| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375520 | A. Building<br>B. Wing | 07/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Northwest Nursing Center | 2801 Northwest 61st Street<br>Oklahoma City, OK 73112 |

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|---|---|
| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident when there is a significant change in condition<br><br>Based on record review and interview, the facility failed to ensure a significant change assessment had been completed when hospice services were elected for 2 (#4 and #75) of 19 sampled residents whose assessments were reviewed.The administrator identified 11 residents on hospice services.Findings: 1. A progress note, dated 03/19/25, showed Resident #75 wanted to switch hospice companies. A physician order, dated 03/21/25, showed Resident #75was ordered to be evaluated by the resident's hospice of choice. A significant change assessment, dated 05/16/25, showed Resident #75 had a BIMS score of 12, which indicated the resident was moderately impaired in cognition for daily decision making, had a life expectancy of less than 6 months, and the sections of the assessment had been completed on 06/02/25. On 07/23/25 at 6:00 p.m., the administrator was asked when Resident #75 had been originally admitted to hospice services. They stated they did not have an order for the first hospice Resident #75 had been admitted to, but they had elected the hospice benefit in February or March 2025 with the first hospice company. The administrator stated a significant change assessment should have been completed when Resident #75 had initially elected the hospice benefit.2. On 03/19/25, an initial hospice assessment showed Resident #4 had been assessed by the RN with the hospice company.A significant change assessment, dated 06/11/25, showed Resident #4 had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision making, had a life expectancy of less than 6 months, and the sections of the assessment had been completed on 06/20/25. On 07/22/25 at 1:47 p.m., the MDS coordinator stated they had noticed in June, shortly after beginning the role as MDS coordinator, a significant change assessment had not been completed when Resident #4 had elected the hospice benefit. On 07/23/25 at 4:23 p.m., the administrator stated the significant change assessment for Resident #4 had not been completed when they had elected the hospice benefit because they had been transitioning MDS coordinators at that time. |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 3 (#20, 29, and #69) of 18 sampled residents reviewed for baseline care plans.The administrator identified 62 residents resided in the facility. Findings:An undated policy titled Care Plans, read in part, To assure the resident's immediate care needs are met and maintained, a preliminary care plan will be developed within twenty-four (24) hours of the resident's admission.<br><br>A policy titled Baseline Care Plan, dated 08/01/24, read in part, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality .The baseline care plan will .Be developed within 48 hours of a resident's admission<br><br>1.An admission MDS, dated 02/19/25, showed Resident #20 was admitted to the facility on [DATE] with diagnoses to include depression and psychotic disorder other than schizophrenia.<br><br>A review of Resident #20's medical chart did not show a baseline care plan was developed within 48 hours of admission.<br><br>On 07/16/2025 at 11:11 a.m., MDS coordinator #1 was asked when a baseline care plan is to be developed by the facility. They stated, Within 48 hours of admission. [Resident #20] was admitted in February and I didn't get their care plan done until May. MDS coordinator #1 was asked if Resident #20 had a baseline care plan in place. They stated, No.<br><br>2. An undated order summary for Resident #69 showed diagnoses which included acute respiratory failure with hypoxia, acute on chronic systolic congestive heart failure, and tracheostomy status.<br><br>A review of Resident #69's electronic medical record did not show a baseline care plan had been completed.<br><br>A resident admission assessment, dated 04/07/25, showed an admission date of 03/29/25.<br><br>On 07/22/25 at 10:32 a.m., MDS coordinator #1 stated there was not a baseline care plan for the resident. They stated they started in May of this year and had to catch things up. They stated there was no coordinator since February and corporate was doing them during that time.<br><br>3. The Baseline Care Plan v1.1-V1, dated 05/19/25, did not show Resident #29 or the resident's representative had been provided a summary of the baseline care plan.<br><br>The admission assessment, dated 05/23/25, showed Resident #29 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of unspecified dementia.<br><br>On 07/22/25 at 1:45 p.m., MDS coordinator #1 stated they completed baseline care plans within 48 hours of admission in the electronic clinical record. They stated they had not provided residents or resident representatives with a summary of the baseline care plan.