STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375132	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Manor Nursing Home	500 South York Muskogee, OK 74403

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, the facility failed to maintain evidence of grievances with resolutions for 1 (#8) of 1 sampled resident sampled reviewed for grievances.The administrator identified 41 residents resided in the facility.Findings:An undated, facility grievances policy, read in part, To provide structure and a forum for residents to voice complaints, grievances and seek their resolution .Procedure: 1. The resident has the right, and the facility will promptly work to resolve the grievance with the resident. 2. Grievances may be communicated orally or in writing. The resident also has the right to file grievances anonymously. 3. The resident will receive the resolution decision in writing. A quarterly assessment, dated 08/14/25, showed a BIMS of 14 which indicated Resident #8 was cognitively intact for daily decision making. The assessment showed Resident #8 had diagnoses which included Parkinson's disease and schizophrenia. On 09/09/25 at 10:11 a.m., Resident #8 stated their flip phone was missing about a month ago. Resident #8 stated they let the administrator know and they looked for it but had not received any follow up on it yet. On 09/12/25 at 2:38 p.m., the administrator stated they did not have a grievance log to track resident grievances. The administrator stated if they did, it would be a mile long.

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

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to include the actual and working hours of licensed and unlicensed staff on the daily posted staffing and failed to ensure disciplines were included on the nurse staffing data for 7 (09/08/25 through 09/14/25) of 7 days reviewed for posted nurse staffing.The DON identified 41 residents resided in the facility.Findings: On 09/15/25 at 3:18 p.m., a dry erase board was observed to show staff names, the shift, the date and the census. The dry erase board did not show the number of hours worked. The undated policy titled Nurse Staffing Information, read in part, The facility must post the following information on a daily basis.The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident are per shift: a. Registered nurses b. Licensed practical nurses or licensed vocational nurses (as defined under State Law) c. Certified nurse aides. A Daily Nursing Sign-In Sheet, dated 09/08/25, showed 19 staff worked the day shift. The sheet did not show the discipline for 17 of 19 employees. The Daily Nursing Sign-In Sheet showed eight staff worked the evening shift. The sheet did not show the discipline for five of the eight employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for two of the three employees. A Daily Nursing Sign-In Sheet, dated 09/09/25, showed 15 staff worked the day shift. The sheet did not show the discipline for 12 of 15 employees. The Daily Nursing Sign-In Sheet showed nine staff worked the evening shift. The sheet did not show the discipline for six of the nine employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for two of the three employees. A Daily Nursing Sign-In Sheet, dated 09/10/25, showed 15 staff worked the day shift. The sheet did not show the discipline for 12 of 15 employees. The Daily Nursing Sign-In Sheet showed eight staff worked the evening shift. The sheet did not show the discipline for six of the eight employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for three of the three employees. A Daily Nursing Sign-In Sheet, dated 09/11/25, showed 15 staff worked the day shift. The sheet did not show the discipline for 12 of 15 employees. The Daily Nursing Sign-In Sheet showed nine staff worked the evening shift. The sheet did not show the discipline for eight of the nine employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for three of the three employees. A Daily Nursing Sign-In Sheet, dated 09/12/25, showed 14 staff worked the day shift. The sheet did not show the discipline for 11 of 14 employees. The Daily Nursing Sign-In Sheet showed seven staff worked the evening shift. The sheet did not show the discipline for five of the seven employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for two of the three employees. A Daily Nursing Sign-In Sheet, dated 09/13/25, showed ten staff worked the day shift. The sheet did not show the discipline for 9 of ten employees. The Daily Nursing Sign-In Sheet showed eight staff worked the evening shift. The sheet did not show the discipline for six of the eight employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for two of the three employees. A Daily Nursing Sign-In Sheet, dated 09/14/25, showed 7 staff worked