

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Biltmore Haven Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3864 Sweeten Creek Road Arden, NC 28704	
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 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 accurately code Minimum Data Set (MDS) assessments in the areas of range of motion, dental, Preadmission Screening and Resident Review (PASRR), physical restraints, and active diagnoses for 5 of 36 assessments reviewed for MDS accuracy (Residents #4, #13, #49, #50, and #59). Findings included: a. Resident #4 was admitted to the facility on [DATE]. His cumulative diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right dominant side and contracture of muscle-left upper arm. An activities of daily living (ADL) care plan initiated on 10/10/18 revealed Resident #4 had a self-care performance deficit related to limited mobility as evidenced by right sided upper and lower extremity weakness, hemiplegia/hemiparesis and bilateral upper extremity contractures. Interventions included a right resting hand splint for 2 hours during the day or as tolerated and side rails: left side mobility aide. A bed rail assessment signed by Resident #4 and dated 06/17/26 revealed Resident #4 utilized a left side rail/assist bar as an enabler to promote independence. The annual MDS assessment dated [DATE] revealed Resident #4 had intact cognition and no impairment of the upper or lower extremities. He was independent with rolling left and right and required supervision or touching assistance with moving from a sitting-to-lying position, lying-to-sitting position, and sit-to-stand position. The MDS indicated Resident #4 used a physical restraint daily and bed rail was marked as the type of restraint utilized. The quarterly MDS assessment dated [DATE] revealed Resident #4 had intact cognition, no impairment of the upper extremity and impairment of both sides of the lower extremities. He was independent with rolling left and right and required supervision or touching assistance with moving from a sitting-to-lying position, lying-to-sitting position, and sit-to-stand position. The MDS indicated Resident #4 used a physical restraint daily and bed rail was marked as the type of restraint utilized. During an interview on 07/30/26 at 1:37 PM, the MDS Coordinator revealed the facility used to have another staff member that assisted with completing MDS assessments; however, the staff member was no longer employed due to the inaccuracy errors discovered in the MDS assessments she completed. The MDS Coordinator explained the side rail used by Resident #4 was an enabler to promote independence and should not have been coded as a physical restraint. The MDS Coordinator also stated Resident #4 had a right hand contracture and the MDS assessments should have reflected he had an impairment of the upper extremity. b. Resident #13 was admitted to the facility on [DATE]. A dental progress note dated 01/16/26 revealed Resident #13 was edentulous (missing all natural teeth). The annual MDS assessment dated [DATE] revealed Resident #13 had no dental issues. During an interview on 07/31/26 at 10:25 AM, the Regional MDS Consultant confirmed Resident #13 was edentulous and the MDS assessment dated [DATE] was coded incorrectly. c. Resident #49 was admitted to the facility on [DATE] with diagnoses that (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345477
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included bipolar disorder and anxiety disorder. A PASRR Level II determination notification letter dated 06/17/25 revealed Resident #49 had a Level II PASRR with no expiration date. The annual MDS assessment dated [DATE] revealed Resident #49 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 07/30/26 at 1:37 PM, the MDS Coordinator revealed she completed the PASRR section of the MDS assessment. The MDS Coordinator reviewed Resident #49's Level II PASRR determination notification letter dated 06/17/25 and explained when completing the MDS assessment, she looked at the year wrong thinking the letter was dated 2026 and not 2025. She stated it was an honest mistake and the MDS assessment dated [DATE] should have been coded to reflect Resident #49 had a Level II PASRR.d. Resident #50 was admitted to the facility on [DATE] with diagnoses that included a group of permanent movement and posture disorders that affects muscle control, coordination and balance. A bed rail assessment dated [DATE] revealed Resident #50 utilized bilateral half-side rails as an enabler to promote independence. The quarterly MDS assessment dated [DATE] revealed Resident #50 had severe cognitive impairment and had impairment on both side of the upper and lower extremities. He required substantial/maximal assistance with rolling left-to-right and partial/moderate assistance with moving from a sitting-to-lying position, lying-to-sitting position, and sit-to-stand position. The MDS indicated Resident #50 used a physical restraint daily and bed rail was marked as the type of restraint utilized. During an interview on 07/30/26 at 1:37 PM, the MDS Coordinator revealed the facility used to have another staff member that assisted with completing MDS assessments; however, the staff member was no longer employed due to the inaccuracy errors discovered in the MDS assessments she completed. The MDS Coordinator explained the side rail used by Resident #50 was an enabler to promote independence and should not have been coded as a physical restraint on the MDS assessment dated [DATE].e. Resident #59 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (other than bipolar) and anxiety disorder. A Psychiatric FNP (Family Nurse Practitioner) progress note dated 05/01/25 revealed Resident #59 required follow-up of chronic psychiatric conditions that included paranoid schizophrenia and depression. The Psychiatric FNP noted Resident #59 received bupropion 150 milligrams (mg) for major depression and although she met the criteria for paranoid schizophrenia, he would not be starting her on an antipsychotic medication because she was unlikely to provide consent due to family reporting Resident #4 had little insight that her delusions were not real. The admission MDS assessment dated [DATE] revealed schizophrenia was not coded as an active diagnosis. During an interview on 07/30/26 at 1:37 PM, the MDS Coordinator revealed she had been in her position since 10/05/25. The MDS Coordinator explained that even though Resident #59 refused medications, she did have hallucinations and delusions and the diagnosis of schizophrenia should have been coded on the MDS assessment. During interviews on 07/30/26 at 1:45 PM and 07/30/26 at 4:30 PM, the Regional MDS Consultant revealed they had discovered inaccuracies in coding and completing late MDS assessments and put a performance improvement plan into effect. He explained the inaccuracies were discovered by utilizing a software program that ran a scrubber report which he described as a report that provided compliance alerts (late completion/transmission) and quality alerts (coding/Care Area Assessments/care plans) based on the information entered in the MDS assessments that was used to ensure MDS assessments were completed accurately. The Regional MDS Consultant stated the MDS Coordinator was to run a scrubber report after each MDS assessment was completed and review with the clinical team prior to submission. During an interview on 07/30/26 at 4:45 PM the Administrator stated he expected for all MDS assessments to be completed accurately. The facility provided a plan of correction that was not (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accepted by the state agency due to the initial audit the facility conducted to identify other residents that had the potential to be affected only included open, unsubmitted and recently submitted MDS assessments which was not sufficient to capture all late completion or discrepancies in inaccurate coding of MDS assessments. In addition, the facility's plan of correction did not identify how visual assessments of the MDS would be identified for coding inaccuracies.		

