Albemarle, NC 28001

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Admission/Readmission Data Collection, dated 01/30/25, revealed Resident #206 was alert and oriented to person, place, and time. She was frequently incontinent with bowel and bladder and wore briefs. She also required assistance from one staff member with activities of daily living. An interview was conducted on 02/02/25 at 6:21 PM with Resident #206's and her family member. The family member stated on 02/01/25 at 5:10 PM when dinner trays were being served, he told the Nursing Assistant (NA) (did not know the NAs name) that the resident needed incontinence care to be provided because Resident #206 was wet. He also stated the NA told him she would be back, however, no one returned to change her. He indicated he turned the call bell on at 5:20 PM and at 5:40 PM a nurse and an NA (did not know their names) were in the hallway, he stopped them and told them Resident #206 needed incontinence care to be provided but they did not come into the room to assist. The family member stated he then put the call bell on again at 5:45 PM but no one responded. He explained that he walked up the hall, looked at the nurses' station and down all the halls but he did not see anyone at all. He stated by this time his mom and the bed were saturated with urine. At 6:30 PM a different NA came by the room, and he stopped her and asked if she could provide incontinent care to Resident #206, which she did. Resident #206 stated that what her son had stated was correct, they didn't come after being asked several times. An interview was conducted on 02/04/25 at 2:20 PM with Resident #206. She stated the Nursing Assistant (NA) was good today and had provided incontinent care like she should. She then stated on 01/31/25 she waited 1 hour and 30 minutes for the NA to come and change her and on 02/01/25 she waited 1 hour and 20 minutes to be changed. She explained that her family member timed the occurrences because no one would answer her call bell or respond to her family member's request for assistance needed. She also explained that she did not know the NAs name that assisted her, only that it was an African American female. Multiple unsuccessful attempts were made to contact the Nursing Assistant that worked from 4:00 PM until 7:00 PM on 01/31/25 and from 3:00 PM until 7:00 PM on 02/01/25. 40197 8. Resident #33 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, and diabetes type 2. The active care plan, last reviewed 9/6/24, included a focus area for Activities of Daily Living (ADLs) self-care performance deficit related to activity intolerance, impaired balance and is at risk for further decline. The interventions included one person assistance for bathing/showering and personal hygiene. The care plan did not include any refusals of nail care. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #33 was cognitively intact and was dependent on staff for bathing and personal hygiene. A review of Resident #33's nursing progress notes from 2/1/24 to 2/2/25 revealed no refusals of nail care documented. A review of the Nurse Aide (NA) shower sheets for December 2024 to February 2025 revealed that nails were cleaned but not cut. A shower sheet dated 2/1/25 indicated that Resident #33's nails were cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/2/25 at 11:10 AM, an interview and observation were conducted with Resident #33. A dark substance was present under the nails to both hands and jagged nails were observed to the third and fourth finger on the right hand. Resident #33 explained that he was not able to see very well and relied on others to care for his fingernails. He stated that occasionally a nurse came by to cut his fingernails. An observation occurred on 2/3/25 at 11:33 AM while Resident #33 was lying in bed. A dark substance was present under the nails to both hands and jagged nails were observed on the third and fourth fingers of the right hand. A phone interview occurred on 2/4/25 at 1:02 PM with NA #7. She was assigned to care for Resident #33 on 2/1/25 and had indicated on the shower sheet that she had cleaned his fingernails. NA #7 explained that she provided Resident #33 with his scheduled shower on 2/1/25 and had used the stick to clean under his nails. She stated she observed the jagged nails and indicated she could have filed them but didn't stating, Maybe I'll try that next time I see they are jagged. She was unsure if she had let the nurse know of the jagged fingernails. A phone interview with a family member for Resident #33 was completed on 2/4/25 at 4:23 PM. She indicated that nail care was a concern when she visited, and she would often let staff know when she identified a dark substance under his fingernails or if they needed to be trimmed. On 2/5/25 at 9:49 AM, NA #2 was interviewed and indicated when she provided personal care to Resident #33, she would use a washcloth to clean his