<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/22/25 at 2:26 p.m., corporate nurse consultant #1 stated baseline care plans were completed within 48 hours of admission and documented in the electronic clinical record. They stated the social services director provided a summary of the baseline care plan to the resident and or resident representative.<br><br>On 07/23/25 at 8:27 a.m., Resident #29 stated they did not believe they had been provided a summary of their baseline care plan.<br><br>On 07/23/25 at 9:18 a.m., corporate nurse consultant #1 stated they had spoken with social services, and they said they had not provided a baseline care plan summary to Resident #29 or their representative. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review and interview the facility failed to ensure a comprehensive care plan was developed for 3 (#61, 69, and #73) of 18 sampled residents reviewed for care plans. The administrator identified 62 residents resided in the facility. Findings:<br><br>1. An admission assessment, dated 02/20/25, showed Resident #73 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of end stage renal disease. The care area assessment summary showed visual function, ADL function, urinary incontinence/indwelling catheter, psychosocial well-being, activities, falls, nutritional status, pressure ulcer, psychotropic drug use, pain, and return to the community referral were all triggered care areas from the assessment and care planning decisions had been made. The admission assessment showed the care area assessment summary and care planning decisions had been completed by the VP of reimbursement on 02/28/25.<br><br>A care plan, reviewed 06/09/25, showed a care plan for falls. The care plan did not show the other triggered areas on the admission assessment had been care planned.<br><br>On 07/23/25 at 9:31 a.m., the VP of reimbursement stated they had completed assessments and the care area summary. They stated they had informed the former DON they needed to develop a comprehensive care plan. The VP of reimbursement stated corporate nurse consultant #1 was responsible to monitor to ensure comprehensive care plans were developed.<br><br>On 07/23/25 at 9:36 a.m., corporate nurse consultant #1 stated the VP of reimbursement would need to be asked why the comprehensive care plan had not been developed for Resident #73.<br><br>On 07/23/25 at 9:38 a.m., the administrator stated a previous corporate MDS coordinator was responsible to ensure a comprehensive care plan had been developed for Resident #73.<br><br>2. A significant change assessment, dated 06/12/25, showed Resident #61 was severely impaired in cognition for daily decision making by staff assessment, and had limited range of motion on both sides of their upper and lower extremities.<br><br>A care plan, revised on 07/14/25, did not show the resident had limitation in their upper and lower extremities.<br><br>On 07/23/25 at 5:24 p.m., the MDS coordinator stated the care plan for Resident #61 had been revised on 07/14/25 and the resident had limited range of motion to both sides of the upper and lower extremities. The MDS coordinator reviewed the resident's significant change assessment and the care plan and stated they should have addressed the limited range of motion on the care plan.<br><br>A policy titled Care Plans, Comprehensive Person-Centered, dated 12/2016, read in part<br><br>3. An admission/discharge return anticipated assessment for Resident #69, dated 04/07/25, showed the admission date of 03/29/25. The assessment showed the resident went to the hospital.<br><br>An undated order summary for Resident #69's showed an admission date of 04/14/25.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #69's electronic medical record did not show a comprehensive care plan had been initiated or completed.<br><br>An undated order summary for Resident #69's showed diagnoses which included acute respiratory failure with hypoxia, acute on chronic systolic congestive heart failure, and tracheostomy status.<br><br>On 07/22/25 at 10:32 a.m., the MDS coordinator stated there was not a comprehensive care plan for the resident. They stated they started in May of this year and had to catch things up. They stated there was no coordinator since February and corporate was doing them during that time. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>Based on observation, record review, and interview, the facility failed to ensure range of motion was provided to residents for 3 (#2, 13, and #61) of 3 sampled residents reviewed for position and mobility.The administrator identified 12 residents had limited range of motion resided in the facility.Findings:1. On 07/15/25 at 11:57 a.m., Resident #2 was in bed and had contracted upper and lower extremities.<br><br>A quarterly resident assessment, dated 06/16/25, showed Resident #2 had diagnoses which included spastic quadriplegic cerebral palsy and aphasia. The assessment showed the resident's cognition was severely impaired. The assessment showed the resident had impairment on both upper and lower extremities. The assessment showed no passive or active range of motion was perform in the seven days look back period. The assessment showed the resident was dependent on staff assistance for all activities of daily living.