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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 a comprehensive Minimum Data Set (MDS) assessment no later than 14 calendar days of the Assessment Reference Date (ARD, referring to the last day of the assessment period) for 1 of 36 sampled residents (Residents #13). Findings included: Resident #13 was admitted to the facility on [DATE]. Review of Resident #13's electronic medical record revealed an annual MDS assessment dated [DATE] that was marked as completed on 06/03/26. The MDS assessment should have been completed on 05/20/26 (ARD plus 14 calendar days) but was not completed until 06/03/26 which made the assessment 14 days late. During an interview on 07/30/26 1:37 PM, the MDS Coordinator revealed she had been in her position since 10/05/25. She explained at the time the assessment was completed for Resident #13, the facility had a lot of new admissions and she got overwhelmed with completing MDS assessments. The MDS Coordinator verified Resident #13's MDS assessment was not completed within the regulatory timeframe. During interviews on 07/30/26 at 1:45 PM and 07/30/26 at 4:30 PM, the Regional MDS Consultant revealed they had discovered inaccuracies in coding and completing late MDS assessments and put a performance improvement plan into effect. He explained the inaccuracies were discovered by utilizing a software program that ran a scrubber report which he described as a report that provided compliance alerts (late completion/transmission) and quality alerts (coding/Care Area Assessments/care plans) based on the information entered in the MDS assessments that was used to ensure MDS assessments were completed accurately. The Regional MDS Consultant stated the MDS Coordinator was to run a scrubber report after each MDS assessment was completed and review with the clinical team prior to submission. The Regional MDS Consultant confirmed Resident #13's annual MDS assessment was completed late and stated he was not sure what happened. During an interview on 07/30/26 at 4:45 PM the Administrator stated it was his expectation for MDS assessments to be completed and submitted within the regulatory timeframes. The facility provided a plan of correction that was not accepted by the state agency due to the initial audit the facility conducted to identify other residents that had the potential to be affected only included open, unsubmitted and recently submitted MDS assessments which was not sufficient to capture all late completion or discrepancies in inaccurate coding of MDS assessments. In addition, the facility's plan of correction did not identify how visual assessments of the MDS would be identified for coding inaccuracies.		

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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 observations, record review, resident and staff interviews, the facility failed to provide showers as scheduled to a resident dependent on staff assistance for bathing for 1 of 6 residents reviewed for activities of daily living (Resident #13). Findings included: Resident #13 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (trouble breathing), chronic respiratory failure, and seizure disorder. The annual Minimum Data Set (MDS) dated [DATE] documented Resident #13 had severe cognitive impairment. She was dependent on staff assistance with showering/bathing and transfers. She displayed no behaviors and did not reject care during the MDS assessment period. An activities of daily living (ADL) care plan last revised on 06/03/26 revealed Resident #13 had an ADL self-care performance deficit related to encephalopathy (disturbance of brain function that causes altered mental state) and impaired mobility. Interventions included dependence on staff with showering per resident's requested schedule and routine. Further review revealed no care plan for refusal of care or a care plan for cognitive loss. Review of the June 2026 and July 2026 staff progress notes revealed no entries related to Resident #13 refusing showers and/or bathing assistance. A Nurse Practitioner (NP) progress note dated 07/09/26 revealed Resident #13 was alert and oriented to person, place and time. The NP further noted Resident #13's speech was clear and she was able to provide answers to questions asked. Review of the Nurse Aide (NA) point of care documentation report for July 2026 revealed Resident #13 was scheduled to receive a shower on Monday and Thursday during the hours of 7:00 PM to 7:00 AM and as needed. Further review revealed the only shower Resident #13 received was documented as provided on 07/27/26, the other scheduled shower days (07/02/26, 07/06/26, 07/09/26, 07/13/26, 07/16/26, 07/20/26, and 07/30/26) were documented as not attempted and/or refused. Review of the July 2026 shower sheets provided by the Assistant Director of Nursing (ADON) revealed Resident #13 received a bed bath on 07/09/26 and showers on 07/22/26 and 07/27/26. The ADON was unable to provide any additional shower sheets for Resident #13 for the month of July 2026. During an observation and interview on 07/27/26 (a Monday) at 12:13 PM, Resident #13 was lying in bed wearing a hospital gown and her hair was noted to have been disheveled and had an oily sheen. Resident #13 was alert and able to answer simple, direct questions. Resident #13 reported she was supposed to receive two showers a week, but she didn't always get them as scheduled. Resident #13 stated she received a shower last Thursday (07/23/26) which was the first one she had received in over three weeks. Resident #13 could not recall the name of the staff member she spoke with but stated she had voiced