the day shift. The sheet did not show the discipline for six of seven employees. The Daily Nursing Sign-In Sheet showed eight staff worked the evening shift. The sheet did not show the discipline for six of the eight employees. The Daily Nursing Sign-In Sheet showed three staff worked the night shift. The sheet did not show the discipline for two of the three employees. On 09/15/25 at 3:20 p.m., the administrator stated they posted the daily staffing information was posted on the dry erase board and they maintained the information on the Daily Nursing Sign-In Sheets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure kitchen equipment was properly dried before storing, the ice machine was free of debris and build-up and cross contamination was prevented during 2 of 2 meal services observed.The DON identified 41 residents ate meals from the kitchen.Findings:On 09/08/25 at 12:44 p.m., cook #1 was observed to stack wet trays by the steam table and place wet cooking utensils in the drawers. On 09/08/25 at 12:59 p.m., the maintenance supervisor removed the front cover of the ice machine, and a black substance was observed on the back of the cover. A black and red growth were observed in the corners and underneath where the pump was held. On 09/08/25 at 12:58 p.m., the maintenance supervisor stated the ice machine was professionally cleaned by a company last week. The maintenance supervisor looked and stated it was mold. The maintenance supervisor stated they were shutting down the ice machine to clean it and contacting the company that cleaned the ice machine last week. The maintenance supervisor stated there was no documentation of when the facility cleaned the ice machine. On 09/09/25 at 11:58 a.m., DA #1 was observed wearing gloves, placed a spoon and fork on a napkin on a tray, then touched their shirt and left hip in a rubbing motion. They continued to place silverware on trays and not to wash their hands or change their gloves. On 09/09/25 at 12:01 p.m., the DM was observed to wear gloves and touch the counter, meal cards, thermometer, plates, then pulled out the tortillas from the bag, and rolled them from side to side to separate them from each other. They were not observed to change gloves or wash their hands between touching surface items and food. On 09/15/25 at 2:03 p.m., the DM stated kitchen staff wore gloves to stop cross contamination. They stated they changed their gloves and washed their hands when they left the kitchen. The DM stated they prevented the growth of mold and mildew on trays and dishes by allowing them to air dry before putting them away. They stated they were not present on 09/08/25 and could not speak to what happened on that day.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to implement an antibiotic stewardship program.The DON identified 41 residents resided in the facility.Findings:An undated facility Antibiotic Stewardship policy, read in part, Develop and implement protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic .Develop, promote and implement a facility-wide system to monitor the use of antibiotics .Facility leadership commitment to safe and appropriate antibiotic use; Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship .Implement policy(ies) or practice to improve antibiotic use; Track measures of antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff. On 09/10/25 at 12:25 p.m., the DON stated they had not been able to locate the trending of infections. They stated the nurses documented and monitored for side effects of antibiotics in progress notes and they monitored the nurse's notes. The DON stated they would expect to find a facility map with color coding for different infections to trend infections, but they had not found that. The DON stated they were to use McGreers criteria but had not been doing it.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interview, the facility failed to ensure an individual was designated as the infection preventionist.The DON identified 41 residents resided in the facility.Findings: An undated staff list did not show the facility had an individual designated as an infection preventionist. On 09/08/25 at 1:44 p.m., the administrator stated they did not currently have an infection preventionist. On 09/15/25 at 3:11 p.m., the DON stated they were trying to determine who would complete training to become the infection preventionist. They stated the former DON was the previous infection preventionist.