<br><br>There was no documentation Resident #2 received range of motion services.<br><br>2. On 07/15/25 at 12:53 p.m., Resident #13 was observed in bed with right side weakness and contracted left hand.<br><br>A quarterly resident assessment, dated 04/16/25, showed Resident #13 had diagnoses which included nontraumatic intracerebral hemorrhage and muscle spasm. The assessment showed the resident's cognition was severely impaired with a BIMS of 05. The assessment showed the resident had impairment on one side of their upper and lower extremity. It showed no passive or active range of motion was perform in the seven days look back period. The assessment showed the resident was dependent on staff assistance for all activities of daily living.<br><br>There was no documentation Resident #13 received range of motion services.<br><br>On 07/22/25 at 2:37 p.m., corporate nurse consultant #1 stated therapy would do a screen and develop a contracture management plan and refer it to restorative to carry out the plan.<br><br>On 07/22/25 at 2:48 p.m., corporate nurse consultant #1 stated Resident #2 and Resident #13 had not received restorative services for range of motion. They stated the residents above would qualify for range of motion.<br><br>On 07/22/25 at 3:10 p.m., CNA #4 was asked what care they provided for Resident #2 and Resident #13. They stated they repositioned and changed Resident #2 and Resident #13's pads. They stated they put pillows between Resident #13's legs.<br><br>CNA #4 did not mention providing active or passive range of motion for Resident #2 and Resident #13.<br><br>On 07/22/25 at 3:15 p.m., LPN #3 stated they did not perform range of motion on Resident #2 and Resident #13. They stated therapy were the main staff that perform range of motion on residents but nurses and CNAs can do it as well.<br><br>3. A significant change assessment, dated 06/12/25, showed Resident #61 was severely impaired in cognition for daily decision making by staff assessment, and had limited range of motion on both<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sides of their upper and lower extremities.<br><br>A care plan, revised on 07/14/25, did not show the resident had limitation in their upper and lower extremities.<br><br>On 07/15/25 at 3:45 p.m., review of the physician orders, care plan, assessments, and scanned documents in the electronic clinical record did not show Resident #61 had been assessed or evaluated for range of motion services.<br><br>On 07/15/25 at 3:38 p.m., family member #1 stated Resident #61 had refused therapy in the past but would like for them to be assessed for exercises of their joints.<br><br>On 07/23/25 at 3:41 p.m., the DON stated the nurses periodically assessed for range of motion services.<br><br>On 07/23/25 at 3:56 p.m., the DON was asked how they ensured residents with limited range of motion did not experience a further decline in range of motion. They stated they did not know. The DON stated they did not have a restorative program at the facility, but they offered physical therapy. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on record review and interview, the facility failed to ensure residents who received dialysis services were assessed before and after dialysis for 1 (#7) of 1 sampled resident reviewed for dialysis.Corporate Nurse Consultant #1 identified two residents who required dialysis.Findings: An undated policy titled End-Stage Renal Disease, Care of a Resident with, read in part, Residents with end-stage renal disease [ESRD] will be cared for according to currently recognized standards of care. An annual assessment, dated 04/12/25, showed Resident #7 had a BIMS score of 12, which indicated the resident was moderately impaired in cognition for daily decision making, had a diagnosis of end stage renal disease, and received dialysis. A July 2025 treatment record showed the fistula for Resident #7 was monitored every shift. A care plan, reviewed 07/14/25, showed Resident #7 required dialysis and was scheduled weekly on Monday, Wednesday, and Friday at 1:30 p.m. A Dialysis Communication form, dated 07/18/25, showed vital signs had been obtained for Resident #7 by facility staff. The bottom of the form showed the dialysis center obtained vital signs. On 07/16/25 at 3:13 p.m., review of the assessments, progress notes, and scanned documents in the electronic clinical record, dated 06/01/25-07/16/25, did not show Resident #7 had been assessed before and after dialysis. A Dialysis Communication form, dated 07/21/25, showed vital signs had been obtained by dialysis staff. The form did not have Resident #7's name on it and the facility staff had not documented the pre-dialysis vital signs. On 07/23/25 at 8:34 a.m., Resident #7 stated uh huh when asked if they received dialysis. Resident #7 did not participate further with an interview. On 07/23/25 at 10:44 a.m., LPN #2 stated they obtained vital signs before the resident went to dialysis but was not on shift when they returned. They stated they documented the pre-dialysis vital signs in the dialysis communication book or in