her concerns about not receiving her showers as scheduled. An unsuccessful telephone attempt was made on 07/31/26 at 7:49 AM for an interview with NA #6 who documented Resident #13's shower was not attempted or provided on 07/02/26. A phone interview was conducted on 07/31/26 at 8:10 AM with NA #7 who documented Resident #13 refused showers on 07/06/26, 07/09/26, 07/13/26, and 07/20/26. NA #7 revealed she was routinely assigned to provide Resident #13's care during the hours of 7:00 PM to 7:00 AM. NA #7 reported Resident #13 was dependent on staff for care and did have confusion at times, but she was able to voice her needs. NA #7 stated Resident #13 frequently refused her scheduled showers. She explained Resident #13 would state she did not feel like getting a shower if it was offered too late in the evening or she would forget a shower was offered and then state she didn't receive her scheduled shower. NA #7 stated when Resident #13 refused a shower, she always offered to give her a bed bath and change her bed linens, sometimes Resident #13 would agree and other times she wouldn't. NA #7 stated when Resident #13 refused a shower, she (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the refusal in the computer, informed the hall nurse and then informed the oncoming NA (7:00 AM to 7:00 PM) for them to try and provide the resident with a shower. An unsuccessful telephone attempt was made on 07/31/26 at 8:42 AM for an interview with NA #8 who documented Resident #13's shower was not attempted or provided on 07/30/26. During an interview on 07/31/26 at 5:13 PM, Confidential Staff Member #1 revealed Resident #13 did have confusion at times but for the most part she was alert and oriented and able to voice her needs. Confidential Staff Member #1 recalled Resident #13 was begging for a shower just last week and seemed to remember Resident #13 had talked to the Administrator. Confidential Staff Member #1 reported that the NAs on the evening shift frequently did not provide resident showers as scheduled but was not sure why. Confidential Staff Member #1 stated Resident #13 was provided with a shower this past Monday (07/27/26) and Resident #13 had voiced it was the first shower she had in weeks. Confidential Staff Member #1 stated anytime they provided care or offered a shower to Resident #13, she never refused. During an interview on 07/31/26 at 5:03 PM, the Director of Nursing (DON) could not recall the date but stated Resident #13 had mentioned missing one shower and she (DON) made sure a shower was provided to Resident #13 the next day. The DON explained Resident #13 would refuse care at times but not constantly. During an interview on 07/31/26 at 6:10 PM, the Administrator stated staff were expected to provide residents with their showers as scheduled. The Administrator revealed Resident #13 had behaviors of refusing care, including showers, that should have been documented in her medical record. He explained Resident #13 was on his daily room rounds and any time she mentioned not receiving her scheduled shower, he made sure one was provided.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and Nurse Practitioner (NP), staff, and resident interviews, the facility failed to follow physician order for referral to Gastrologist for routine endoscopy (procedure to examine esophagus, stomach, and upper part of small intestine) and colonoscopy (procedure to examine large intestine and rectum). These practices occurred for 1 of 3 residents reviewed for care to maintain wellbeing (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE]. Diagnoses included type 2 diabetes, chronic obstructive pulmonary disease (COPD), and Barrett's Esophagus (condition where the flat lining of the lower esophagus becomes damaged due to long term acid reflux). Review of physician progress note for Resident #57 written by the previous Nurse Practitioner (NP) dated 1/21/26 revealed Resident #57 requested a referral to for endoscopy and colonoscopy. Resident #57 had Barrett's esophagus and had recurring endoscopy every 3 years, was due for a colonoscopy, and was previously seen by gastrology. Entered order for referral to gastrology for Resident #57. Review of physician order for Resident #57 written and entered by the previous NP dated 1/21/26 revealed referral to Gastrologist for endoscopy and colonoscopy for Barrett's Esophagus. One time order for 30 days. Attempted to contact previous NP and they were unable to be reached. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively intact. An interview was conducted with Resident #57 on 7/27/25 at 10:45 AM. Resident #57 revealed that she had a diagnosis of Barrett's Esophagus and earlier this year she had spoken with the previous NP about a referral for scheduling a routine endoscopy and colonoscopy. Resident #57 stated the previous NP stated that she would make the referral for the gastrologist and to her knowledge that appointment had not been made and she had not received her endoscopy or colonoscopy. She revealed she had not asked nursing staff or the new facility NP about her appointment because she assumed they were working on it and would let her know when the appointment had been scheduled. Resident #57 stated that she was not having any current flare ups with her disease but would like to see the gastrologist and have her routine endoscopy and colonoscopy to make sure there were no issues or concerns. An interview was conducted with the Nurse Practitioner (NP) on 7/29/26 at 9:30 AM. The NP revealed that she began working at the facility in February 2026. She stated that she was not aware of previous orders for an endoscopy or colonoscopy or that those orders had