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to provide care for 1 (#4) of 1 sampled resident reviewed for nephrostomy care.The administrator identified one resident who had a nephrostomy in the facility.Findings:An annual assessment, dated 08/09/25, showed Resident #4 had a BIMS of 13 which indicated they were cognitive for daily decision making. The assessment showed diagnoses which included spina bifida and cerebral palsy. A review of physician orders, dated 05/20/24 through current, showed no active orders for the care of a nephrostomy for Resident #4. A care plan, revised 08/27/25, showed a focus for suprapubic catheter and colostomy, the care plan did not address the nephrostomy. Review of the July, August and September 2025 treatment record, showed the nurse to clean the area to the suprapubic catheter. The treatment records did not address care for the nephrostomy for Resident #4. On 09/15/25 at 9:38 a.m., CNA #3 stated Resident #4 had a nephrostomy and they emptied it daily. On 09/15/25 at 1:41 p.m., the DON stated Resident #4 had a colostomy, nephrostomy and suprapubic catheter. They stated staff did not change the nephrostomy they monitored, cleaned the catheter and placed a dressing around it. The DON stated an order was not entered in the system; therefore, it would not have populated on the treatment administration record. A care plan was not updated to reflect the care of the nephrostomy. They stated the staff must have assumed they were to clean the nephrostomy when they cleaned the colostomy and suprapubic catheter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure ordered medication was available for 2 (#45 and #11) of 10 sampled residents were reviewed for medication availability. The DON identified 41 residents received medications. Findings: 1. On 09/10/25 at 8:19 a.m., during medication administration observation, CMA #2 was not observed to administer Daliresp (an anti-inflammatory medication) 250mcg to Resident #45. A quarterly assessment, dated 06/23/25, showed Resident #45 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making. A physician order, dated 07/02/25, showed an order for Daliresp oral tablet 250mcg by mouth once daily for chronic obstructive pulmonary disease. The medication administration record, dated July 2025, did not show Daliresp had been administered. The medication administration record showed Other/See nurses notes from 07/02/25 through 07/12/25 and 07/31/25. The medication administration record showed the medication was on hold from 07/13/25 through 07/26/25. The medication administration record showed Resident #45 was hospitalized from [DATE] through 07/30/25. The medication administration record, dated August 2025, did not show Daliresp had been administered. The medication administration record showed Other/See nurses notes from 08/01/25-08/31/25. The medication administration record, dated 09/01/25 through 09/10/25, did not show Daliresp had been administered. The medication administration record showed Other/See nurses notes from 09/01/25 through 09/10/25. On 09/10/25 at 8:19 a.m., during medication administration observation, CMA #2 stated they were waiting for the pharmacy to deliver the Daliresp 250mcg. CMA #2 stated they had called the pharmacy on 09/09/25 and was told the medication required a prior authorization. On 09/10/25 at 1:09 p.m., CMA #2 stated if a medication was not available to administer, they were to contact the pharmacy and notify the charge nurse or DON. CMA #2 stated they had notified the DON the medication was not available on 09/09/25. On 09/11/25 at 4:14 p.m., the DON stated the Dalirep had not been available because the physician had not signed the prior authorization. 2. A physician order, dated 03/08/22, showed Resident #11 was ordered Abilify Maintena (an antipsychotic medication) 400mg intramuscularly one time per day on the 8th of every month. The quarterly assessment, dated 06/15/25, showed Resident #11 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of bipolar disorder. The treatment administration record, dated September 2025, showed Abilify Maintena 400mg was ordered to be administered on 09/08/25. The treatment administration record showed Other/See nurses notes on 09/08/25 for the Abilify Maintena 400mg intramuscularly. An eMar Medication Administration Note, dated 09/08/25, read in part, Med [medication] not administered due to it is not in the building. Med reordered. On 09/11/25 at 2:58 p.m., the DON reviewed the electronic clinical record for Resident #11 and stated they were to receive Abilify Maintena on the 8th of every month. On 09/11/25 at 4:12 p.m., the DON stated the nurse had notified the oncoming shift they had administered the Abilify Maintena on 09/08/25. The DON stated they would notify the pharmacy and the physician. They stated they had not been made aware the medication had been unavailable on 09/08/25. On 09/15/25 at 1:51 p.m., Resident #11 stated they were supposed to receive an injection monthly for auditory hallucinations. They stated they had not experienced auditory hallucinations and had