fingernails but didn't cut them. She could not recall if she had noticed the jagged nails to his right hand when she had cared for him on 2/3/25. Attempts were made to contact NA #3 on 2/4/25 and 2/5/25, who was assigned to care for Resident #33 on 2/2/25 during the 7:00 AM to 7:00 PM shift but were unsuccessful. The Director of Nursing (DON) was interviewed on 2/4/25 at 10:00 AM and explained the NAs were to complete nail care during showers/baths, personal care and as needed. For diabetic residents, the NAs were able to clean and file fingernails and if they needed to be trimmed would need to let the nurse know. On 2/4/25 at 10:33 AM, an interview occurred with the Infection Control nurse who explained that she randomly went throughout the facility checking fingernails and would clean, file and trim as needed at times. The Infection Control nurse stated that ultimately it was the responsibility of the NAs to perform nail care during personal care and baths. On 2/4/25 at 10:39 AM, an observation was conducted of Resident #33's fingernails with the Infection Control Nurse. She confirmed they had a dark substance under the nails to both hands and there were 2 fingernails that were jagged on the right hand. Resident #33 agreed to let the nurse care for his fingernails. Nurse #1 was interviewed on 2/4/25 at 12:50 PM. She worked in the facility as both the wound care nurse and a floor nurse when needed. She explained that nail care should be completed by the NAs during personal care and baths. They are to clean under the fingernails and file if uneven. If the resident was diabetic and needed their nails cut the NA would let the nurse know. She had not been made aware that Resident #33 had jagged fingernails on his right hand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another interview was completed with the DON on 2/6/25 at 9:32 AM and stated Resident #33's jagged fingernails should have been reported to the nurse so they could have trimmed them. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.

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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. 46095 Based on observations, record review and staff interviews, the facility failed to maintain a safe environment as evidenced by a housekeeping staff member mopping the entire width of the F hallway (Rooms 135-146) which would have required residents, staff, and visitors to walk on the wet floor. This was for 1 out of 5 resident hallways. Findings included: A continuous observation was conducted on 02/03/25 from 10:30 AM until 10:35 AM of the Housekeeping Manager mopping the floor at the top of the F Hall and the hall area in front of the nurse's station. The Housekeeper Manager was actively mopping the area to the left then middle of hall. When asked if the floor was wet all the way across the hall, she stopped to let the surveyor walk through to the right side of the hall where there was a 2 foot area of dry floor. As soon as the surveyor walked through the area the Housekeeper Manager mopped the only dry area left. The total area was 4 foot (ft) x 10 ft. The floor was wet completely across the hall with the wet sign located in middle of walkway. An interview was conducted with the Housekeeping Manager on 02/03/25 at 10:40 AM. She stated she mops and assists with other housekeeping duties daily. She then stated she did mop completely across the hall/walk area but did not give a reason why. She explained that she normally mops half of the hall area at a time and will wait for that half to dry prior to mopping the other side. She further stated that waiting for the floor to completely dry before starting the other side prevents residents and staff from accidentally falling. An interview was conducted with Nurse #1 on 02/03/25 at 10:48 AM. She stated some housekeepers mop completely across the hall area and some only mop one side at a time. She verified the floor at the top of the F Hall and the hall area in front of the nurse's station were wet completely across. She explained that was why she walked around the other side of the nurse's station because she did not want to fall. An interview was conducted with the Housekeeping District Manager on 02/03/25 at 3:15 PM. He explained when housekeepers were mopping the halls they should be mopping half of the hall at a time. After one side was completely dry, they were to mop the opposite side. He stated this was to prevent anyone from falling. He then stated all housekeeping staff have been educated and trained to mop the floors in that manner.