not been completed. The NP revealed she was not aware of any current flare ups from Resident #57's disease but agreed that routine colonoscopy should be completed as ordered. Review of physician order for Resident #57 dated 7/29/26 written by the NP revealed referral to Gastrologist for endoscopy and colonoscopy for Barrett's Esophagus. An interview was conducted with the facility Scheduler on 7/30/26 at 12:45 PM. She stated she was responsible for scheduling all the outside medical appointments for the residents. The Scheduler stated that she believed she had not received any referrals for scheduling an appointment for Resident #57 to see the Gastrologist until yesterday (7/29/26). She revealed Resident #57 had an appointment with gastrology for an endoscopy and colonoscopy scheduled for 9/04/26. An interview on 7/31/26 at 5:05 PM with the Director of Nursing (DON). The DON stated she was not aware of Resident #57 having a previous order for a referral to be made to the Gastrologist. She revealed in that past they had problems with their NPs and physicians writing and entering their own orders with a stop or discontinued date. The DON stated the facility NPs and physicians were not informing nursing staff or the Scheduler about the orders and then the orders would discontinue after their stop date, which she believed might have been what happened with this order. She revealed in her opinion (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this was just an oversight on the previous NP and nursing staff's part. The DON indicated they have asked the facility NPs and physicians to please stop putting a stop or discontinued date on their orders and to notify the nursing staff and the Scheduler when they have written a new order or entered a new order for a resident so staff will know and they can follow-up with the order. The DON stated she expected nursing staff to review all physician orders and any referrals for appointments were scheduled as ordered and in a timely manner. An interview was conducted with the Administrator on 7/31/26 at 5:40 PM. The Administrator revealed that he expected nursing staff to review all physician orders and assure any order or referrals for appointments are being scheduled as ordered and in a timely manner.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, Nurse Practitioner (NP), staff, and resident interviews, the facility failed to follow through with the eye physician's recommendations for an Ophthalmology consult for cataract surgery. This practice occurred for 1 of 1 resident reviewed for care and treatment to maintain vision (Resident #57). The findings included: Resident #57 was admitted to the facility on [DATE] with readmission on [DATE]. Diagnoses included type 2 diabetes, chronic obstructive pulmonary disease (COPD), and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was cognitively intact and was dependent on staff with activities of daily living (ADL). Resident #57 was coded for adequate vision. Review of Optometrist progress note from facility vision clinic for Resident #57 dated 3/03/26 revealed cataracts were visually significant in both eyes. The Optometrist recommended cataract surgery, an Ophthalmology consult, and inform facility physician. Resident #57 wanted to proceed with surgery. An interview was conducted with Resident #57 on 7/27/25 at 10:45 AM. Resident #57 revealed that she had been seen by the facility eye doctor in March 2026. She stated during that visit, the eye doctor had informed her that she had cataracts that would require surgery. Resident #57 revealed that she agreed with the eye doctor about needing surgery to remove her cataracts and the eye doctor was supposed to put in a referral for cataract surgery. Resident #57 stated to her knowledge no appointment had been made for her to have her cataracts removed and she would like to have the surgery as soon as possible so that her vision does not continue to get worse. An interview was conducted with the Nurse Practitioner (NP) on 7/29/26 at 9:30 AM. The NP revealed that she came here in February 2026. She stated that she was not aware of previous orders for cataract surgery or that those orders had not been completed. The NP revealed she was not aware of any current vision problems with Resident #57 but agreed the order or referral for cataract surgery should have been completed as ordered. An interview was conducted with the facility scheduler on 7/30/26 at 12:45 PM. She stated she had not received any orders or referrals for Resident #57 to be seen for cataract surgery. An interview was conducted with the Director of Nursing (DON) on 7/31/26 at 5:05 PM. The DON stated she was not aware of Resident #57 having a previous order for a referral to be made to the Ophthalmologist for cataract surgery. She revealed typically when a resident was seen at the in-house facility eye clinic, the clinician would email her their treatment report with their recommendations. The DON stated she would review the report, notify nursing staff of the recommendations, notify the facility physician, and obtain any orders needed for further treatment. She revealed she could not explain why Resident #57's recommendation for cataract surgery had not been scheduled, other than it had just been overlooked. The DON stated that all physician orders, recommendations, and referrals should be scheduled as ordered and in a timely manner. An interview was conducted with the Administrator on 7/31/26 at 5:40 PM. The Administrator revealed that he expected nursing staff to review all physician orders and assure any order or referrals for appointments are being scheduled as ordered and in a timely manner.		