not yet received the injection for September. On 09/15/25 at 2:23 p.m., the DON stated they had put an order into the electronic clinical record to administer the Abilify Maintena 400mg intramuscularly on 10/11/25 rather than 09/11/25. They stated they would clarify the order and administer the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to provide rationales for gradual dose reductions for 4 (#8, 45, 9 and #11) of 5 sampled residents reviewed for unnecessary medications.The DON identified 27 residents resided in the facility and received psychotropic medications.Findings:3. A quarterly assessment, dated 06/11/25, showed Resident #9 had a BIMS score of six, which indicated the resident was severely impaired in cognition for daily decision making. A Note to Attending Physician/Prescriber, dated 07/12/25, showed the pharmacist had recommended a gradual dose reduction for Clonazepam (an antianxiety medication) 2mg every 12 hours as needed and Lorazepam (an antianxiety medication) 2mg every 6 hours as needed. The Note to Attending Physician/Prescriber showed the physician disagreed with the recommendation but did not show the physician had documented a clinical rationale. On 09/11/25 at 3:00 p.m., the DON stated the physician should have documented a clinical rationale for declining the gradual dose reduction for Resident #9. 4. A quarterly assessment, dated 06/15/25, showed Resident #11 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making. A Note to Attending Physician/Prescriber, dated 08/25/25, showed the pharmacist had recommended a gradual dose reduction for celexa (an antidepressant medication) 40mg daily and trazodone (an antidepressant medication) 50mg at bedtime. The Note to Attending Physician/Prescriber showed the physician disagreed with the recommendation but did not show the physician had documented a clinical rationale. On 09/11/25 at 2:58 p.m., the DON stated the physician should have documented a clinical rationale for declining the gradual dose reduction for Resident #11. 1. A quarterly assessment, dated 08/14/25, showed a BIMS of 14 which indicated Resident #8 was cognitively intact for daily decision making. The assessment showed diagnoses which included borderline personality disorder, dementia, anxiety, depression, schizoaffective disorder and Parkinson's disease. A care plan, revised 08/29/25, showed focus' which included anti-anxiety medication. A physician's order, dated 09/11/25, showed to administer buspirone HCl Oral Tablet 10 MG (an anxiolytic.) Review of medication regimen reviews and gradual dose reductions from 08/20/24 to 08/25/25, showed a gradual dose reduction, dated 06/13/25 for Buspirone 10 mg TID. The physician marked disagree with no rationale provided. On 09/10/25 at 12:51 p.m., the DON provided a physician's note dated 06/18/25. The note showed Resident #45 had depression and anxiety as a diagnosis on the same date as the GDR was signed. The DON also provided a written letter from the physician which showed the reason the Buspar was not reduced was due to Resident #45 exhibited s/s of depression and anxiety during the visit on 06/18/25. A rationale was not provided by the end of the survey. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A quarterly assessment, dated 06/23/25, showed Resident #45 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses of anxiety, depression and schizophrenia. A physician's order, dated 08/26/24, showed to administer buspirone 10 mg (an antianxiety medication) 1 tablet by mouth two times a day related to anxiety disorder. Review of gradual dose reductions (GDR) and medication regimen reviews (MRR) from 08/20/24 to 08/01/25, showed a GDR dated 06/01/25 for Buspirone 10 mg by mouth twice a day was denied by the physician with no rationale provided. A care plan, dated 07/03/25, showed concerns which included anxiety. On 09/10/25 at 12:51 p.m., the DON stated the pharmacist sends us the recommendations and then the doctor reviewed them. The DON stated they did not know who followed up but would check. By the end of the survey an answer was not provided.