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46095 Based on observations, record reviews, staff interviews, resident interviews, and resident family interviews, the facility failed to provide sufficient nursing staff to provide incontinence care in a manner to maintain the residents' dignity (Resident #1, #206, and #9) and failed to provide assistance with Activities of Daily Living (ADL) to residents who required extensive to total care with nail care and incontinence care (Residents #9, #32, #35, #51, #205, #1, #206, and #33). This affected 8 of 18 sampled residents reviewed for sufficient staffing. The findings included: This tag is cross-referred to: 1. F550: Based on record review, observations, resident, resident family, and staff interviews, the facility failed to provide incontinence care in a manner to maintain the residents' dignity for 3 of 5 residents reviewed for dignity (Residents #1, #206 ,and #9). 2. F677: Based on record reviews, observations, and family, resident, and staff interviews, the facility failed to provide nail care and/or incontinence care for 8 of 13 residents dependent on staff for activities of daily living (ADL) (Residents #9, #32, #35, #51, #205, #1, #206, and #33). Review of staff posting, assignment sheets, and the time cards revealed: On 01/12/25 there was 1 Nursing Assistant (NA) providing resident care from 3:40 PM until 7:00 PM for a census of 50 residents. On 01/27/25 there was 1 NA providing resident care from 4:00 PM until 7:00 PM for a census of 52 residents. On 01/30/25 there was no NA working the floor from 4:00 PM until 7:00 PM and 1 NA providing resident care from 7:00 PM until 11:00 PM for a census of 54 residents. On 01/31/25 there was 1 NA providing resident care from 4:00 PM until 11:00 PM and from 11:00 PM until 7:00 AM for a census of 54 residents. On 02/01/25 there was 1 NA providing resident care from 3:00 PM until 7:00 PM for a census of 54 residents. On 02/02/25 there was 1 NA providing resident care from 3:00 PM until 7:00 PM for a census of 54 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted on 02/05/25 at 10:40am with Nurse #2. She stated she hadn't been at the facility working for about a month. She explained when she started working at the facility it was on day shift however, about a month later she went to night shift because she was overwhelmed on day shift due to not having enough Nursing Assistants (NA) working. She further explained she was no longer a full-time employee, she only worked as needed because of her concerns with staffing. She went on to say when she worked 7:00 PM-7:00 AM there were nights, and could not recall how many, she would come in and there wouldn't be an NA until 11:00 PM. She indicated she would be over a medication aide, have her own medication cart to pass out medications, do blood sugars, and there were times the residents received incontinent care and/or were assisted to bed later than they should have. She went on to say she felt like there needed to be a plan in place when an NA wasn't coming to work, but the facility didn't have a plan when an NA was not going to come to work. She then stated the nurses assisted as much as they could, but they were trying to pass out medications. A phone interview was conducted on 02/05/25 at 06:09 PM Nursing Assistant (NA) #8. She stated she normally worked 7:00 PM-7:00 AM and she had to work the whole building by herself two to three times a week. She also stated it was not possible to keep every person dry when working by herself or conduct routine rounds and provide incontinent care at least every two hours. She further explained some nurses would assist, and some wouldn't. She concluded the interview by stating, you just can't operate a building like that. An interview was conducted on 02/06/25 at 9:01 AM with Nursing Assistant (NA) #6. She stated she had worked at the facility for 9 years and she had never seen staffing as bad as it was over the past three to four months. She explained she worked all shifts but at times when she would come in at 11:00 PM there would not be any NAs in the building, and she would normally have to work by herself on the night shift. She indicated there was one nurse, a med aide and herself on night shift. She further explained there was no way to keep all of the residents dry and do all of the required tasks when there were only 2 NAs on first shift or 1 NA at any time. She went on to say the census was normally above 50 residents. An interview was conducted on 02/06/25 at 9:33 AM with the Director of Nursing (DON). She stated staffing was hard, she had requested to use an agency, and to give bonuses to the staff that did come in and work extra. However, she explained both requests had to be approved by corporate and they had not approved the facility to use agency. She explained qualified department heads would assist the NAs when they were short staffed to ensure the residents were fed and provided with incontinent care. She also stated she expected all residents to be fed and provided incontinent care timely. She explained on the day shifts when there were 2 NAs scheduled it was not possible to complete all showers and tasks. She verified the staffing numbers on 01/12/25, 01/27/25, 01/30/25, 01/31/25, 02/01/25, and 02/02/25 were correct.