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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 observations, record review, residents, staff, and Nurse Practitioner (NP) interviews, the facility failed to ensure resident's toenails were trimmed and podiatry services were arranged for 3 of 3 residents reviewed for foot care (Resident #34, Resident #44, and Resident #65). The findings included: 1. Resident #34 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, heart disease, and muscle weakness. Review of revised care plan dated 4/24/26 revealed Resident #34 was care planned for activities of daily living (ADL) self-care performance deficits related to her disease process. Resident #34 was dependent on staff for her ADL care. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact and had been assessed as requiring substantial assistance from staff with all ADL care. Resident #34 was also coded as having no refusals with care. Review of Resident #34's weekly nursing assessments from January 2026 through July 2026 revealed no notation that her toenails were long and thick and needed trimmed. Review of the facility's podiatry clinic schedules for 4/07/26, 4/28/26, and 6/26/26, revealed Resident #34 was not seen by the podiatrist. There were no consultation reports or notations in Resident #34's Electronic Medical Record (EMR) that she had been referred to or seen by a podiatrist since her admission to the facility. A telephone interview with Resident #34's Responsible Person (RP) on 7/29/26 at 8:59 AM revealed she visited daily and would assist Resident #34 with fingernail care. She stated that due to Resident 34's toenails being long and thick she could not assist with her toenail care and did not believe Resident #34's had been cut or trimmed since she had been admitted to the facility. Resident #34's RP revealed that about 4 months ago, Resident #34 had complained about her toenails being long and that her left great toenail was a little tender on the side and she believed her toenail had become ingrown. Resident #34's RP stated that she and Resident #34 informed Nurse Aide (NA) #1 on that date about Resident #34's toenails and NA informed them the facility held a podiatry clinic each month and to speak with social worker (SW) #1 about adding Resident #34's name to the schedule so she could be seen by podiatry. Resident #34's RP revealed that she went that day or the following day and spoke with SW #1 about Resident #34's toenails and asked that she be added to the schedule to be seen at the next scheduled podiatry clinic. Resident #34's RP stated SW #1 informed that she would send the referral to podiatry that day and they should be able to add Resident #34 to the next scheduled clinic. Resident #34's RP stated her conversation with SW #1 about adding Resident #34's name to the podiatry clinic schedule was 4 months ago, Resident #34's name had still not been added to the schedule, and she still had not been seen by podiatry. Resident #34's RP revealed she had followed up with SW #1 about Resident #34's podiatry clinic referral and asked how long it took to add a resident's (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	name to the schedule and each time SW #1 stated the referral had been completed, Resident #34 should be on the following months schedule, but Resident #34 had still not been added to the schedule or seen by the podiatrist. Resident #34's RP stated Resident #34 had not complained of any pain as of now with her toenails only that the area around her left great toenail was a little tender. Resident #34's RP revealed Resident #34's had recently started to receive physical therapy which required her to wear shoes. She stated that she was concerned the rubbing Resident #34's shoes against her toenails could cause them to become irritated and begin to cause her pain. An interview was conducted with the Nurse Practitioner (NP) on 7/29/26 at 9:30 AM. The NP stated that she was not aware of the condition of Resident #34's toenails but given her disease process she could see how her toenails may require podiatry services. She revealed the nurses were supposed to complete weekly skin and nail assessments on each resident and if a resident had nail issues that required podiatry services, they were supposed to notify the social worker to have their name added to the podiatry list. An interview and observation with Resident #34 were conducted on 7/30/26 at 2:55 PM. Resident #34 stated that she did not believe her toenails had been cut since her admission and that she also had not been seen by podiatry. Resident #34 revealed that her left great toenail was tender to the touch and she believed that her toenail had become ingrown. She stated that she had informed nursing staff about it over the past few months, and they had told her that she would need to see podiatry, but she had not been seen by podiatry yet and was not aware if an appointment had been made. Observation of Resident #34's right and left foot revealed thick, long toenails. Resident #34's right great toenail was thick and raised away from skin and her left great toenail was also thick and raised away from skin and the skin was slightly red in color on the side she believed to be ingrown. An interview and observation were conducted with Nurse #3 on 7/30/26 at 2:55 PM. Nurse #3 routinely cared for Resident #34 during the 7AM to 7 PM shift. Nurse #3 stated that she could not recall the condition of Resident #34's toenails but believed she had overheard Resident #34's RP speaking about Resident #34 needing to be seen by podiatry or was waiting to be seen by podiatry. Nurse #3 observed Resident #34's toenails and stated that due to the condition of Resident #34's toenails being that long and that thick nursing staff would not have been able to care for them in-house and agreed that Resident #34 should have been seen by a podiatrist. Nurse #3 explained that usually when nursing staff saw a resident who required more toenail care then she felt comfortable providing they would tell SW #1 who was responsible for adding the resident to the podiatry list. Nurse #3 further explained that she was not exactly sure the exact time frame but she did believe typically once a podiatry referral was completed for a resident, they were usually seen at the next scheduled clinic and if a resident's toenails were bad enough, they could even arrange some type of emergency visit if needed. An interview was conducted with Social Worker (SW) #1 on 7/30/26 at 3:30 PM. SW #1 stated that she handled the schedule for the podiatry clinic, and the podiatry clinic was held every other month or every month depending on how many residents needed to be seen. SW #1 further explained that the last podiatry