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure resident representatives were notified of a change in condition for 1 (#9) of 1 sampled resident reviewed for notification of change.The DON identified 41 residents resided in the facility.Findings: An undated policy Notification of Change, read in part, The facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident representative(s) when there is.A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or A decision to transfer or discharge the resident from the facility. The guardianship paperwork, dated 02/13/25, showed Resident #9 had a guardian. A nurse note, dated 08/05/25 at 9:34 a.m., showed Resident #9 was sent to the emergency room. The note did not show the resident's guardian had been notified. A nurse note, dated 08/12/25 at 9:19 a.m., showed Resident #9 was sent to the emergency room. The note did not show the resident's guardian had been notified. A nurse note, dated 08/12/25, showed the physician had discontinued clonidine (a medication used to treat high blood pressure), started prazosin (a medication used to treat high blood pressure) 2mg twice daily, prazosin 1mg every eight hours as needed, and Aldactone (a medication used to treat high blood pressure) 25mg daily. The note did not show the resident's guardian had been notified. A nurse note, dated 08/25/25 at 8:05 p.m., showed the physician had ordered propranolol (a medication used to treat high blood pressure and anxiety) for Resident #9. The note did not show the resident's guardian had been notified. A nurse note, dated 08/27/25 at 12:38 p.m., showed the physician had increased the propranolol to 60mg every eight hours as needed for anxiety and agitation. The note did not show the resident's guardian had been notified. A nurse note, dated 08/28/25 at 7:13 p.m., showed propranolol had been decreased to 40mg every eight hours as needed. The note did not show the resident's guardian had been notified. On 09/09/25 at 1:42 p.m., Resident #9's guardian stated they were not consistently notified of changes in the resident's treatment/medication and hospitalization. On 09/15/25 at 9:26 a.m., LPN #1 stated the residents' representatives were to be notified of any change in condition. LPN #1 stated they documented notification of change in the nurse progress notes. On 09/15/25 at 10:19 a.m., the DON stated the residents' representatives were to be notified of any change in condition and they were to document the notification in a nurse progress note. On 09/15/25 at 11:48 a.m., the DON reviewed the electronic clinical record and stated it did not show Resident #9's guardian had been notified of the changes on 08/05/25, 08/12/25, 08/25/25, 08/27/25, or 08/28/25.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a recapitulation of the resident's stay had been completed and discharge medication information had been provided for 1 (#44) of 1 sampled resident who was reviewed for discharge.The DON identified one resident had been discharged in the past 3 months.Findings: An annual assessment, dated 02/12/25, showed Resident #44 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making and was independent with most activities of daily living. A care plan, revised on 02/13/25, showed Resident #44 would like to be discharged to their own apartment. A nurse note, dated 07/11/25, showed the resident discharged from the facility with their personal belongings and medications. A discharge return not anticipated assessment, dated 07/11/25, showed the resident had a planned discharge to their home/community. The assessment did not show the facility had provided the resident/resident representative the resident's current reconciled medication list. An Interdisciplinary Discharge summary, dated [DATE], showed Resident #44 was discharged to their private residence. The discharge summary did not show a recapitulation of the resident's stay, or documentation that medication instructions had been provided. A Check Out Medication List, dated 7/11/25 showed the medication name, dosage, and the number of pills provided to Resident #44. The list did not contain the frequency of the medications or instructions for use. A Resident Transfer/Discharge Form, dated 07/11/25, showed the resident was discharged home, was alert, oriented, and ambulated independently. The form did not show a recapitulation of the resident's stay or documentation that medication instructions had been provided. On 09/11/25 at 3:45 p.m., the administrator stated the MDS coordinator completed discharge summaries which included a recapitulation of the residents stay. On 09/11/25 at 4:25 p.m., the MDS coordinator stated they had completed the discharge summary for Resident #44. They stated they had not included a recapitulation of the resident's stay on the discharge summary, or documented medication instructions had been provided. On 09/12/25 at 10:22 a.m., the DON stated Resident #44 should have been discharged with medication instructions, but they had not found documentation the information had been provided to Resident #44.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to ensure assessments were encoded and transmitted for 2 (#9 and #45) of 12 sampled residents whose assessments were reviewed.The DON identified 41 residents resided in the facility.Findings: 1. A quarterly assessment, dated 06/11/25, showed Resident #9 had a BIMS score of six, which indicated the resident was severely impaired in cognition for daily decision making. An entry assessment, dated 07/21/25, showed Resident #9 had been readmitted to the facility. A nurse note, dated 07/28/25, showed the resident was sent to the hospital.Review of the assessments in the electronic clinical record did not show a discharge assessment had been completed.An entry assessment, dated 08/04/25, showed Resident #9 had been readmitted to the facility.On 09/11/25 at 12:40 p.m., the MDS coordinator reviewed the assessments in the electronic clinical record and stated they should have completed a discharge return anticipated assessment on 07/28/25.2. A quarterly assessment, dated 06/23/25, showed Resident #45 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making. Review of the assessments in the electronic clinical record, showed the most recent assessment completed was a discharge return anticipated assessment, dated 07/26/25, and did not show Resident #45 had been readmitted to the facility. A nurse note, dated 07/30/25 at 12:58 p.m., showed Resident #45 had been readmitted to the facility. On 09/09/25 at 2:36 p.m., the MDS coordinator reviewed the electronic clinical record and stated Resident #45 had discharged from the facility on 07/26/25 and they should have completed an entry assessment upon the resident's return on 07/30/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#16) of 12 sampled residents whose assessments were reviewed.The DON identified 41 residents resided in the facility. Findings:A nurse note, dated 06/18/25, showed Resident #16 had delusions.A nurse note, dated 06/20/25, showed Resident #16 had delusions.A quarterly assessment, dated 06/23/25, showed Resident #16 had a BIMS score of 13 which indicated the resident was cognitively intact for daily decision making, had a diagnosis of schizophrenia, and did not experience delusions during the seven-day look-back period.On 09/11/25 at 2:12 p.m., the DON stated Resident #16 experienced delusions.On 09/11/25 at 3:38 p.m., the MDS coordinator stated they reviewed nurse progress notes when they completed assessments. They stated they were unsure if the assessment was correct related to delusions for Resident #16.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure care plans were comprehensive for 2 (#16 and #4) of 12 sampled residents reviewed for comprehensive care plans.The DON identified 41 residents resided in the facility.Findings:1. On 09/09/25 at 10:03 a.m., Resident #16 was observed to speak, and their dentures did not stay in their mouth correctly. On 09/09/25 at 11:03 a.m., Resident #16's upper denture did not stay in place while talking and they repeatedly pushed the upper denture in place with their hand during the interview. An admission assessment, dated 09/23/24, showed the care area assessment triggered dental concerns due to Resident #16 being edentulous. An undated policy Comprehensive Care Plan, read in part, Each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals and address the resident's medical, physical, mental and psychosocial needs. A significant change assessment, dated 07/08/25, showed a BIMS of 13 which indicated Resident #16 was cognitively intact for daily decision making. The assessment showed diagnoses which included cancer and schizophrenia. The care area assessment triggered dental concerns due to Resident #16 being edentulous. A care plan, revised 07/15/25, showed no concern/focus for dental. Review of provider documents for Resident #16 showed no dental documents. On 09/09/25 at 11:03 a.m., Resident #16 stated their dentures did not fit correctly. They stated they had not told the facility staff, but they know because they can see it just like you. On 09/12/25 at 11:07 a.m., CNA #1 stated Resident #16 had not been seen by a dentist to their knowledge. They stated Resident #16 had dentures and they were loose. On 09/12/25 at 11:22 a.m., the social services director stated the dentist came last month and they provided a list of people who had their insurance. The social services director stated the nurses documented when a resident was seen by the dentist. On 09/12/25 at 11:26 a.m., the DON stated dental visits were documented in progress notes by nursing. The DON stated Resident #16 would not allow the dentist to see them. They stated the MDS coordinator would know if the refusals by Resident #16 were care planned. On 09/12/25 at 12:33 p.m., the MDS coordinator stated Resident #16 refused a lot of treatments. They stated the dentist was recently in the facility and Resident #16 did not see them. The MDS coordinator stated Resident #16 was not on the list to be seen by the dentist. They stated they did not know if Resident #16 refusals were care planned. The MDS coordinator, after checking the care plan, stated the care plan did not address dental and they did not know why, but it was triggered by the care area assessment. 