clinic was held 6/26/26 and the next podiatry clinic was scheduled for 8/17/26. SW #1 stated that she did not recall any nursing staff or Resident #34's RP requesting Resident 34 to be (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added to the podiatry prior to this week. SW #1 revealed she had completed a referral for Resident #34 to be seen by the podiatrist and for her name to be added to the next podiatry clinic scheduled for 8/17/26. An interview was conducted with NA #1 on 7/31/26 at 10:35 AM. NA #1 stated that she had noticed Resident #34's right and left great toenails being long and very thick. NA #1 revealed about 4 months ago Resident #34 and her RP had complained of Resident #34's toenails needed to be cut and that her left great toenail was feeling a little tender and they were concerned that the toenail had become ingrown. NA #1 stated that she informed Resident #34 and her RP that Resident #34 would need to be seen by the podiatrist and to speak with SW #1 about having Resident #34 added to the podiatry clinic schedule. NA #1 revealed a day or two after her conversation with Resident #34 and her RP regarding the podiatry clinic, Resident #34's RP stated that she had spoken with SW #1 about adding Resident #34 to the podiatry clinic schedule and that SW #1 was supposed to be completing the referral for Resident #34 to be seen at the next clinic. NA #1 stated after Resident #34's RP had spoken with SW #1, Resident #34's RP checked each month to see if Resident #34 had been added to the podiatry clinic schedule and each month Resident #34 name was still not on the list and to her knowledge Resident #34 had not been seen or treated by the podiatrist. An interview was conducted with the Director of Nursing (DON) on 7/31/26 at 5:05 PM. The DON stated that nursing staff discussed nail care and toenail care daily during the nursing huddles. The DON further explained that she was not aware of any issues with Resident #34's toenail care. The DON stated that podiatry clinic was held frequently and SW #1 was responsible for scheduling residents for the podiatry clinic. The DON also stated that nursing staff should be assessing nail care for all residents and referrals for the podiatry clinic should be completed timely whether the resident requests podiatry services or they are required. An interview was conducted with the Administrator on 7/31/26 at 5:40 PM. The Administrator stated that he understood the concerns with Resident #34's toenails. The Administrator stated that nursing staff should observe resident's toenails when they complete their skin assessments and referrals should be completed promptly for any resident who requested or required podiatry services. 2. Resident #65 was admitted to the facility on [DATE] with diagnoses which included acidosis (too much acid in one's body), chronic bronchitis, asthma and diabetes mellites. Review of comprehensive care plan dated 5/04/26 revealed Resident #65 was care planned for functional limitation of self-care skills related to deconditioning with interventions that included for aides to check nail length and trim and clean on bath day and as necessary. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 was cognitively intact and required moderate assistance with oral and personal hygiene and was dependent on staff for toileting, showers and baths, lower body dressing and putting on footwear. (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65 was also coded as having no rejection of care and was unable to walk. Resident #65's weekly nursing assessments from May 2026 through July 2026 revealed no notation that her toenails were long, thick and needed trimmed. An observation and interview of Resident #65 were conducted on 7/28/26 at 4:06 PM. Resident #65's right great toe was visible, protruding from under the bed covers while the rest of her lower extremities remained covered. The right great toe had a long, thick toenail extending about three-quarters of an inch beyond the tip of the toe. When asked, Resident #65 stated she would refuse fingernail trimming but did not care if someone trimmed her toenails. An interview with Nurse Aide (NA) #1 on 7/29/2026 at 3:07 PM revealed that she had given Resident #65 a shower earlier that day (7/29/2026) and that Resident #65 refused fingernail care and needed toenail care. NA #1 stated that Resident #65 would not let her scrub or clean the fingernails or toenails during the shower. NA #1 stated she was going to inform the Social Worker that Resident #65 needed a podiatry appointment. An interview with the Social Worker on 7/30/26 at 3:30 PM revealed Resident #65 had not been seen by podiatry but was added to the list to be seen as a new patient at the next podiatry visit. An interview conducted with NA #2 on 7/31/26 at 9:54 AM revealed that she had assisted Resident #65 with showers and did not remember anything unusual about Resident #65's toenails. NA #2 stated she had no experience with Resident #65 refusing care. NA #2 stated she would let the nurse know if she had noticed long toenails during showers. An interview with Nurse #1, who was assigned to Resident #65, on 7/31/26 at 1:00 PM revealed that he knew nothing about the resident's toenails. He stated he expected his aides to tell him of any refusals of care or any concerns they had regarding providing care to Resident #65. An interview and observation conducted with the Director of Nursing (DON) on 7/31/26 at 3:01 PM showed that the toenails on both of Resident #65's feet were very long and thick, overhanging the great toes by approximately three-quarters of an inch. Resident #65's other toenails were long enough to curl over the ends of the toes. The DON stated she expected NAs to make more than one attempt to provide care if Resident #65 refused, and to inform the nurse of any refusals of care. The DON stated that on shower days NAs fill out a shower sheet and let the nurse know if there are any concerns regarding skin and fingernails and toenails. The assigned nurse was expected to assess the toenails and let the Social Worker know if the resident needs to be added to the podiatry list. An interview conducted with the Administrator on 7/31/26 at 5:41 PM revealed that when Resident #65 refused care, additional attempts with other aides needed to be made. The Administrator stated he expected aides to notify nursing immediately if a resident required a podiatry referral. 3. Resident #44 was admitted on [DATE] with diagnoses including methicillin-resistance staphylococcus aureus (MRSA) infection (antibiotic resistant infection), peripheral vascular disease (circulation disorder of the veins in the arms and legs), multiple skin cancers, hypertension, gait (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abnormalities, coordination deficits, malignant neoplasm (cancer) of the sigmoid colon, thrombocytosis (high platelet count), long-term antibiotic use, atherosclerotic heart disease (plaque buildup in arteries), and history of pulmonary embolism (blockage of arteries in lung), and was receiving Hospice care. Review of a care plan dated 4/21/26 revealed Resident #44 had an activities of daily living (ADL) self-care performance deficit related to cancer of left cheek/nostril/shoulder. Interventions included bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. A significant change Minimum Data Set (MDS) dated [DATE] revealed that Resident #44 was cognitively intact with no behaviors or rejection of care. He had no impairment of the upper or lower extremities and used a walker and wheelchair for mobility. Resident #44 needed set-up for personal hygiene and partial assistance for showering. A podiatry referral made by the Social Worker dated 7/6/26 identified thickened, dystrophic (caused by faulty nutrition, poor development, or degeneration of body tissues), or painful toenails requiring podiatry evaluation. The facility podiatry appointment schedules from April 2026 through August 2026 revealed Resident #44 was never added to the podiatry clinic list and had not been scheduled for evaluation for the 8/17/26 visit. An observation on 7/27/26 at 11:05 AM of Resident #44's toenails on both the left and right feet including all 10 toes showed them to be elongated approximately 0.25 inches with thick red-brown buildup beneath and around the nail and the cuticles were caked with red-brown buildup approximately 0.25 inches. An observation on 7/29/26 at 2:10 PM of Resident #44's toenails on both the left and right feet including all 10 toes showed them to be elongated approximately 0.25 inches, thick, brown-reddish in color with buildup beneath and around the nail, cuticles caked approximately 0.25 inches. An interview on 7/29/26 at 2:35 PM with Resident #44 revealed that he was agreeable with going to podiatry services for toenail care. An interview on 7/29/26 at 2:14 PM with Nurse #2 revealed when she observed Resident #44's toenails the growth and buildup on both the left and right feet for all 10 toenails was not recent, and Resident #44 had previously been agreeable to toenail trimming and cleaning. Nurse #2 indicated that Resident #44's toenails should have been cleaned and trimmed. An interview on 7/29/26 at 2:20 PM with Nurse Aide #3 revealed that Resident #44 refused his scheduled shower on 7/28/26. She stated the Hospice Aide assisted her on 7/29/26 to encourage Resident #44 to shower. Nurse Aide #3 reported Resident #44 refused nail cleaning and trimming during the shower and attempted to put on soiled clothing from the prior day before being convinced to change into clean clothing. She further indicated that Nurse Aides were responsible for the cleaning and trimming of a resident's toenails unless the resident was diabetic or to be seen by podiatry. Nurse Aide #3 further indicated that even if the resident was to be seen by podiatry or diabetic she could (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still clean the resident's toenails. An interview on 7/29/26 at 2:34 PM with the Director of Nursing revealed that Resident #44's toenails should have been trimmed by Podiatry due to their anatomy. She acknowledged podiatry care should have been arranged much sooner. She stated that she initiated a consultation that day. She further indicated that Resident #44's toenails on both the left and right feet should have been cleaned and that was her expectation. An interview on 7/29/26 at 3:06 PM with the Social Service Director revealed that she sent the referral on 7/6/26 but stated enrollment could take up to a month. She confirmed Resident #44 was not seen at the 6/26/26 podiatry clinic and was not scheduled for the upcoming 8/17/26 clinic and she did not know why. An interview on 7/31/26 at 5:10 PM with the Administrator revealed that he was unsure why Resident #44's toenails on both the left and right feet were not cleaned and trimmed, and confirmed staff should refer residents to Podiatry when trimming was unsafe. He stated that his expectation was that staff clean the resident's toenails during shower days or when the resident permitted.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident, staff, and Nurse Practitioner interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for 1 of 2 resident reviewed for respiratory care (Resident #73). Findings included: Resident #73 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure and chronic obstructive pulmonary disease (COPD). A review of Resident #73's care plan area revised on 06/27/26 revealed a focus indicating Resident #73 required oxygen therapy due to a history of shortness of breath and hypoxemia (low oxygen in the tissues). Interventions included administration of oxygen per physician orders. Review of Resident #73's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was cognitively intact. Resident #73 was coded as receiving oxygen therapy. A review of Resident #73's active orders included an order dated 03/12/25 for continuous oxygen at 2 liters per minute (LPM) via nasal cannula to maintain SpO2 (oxygen saturation level of the blood) 90% or greater every shift for COPD. The normal range for oxygen level for someone with COPD is 88% to 92%. A review of the July 2026 Medication Administration Record (MAR) revealed an entry for continuous oxygen at 2 LPM via nasal cannula to maintain SpO2 at 90% or greater every shift for COPD. The MAR had a daily check mark with Medication Aide (MA) #1's initials during morning shifts on 07/26/26 and 07/27/26. The flow rate was charted on the MAR by MA #1 as 2 LPM with a SpO2 of 96% on 07/26/26 and 2 LPM with a SpO2 of 95% on 07/27/26. An observation of Resident #73's oxygen concentrator was conducted on 07/27/26 at 10:51 AM. The oxygen flow rate was noted to be set at 4 LPM when viewed at eye level. Resident #73 was lying in bed wearing her nasal cannula and did not exhibit symptoms of shortness of breath or respiratory distress. An interview was conducted with Resident #73 at the time of the observation, and she denied any shortness of breath or respiratory distress. Resident #73 stated she was ordered 2 LPM of oxygen and did not know why it was set at 4 LPM. MA #1 was interviewed on 07/27/26 at 2:04 PM, and he confirmed he provided care for Resident #73 from 7:00 AM through 7:00 PM on 07/26/26 and 07/27/26. He explained he completed rounds with Resident #73 around 9:00 AM on 07/27/26 and her SpO2 was 95%. MA #1 stated the oxygen concentrator flow rate should be checked when obtaining a resident SpO2 but he had not checked