2. An annual assessment, dated 08/09/25, showed a BIMS of 13 which indicated Resident #4 was cognitively intact for daily decision making. The assessment showed diagnoses which included colostomy, spina bifida and cerebral palsy. An order summary report, dated September 2025, did not show an order for the care of a nephrostomy. A care plan, revised 08/27/25, showed a focus for suprapubic catheter and colostomy to promote wound healing and required total assistance. The care plan did not address the nephrostomy or nephrostomy care. Review of the July, August and September 2025 MAR, did not address the nephrostomy or nephrostomy care. On 09/15/25 at 9:38 a.m., CNA #3 stated Resident #4 had a nephrostomy and CNAs emptied the collection bag. On 09/15/25 at 1:41 p.m., the DON stated Resident #4 had a colostomy, nephrostomy and suprapubic catheter. They stated the facility did not change the nephrostomy; they monitored, cleaned and placed a dressing around it. The DON stated an order was not entered. They stated the nurses must have assumed the order for the colostomy and suprapubic catheter included the nephrostomy care as well. The DON stated the nephrostomy must have been missed on the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise and accurately revise a care plan for 2 (#9 and #4) of 2 residents sampled were reviewed for care plans.The administrator identified 41 residents resided in the facility.Findings: 1. A progress note, dated 06/05/25, showed Resident #9 was in the common area for dinner meal when they began walking toward the nurses' station. The note showed Resident #9 began running and hit the front door until it opened. The note showed staff was headed towards them during the time, however no one was able to reach Resident #9 before they made it out the door. The note showed Resident #9 was stopped by staff approximately five feet outside the building. The note showed the police department and emergency medical services arrived and Resident #9 was taken to the emergency department for evaluation due to increased anxiety. A progress note, dated 06/05/25, showed Resident #9 returned to the facility at 10:20 p.m., and began pacing about the facility walking towards doors and was on one-on-one observation with staff. A progress note, dated 06/06/25, showed Resident #9 continued pacing after they returned from the emergency department on 06/05/25. A quarterly assessment, dated 06/11/25, showed a BIMS of 6 which indicated a severe cognitive impairment for daily decision making. The assessment showed diagnoses which included schizophrenia, heart failure, anxiety and depression. The assessment showed medications taken during the look back period included antipsychotic, antianxiety, antidepressants and anticonvulsant medications. Section E of the assessment showed other behavioral symptoms not directed towards other such as pacing or elopement attempts were not exhibited during the look back period. A care plan, revised 07/01/25, showed Resident #9 was a risk for elopement with an actual incident on 02/16/25 regarding a cut to their right hand. Interventions included to document any wandering behaviors, triggers, and patterns. The care plan was not revised to include the elopement attempt on 06/05/25. On 09/15/25 at 1:41 p.m., the DON stated they did not know why the care plan was not revised. 2. An annual assessment, dated 08/09/25, showed a BIMS of 13 which indicated Resident #4 was cognitive for daily decision making. The assessment showed diagnoses which included spina bifida, cerebral palsy and a stage four pressure ulcer. The assessment showed Resident #4 was at risk for pressure ulcers and had a current pressure ulcer stage three present on admission. A physician wound note, dated 08/27/25, showed the wound as a stage three pressure injury. A care plan, revised 08/27/25, showed Resident #4 had a stage four pressure ulcer. On 09/09/25 at 9:27 a.m., Resident #4 stated they had a wound on their bottom. They stated the staff informed them the wound was getting better but Resident #4 was not sure. On 09/12/25 at 11:31 a.m., the MDS coordinator stated the face sheet showed the pressure wound was a stage four, but the wound doctor staged the wound at a stage three to the right ischium. They stated the care plan was revised 08/27/25. The MDS coordinator stated they should have gone by the wound doctor orders and assessment.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of 5% or less. Two medication errors were observed out of 31 opportunities, which indicated a 6.25% medication error rate.The DON identified 41 residents receive medications in the facility.On 09/10/25 at 8:19 a.m., CMA #2 was observed to administer Budesonide-Fomotorol Fumarate (a corticosteroid medication for chronic obstructive pulmonary disease) 80-4.5 mcg/act 2 puffs to Resident #45. CMA #2 was not observed to encourage or instruct Resident #45 to rinse their mouth after using the inhaler. Resident #45 was not observed to receive Daliresp (a medication for chronic obstructive pulmonary disease) 250 MCG tablet by mouth.An undated policy titled Administration of Inhalers by Certified Medication Aides, read in part, Encourage mouth rinse if corticosteroid inhaler was used.A physician order, dated 11/21/24, showed Resident #45 was ordered Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/ACT two puffs twice daily. The order showed to rinse mouth with water after each dose.A quarterly assessment, dated 06/23/25, showed Resident #45 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making.A physician order, dated 07/02/25, showed Resident #45 was ordered Daliresp 250mcg one tablet by mouth once daily.On 09/10/25 at 1:09 p.m., CMA #2 stated the Daliresp 250mcg tablet was not available for administration to Resident #45. On 09/10/25 at 1:09 p.m., CMA #2 stated Resident #45 would become argumentative if they educated or encouraged them to rinse their mouth after using the inhaler. CMA #2 stated they notified the DON, on 09/09/25, the Daliresp was unavailable. On 09/10/25 at 1:19 p.m., the DON stated the charge nurses were to monitor the CMAs to ensure medications were provided as ordered. They stated they were unaware the Daliresp was unavailable and Resident #45 should have been encouraged to rinse their mouth after the inhaler use. On 09/11/25 at 4:25 p.m., the DON stated they would need to provide training related to the medication error rate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were secured for 1 (treatment cart #1) of 1 treatment carts observed.The DON identified two treatment carts in the facility. Findings: On 09/09/25 at 11:32 a.m., LPN #1 was observed to enter room [ROOM NUMBER]. LPN # 1 was observed to leave the treatment cart #1 unlocked and unattended. On 09/09/25 at 11:34 a.m., LPN #1 returned to treatment cart #1 and lock it. On 09/09/25 at 11:42 a.m., LPN #1 stated they kept medications secured by locking the treatment carts when they were unattended. LPN #1 stated they had not been paying attention when they left treatment cart #1 unlocked and unattended. On 09/09/25 at 4:30 p.m., the DON stated treatment carts were to be kept locked when they were unattended to secure medications.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, record review, and interview, the facility failed to ensure menus were followed for 1 meal of 1 meal observed.The DON identified 41 residents ate meals from the kitchen.Findings:On 09/09/25 at 12:00 p.m., soft beef tacos were observed to be served for lunch, no vegetable was served other than the lettuce and tomatoes. On 09/09/25 at 12:01 p.m., cook #1 used tongs to place lettuce, tomatoes and cheese on each plate. The serving of lettuce, tomatoes and cheese was less than three ounces. An undated facility [policy Menus, read in part, Ensure that menus are developed and prepared to meet resident choices including their nutritional, religious, cultural and ethnic needs while using established national guidelines. The facility Production Guides menu, dated 09/09/25, for the noon meal showed soft beef taco with sauce, Spanish rice, capri blend vegetables, shredded lettuce/tomato and summer fruit cup to be served. The menu showed to use the #8 scoop for the shredded lettuce and tomato. On 09/15/25 at 2:03 p.m., the DM stated the serving size for lettuce tomato and cheese was four ounces. They stated the reason they used the tongs was because the residents will not eat all that lettuce. The DM stated residents eat very little lettuce and cheese. They stated the capri vegetables were not served because they did not have any.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, record review, and interview, the facility failed to ensure trash cans were covered in the kitchen for 1 (the trash can by the handwashing sink) of 2 trash cans observed in the kitchen.The human resources employee identified 2 trash cans in the kitchen, and the DON identified 41 residents received nourishment from the kitchen.Findings: On 09/08/25 at 12:05 p.m., the trashcan by the handwashing sink was observed to be uncovered and without a lid. On 09/09/25 at 11:18 a.m., the trashcan next to the handwashing sink was observed to be uncovered and without a lid. An undated policy titled, Disposal of Garbage/Rubbish, read in part, All containers will have tight-fitting lids or covers and will be kept covered when stored or not in continuous use. On 09/15/25 at 2:03 p.m., the DM stated they had never had a lid for the trashcan by the handwashing sink.