the flow rate on 07/27/26. He confirmed the oxygen concentrator flow rate should have been set at 2 LPM. He stated he did not know who changed the oxygen flow rate on Resident #73's concentrator. On 07/27/26 at 12:44 PM, an observation and interview were conducted with Nurse #2, who was assigned as the nurse supervisor for MA #1. Nurse #2 was accompanied to Resident #73's room and viewed the oxygen concentrator setting at eye level. Nurse #2 verified the flow rate was set at 4 LPM upon viewing and stated the flow rate should have been set at 2 LPM. She stated she was not sure why Resident #73's oxygen flow rate was set at 4 LPM, as MA #1 had charted Resident #73's SpO2 at 95% during his morning rounds. The Nurse Practitioner (NP) was interviewed on 07/30/26 at 09:21 AM and stated staff should verify a resident's oxygen concentrator was set to the physician order by checking whether the bottom of the ball in the flow meter was sitting on the correct flow rate. The NP verified Resident #73 had an order for continuous oxygen at 2 LPM via nasal cannula to maintain SpO2 at 90% or greater every shift. The NP stated she evaluated Resident #73 prior to the interview and Resident #73 did not show any adverse effects related to the increased oxygen flow rate. The Director of Nursing (DON) was interviewed on 07/31/26 at 4:35 PM and stated staff should check an oxygen concentrator at eye level and verify the flow rate matched the physician's order when checking the residents SpO2 levels. The Administrator was interviewed on 07/31/26 at 5:24 PM and stated staff should verify the oxygen concentrator was set at the ordered flow rate.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to document a resident's discharge from the facility, ensure nurse assessments were accurately documented in the electronic medical record and ensure medications were accurately documented on the medication administration record for 1 of 5 discharged residents reviewed for complete and accurate medical records (Resident #81). Findings included: Resident #81 admitted to the facility on [DATE]. A discharge MDS assessment dated [DATE] revealed Resident #81 discharged to the community. A staff progress note written by the Administrator and dated 05/16/26 at 8:12 AM revealed Resident #81 signed out of the facility on 05/15/26 at 4:00 PM to go to the store to buy shoes. Further review revealed no entry related to Resident #81 not returning to the facility after signing himself out to go to the store. Review of the medication administration record (MAR) for May 2026 revealed Nurse #3 initialed Resident #81's medications scheduled for 9:00 PM and 10:00 PM as administered per physician order. Review of Resident #81's electronic medical record revealed a nurse assessment dated [DATE] at 1:43 AM written by Nurse #3 that revealed the following: Temperature 98.2 degrees Fahrenheit - 05/15/26 at 11:01 PM, route: forehead (non-contact). Blood pressure 132/74 - 05/15/26 at 11:01 PM, position: lying right arm. Pulse 76 - 05/15/26 at 11:01 PM, pulse type: regular. Respiration 18.0 - 05/15/26 at 11:01 PM. Oxygen 98% - 05/15/26 at 11:01 PM, method: room air. Weight 161.4 pounds - 05/12/26 at 2:10 PM, scale: standing. Pain issue: no change. Location: generalized. Pain score: 7. PERRLA (pupils equal, round, reactive to light and accommodation): Resident follows commands. Denies weakness, tremors, numbness or tingling. Alert and Oriented times 3. Mood is pleasant, no unwanted behaviors witnessed. Skin warm and pink with brisk capillary refill (test that measures how long it takes for color to return to the skin after applying pressure). No edema present. Abdomen flat, non-tender. Bowel sounds present times 4. Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Taking nutrition and hydration orally. No complaints of thirst. No signs or symptoms of a swallowing disorder. Mucous membranes (moist, inner lining of some organs and body cavities such as the nose, mouth, lungs and stomach). Resident continent of bladder. Urine clear yellow. Denies urinary complaints. Skin issue: has not been evaluated. Location: front right knee. Laterality/Orientation: distal. Additional location information: outer right lower extremity incision closed with 14 staples present. Issue type: surgical wound. Wound was present on admission. Undermining: No. Tunneling: No. A nurse progress note written by Nurse #3 and dated 05/16/26 at 1:45 AM revealed in part, Resident #81's skin was warm and dry with normal skin color and normal turgor (the skin's ability to change shape and quickly return to normal). During a phone interview on 07/30/26 at 10:43 AM, Nurse #3 confirmed she worked on 05/15/26 to 05/16/26 during the hours of 7:00 PM to 7:00 AM and was assigned to provide care to Resident #81. Nurse #3 recalled on 05/15/26 when doing her evening medication pass, she pulled Resident #81's medications that were scheduled for 9:00 PM and 10:00 PM, signed the medications off on the MAR and when she went into Resident #81's room to administer his medications, she realized he was not there. She stated she was not informed that Resident #81 had signed himself out of the facility during shift report. She further stated she destroyed the medications she had pulled to administer to Resident #81 and then sent a text message to the former Unit Manager to inform her that Resident #81 was not at the facility. Nurse #3 recalled she received a response back from the former Unit Manager at 8:00 AM stating she would notify the Administrator. Nurse #3 could not explain why she documented an assessment was completed on Resident #81 when (continued on next page)		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he was not at the facility. During an interview on 07/31/26 at 4:23 PM, the Director of Nursing (DON) stated from what she could recall, Resident #81 signed himself out of the facility to go to a store on 05/15/26 and did not return. She did not know why Nurse #3 documented an assessment was completed after Resident #81 signed himself out of the facility on 05/15/26. She stated Nurse #3 should have documented a progress note and notified her and/or the Administrator when Resident #81 did not return to the facility. The DON explained Nurse #3 should have accurately documented medication administration on Resident #81's MAR by striking out the PM medications were administered and noted Resident #81 was on a leave of absence at the time of the scheduled medications. During an interview on 07/31/26 at 6:10 PM, the Administrator stated Nurse #3 should have accurately documented Resident #81's medications were not administered on his MAR and documented a progress note in Resident #81's electronic medical record when he did not return to the facility.		