a progress note. On 07/23/25 at 10:46 a.m., corporate nurse consultant #1 stated the nurses were to document in the dialysis communication book before and after a resident returned from dialysis. They stated they were to document vital signs and their assessment of the dialysis access site. On 07/23/25 at 11:03 a.m., corporate nurse consultant #1 stated the only form in the dialysis communication book was dated 07/18/25. They stated the facility nurse was to complete the pre-dialysis assessment and the dialysis center was to complete the post-dialysis assessment. They stated the administrator was to monitor to ensure the assessments had been completed. On 07/23/25 at 11:05 a.m., the administrator stated they had completed an audit and noticed the dialysis center did not always return the dialysis communication forms. They stated they had started sending the dialysis communication book with Resident #7 on 07/18/25. On 07/23/25 at 11:15 a.m., corporate nurse consultant #1 stated since 07/18/25 when the dialysis communication book had been implemented the facility had not monitored to ensure pre and post dialysis assessments were being completed. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on record review and interview the facility failed to ensure anticoagulant monitoring was in place for a high-risk medication for 1 (#69) of 5 sampled residents reviewed for unnecessary medication. The administrator identified 62 residents resided at the facility, and 30 residents received anticoagulant therapy. Findings: An undated policy titled High Risk Medications-Anticoagulants, read in part, This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systemic approach to managing anticoagulant therapy for efficacy and safety.The resident's plan of care shall alert staff to monitor for adverse consequences. An undated order summary for Resident #69's showed diagnoses which included acute respiratory failure with hypoxia, acute on chronic systolic congestive heart failure, and tracheostomy status. A physicians order, dated 03/28/25, showed Apixaban (blood thinner) 5 mg tablet two times a day. This order was discontinued on 04/09/25. A physicians order, dated 04/15/25 showed Apixaban (blood thinner) 5 mg tablet two times a day. This order was discontinued on 06/22/25. Review of Resident #69's electronic medical record showed no order or monitoring for side effects of anticoagulant therapy was completed since the inception of the order dated 03/28/25. On 07/22/25 at 10:02 a.m., LPN #2 stated anticoagulant monitoring was done in the electronic medical record and there was something they had to follow. LPN #2 reviewed Resident #69's order list and was unable to locate. On 07/22/25 at 10:26 a.m., LPN #2 requested assistance from the corporate nurse consultant #1 to locate the monitoring. LPN #2 stated they did not have anything. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>Based on record review and interview, the facility failed to ensure an annual comprehensive assessment was completed within 366 days of the previous annual comprehensive assessment for 1 (#9) of 19 sampled residents whose assessments were reviewed.The administrator identified 62 residents resided in the facility.Findings: An annual assessment, dated 11/18/24, showed Resident #9 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and a diagnosis of diabetes mellitus. The annual assessment showed it was completed on 12/13/24. An MDS 3.0 NH Final Validation Report, dated 12/13/24, showed the annual assessment for Resident #9, read in part, Assessment Completed Late: An OBRA comprehensive assessment with the Care Area Assessment [Section V] is due every year unless the resident is no longer in the facility. A prior record with an ARD [A2300] within 366 days of the submitted record could not be found. On 07/23/25 at 6:13 p.m., the administrator stated they had not had an MDS coordinator,. They stated they were utilizing the corporate MDS coordinator and assessments were completed late. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on record review and interview, the facility failed to ensure assessments were transmitted within 14 days of completion for 1 (#7) of 19 sampled residents whose assessments were reviewed.The administrator identified 62 residents resided in the facility. Findings: A SNF Part A discharge assessment, dated 02/26/25, showed Resident #7 had a BIMS score of 12, which indicated the resident was moderately impaired in cognition for daily decision making, Part A skilled services had ended on 02/26/25, and the sections of the assessment were completed on 06/02/25. An MDS 3.0 NH Final Validation Report, dated 06/05/25, showed the SNF Part A discharge assessment for Resident #7, read in part, Assessment Completed Late: Z0500B [assessment completion date] is more than 14 days after A2300 [assessment reference date] On 07/23/25 at 6:13 p.m., the administrator stated the corporate MDS coordinator had been completing assessments, but some were late due to the transition of MDS coordinators in the facility. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's assessment was accurate for 1 (#20) of 18 sampled residents reviewed for accurate assessments.The administrator identified 62 residents resided in the facility.Findings:A document titled, Transition Plan, dated 11/21/24, showed Resident #20 was discharged from an inpatient behavioral health facility on 11/21/24 with a diagnosis of schizophrenia.A Quarterly MDS, dated 05/22/25, showed Resident #20 was admitted to the facility on [DATE] with diagnoses to include depression and psychotic disorder other than schizophrenia. The MDS showed Resident #20 did not receive antipsychotic medications.A review of Resident #20's MAR for February and March 2025 showed Resident #20 received Paliperidone ER Oral Tablet Extended Release 24Hour (an atypical antipsychotic) 6 MG tablet one time daily for schizophrenia.A review of Resident #20's MAR for March, April, and May 2025 showed Resident #20 received Zyprexa Oral Tablet 5 MG (an atypical antipsychotic) one tablet daily for schizophrenia.On 07/16/25 at 11:08 a.m., the MDS coordinator was asked if Resident #20's most recent MDS, the quarterly MDS, reflected their diagnosis of schizophrenia or the antipsychotic medications they had received. The MDS coordinator stated, No it doesn't. They were asked if the MDS should show a diagnosis of schizophrenia. They stated, Yes, it should because [Resident #20] has it. The MDS coordinator was asked if the MDS showed Resident #20 was receiving an antipsychotic medication. They stated, No, those questions were answered incorrectly. |

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|---|---|---|---|
| | 375520 | A. Building<br>B. Wing | 07/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Northwest Nursing Center | 2801 Northwest 61st Street<br>Oklahoma City, OK 73112 |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate documentation of a diagnosis on a PASARR form for a mental health illness for 1 (#20) of 13 sampled residents reviewed for the need of a level II screening.The administrator identified 13 residents with mental illness resided in the facility.Findings:A document titled Transition Plan, dated 11/21/24, showed Resident #20 was discharged from an inpatient behavioral health facility on 11/21/24 with a diagnosis of schizophrenia.An admission MDS, dated 02/19/25, showed Resident #20 was admitted to the facility on [DATE] with diagnoses to include depression and psychotic disorder other than schizophrenia. The MDS showed Resident #20 did not receive antipsychotic medications. The MDS showed Resident #20 was not considered by the state level 2 PASARR process to have serious mental illness and/or intellectual disability or a related condition.A Psychiatric Exam, dated 02/20/25, read in part, Patient is on Paliperidone [an atypical antipsychotic] Patient does have a diagnosis of schizophrenia.A review of Resident #20's MAR for February 2025 showed Resident #20 received Paliperidone ER Oral Tablet Extended Release 24Hour 6 MG tablet one time daily for schizophrenia.On 07/16/25 at 11:02 a.m., the MDS coordinator was asked what was the process for identifying whether a state level PASARR 2 needed to be completed. They stated, If they have any diagnoses like bipolar, schizophrenia, or take antipsychotic medications, we call the state for a state level PASARR 2. MDS coordinator #1 was asked what diagnoses Resident #20 had and they stated, MDD [major depressive disorder] and schizophrenia. [Resident #20] has a state level 2 PASARR in progress. A copy of the initiated state level 2 PASARR was requested. MDS coordinator #1 was asked if based on Resident #20's diagnosis of schizophrenia was question #2 on the PASSAR 1 answered correctly. They stated, Absolutely not.On 07/16/25 at 11:50 a.m., MDS coordinator #1 stated, [Resident #20] actually does not have a level 2 PASARR in progress. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on record review and interview, the facility failed to ensure a care plan had been revised for 1 (#7) of 19 sampled residents whose care plans were reviewed.The administrator identified 62 residents resided in the facility.Findings: A Nutrition Services Note, dated 04/02/25, showed the dietician discontinued the liquid protein for Resident #7. An annual assessment, dated 04/12/25, showed Resident #7 had a BIMS score of 12, which indicated the resident was moderately impaired in cognition for daily decision making, and had a diagnosis of diabetes mellitus. A care plan, reviewed 07/14/25, showed Resident #7 had a nutritional problem and was to receive 30 milliliters of liquid protein each day. On 07/23/25 at 12:24 p.m., the MDS coordinator stated the care plan for Resident #7 had been reviewed on 07/13/25. They stated the nutrition portion of the care plan had not been revised since 09/04/24. They stated the liquid protein should not have still been on the care plan and the care plan had not been fully updated. On 07/23/25 at 12:52 p.m., corporate nurse consultant #1 stated care plans were to be reviewed/revised daily for acute needs and quarterly. They stated they did not know why the care plan for Resident #7 had not been revised to reflect their current needs. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on record review and interview, the facility failed to provide bathing for 1 (#41) of 6 sampled residents reviewed for activities of daily living.The administrator identified 43 residents required assistance with bathing.Findings:An undated facility policy titled Resident Showers, read in part, Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.Resident #41's admission resident assessment, dated 05/29/25, showed the resident had impairment on one side of their upper and lower extremity. The assessment showed the resident required partial to moderate assistance with bathing with the assistance of one person. The assessment showed Resident #41's cognition was intact with a BIMS of 15.A care plan, dated 06/05/25, showed Resident #41 had diagnoses which included cerebral infarction and obesity.A Documentation Survey Report for July 2025 showed Activity itself did not occur or family and/or non facility staff provided care 100% of the time for that activity on:a. 07/05/25,b. 07/12/25, andc. 07/19/25.Resident #41 was identified during resident group meeting held on 07/18/25 at 11:16 a.m. of not receiving their showers as scheduled.On 07/23/25 at 11:53 a.m., CNA #3 stated they looked in the shower book to determine which resident were scheduled for a shower.On 07/23/25 at 11:54 a.m., CNA #3 stated if a resident declined a shower, they informed the nurse, the DON, and administrator. They stated they would document refusal on the shower sheet.On 07/23/25 at 11:56 a.m., CNA #3 stated they would document activity did not occur if the shower was not provided or if the resident refused.On 07/23/25 at 11:57 a.m., CNA #3 stated Resident #41 never refused a shower.On 07/23/25 at 11:58 a.m., CNA #4 stated Resident #41's shower scheduled was every Tuesday, Thursday, and Saturday.On 07/23/25 at 11:59 a.m., CNA #4 stated Resident #41 never refused a shower.On 07/23/25 at 12:10 p.m., the DON stated they could not locate any shower sheets for the above dates to show the resident refused a shower. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on record review and interview the facility failed to ensure medication was administered according to physician orders for 1 (#69) of 5 sampled residents reviewed for unnecessary medications. The administrator identified 62 residents resided at the facility. Findings: A policy titled Medication Administration, dated 05/01/24, read in part, Administer medication as ordered in accordance with manufacturer specifications .Sign MAR after administration. An undated order summary for Resident #69 showed diagnoses which included acute respiratory failure with hypoxia, acute on chronic systolic congestive heart failure, and tracheostomy status. A physician's order, dated 04/19/25, showed Guaifenesin (expectorant) three times a day. A physician's order, dated 04/20/25, showed Ipratropium-Albuterol (bronchodilator to prevent bronchospasm) three times a day for wheezing and sob. A review of Resident #69's medication administration record dated 04/01/25 - through 04/30/25 showed blank boxes for:a. Guaifenesin on 04/19/25 at 8:00 a.m., 2:00 p.m., 8:00 p.m., and on 04/20/25 at 8:00 a.m., 2:00 p.m., 8:00 p.m., andb. Ipratropium-Albuterol on 04/20/25 at 2:00 p.m., 8:00 p.m., and on 04/21/25 at 8:00 a.m., and 2:00 p.m. On 07/22/25 at 10:02 a.m., LPN #2 stated blanks on the medication administration record indicated they missed it. They stated they were supposed to put refused. On 07/22/25 at 10:23 a.m., LPN #2 stated they did not see where the albuterol or the guaifenesin were administered as ordered. The facility failed to ensure a resident with a respiratory diagnosis received supporting medication as ordered. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained:a. during provision of incontinent care for 1 (#13) of 6 sampled residents reviewed for ADL care, andb. appropriate personal protective equipment was worn for a resident on enhanced barrier precautions for 2 (#7 and #13) of 18 sampled residents reviewed for infection control practices. The administrator identified 62 residents resided in the facility, 16 incontinent residents, and 12 residents on EBP. Findings:<br><br>A policy titled Perineal Care, dated 05/01/24, read in part, It is the policy of this facility to provide perineal care to all incontinent residents .as needed to promote cleanliness and comfort, decrease risk of infection to the extent possible . Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate .Clean the bottom of the scrotum and the anal area .Remove gloves and discard. Perform hand hygiene. Re-apply new set of gloves. Place appropriate incontinent product under resident .Remove gloves and discard. Perform hand hygiene. Reposition as desired ad cover resident.<br><br>A facility policy titled Enhanced Barrier Precautions, dated 04/01/24, read in part Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves used during high contact resident care activities.An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.<br><br>1. An undated order summary for Resident #13's showed diagnoses to include nontraumatic intracranial hemorrhage, muscle wasting and atrophy.<br><br>A physician's order, dated 01/23/25, showed to cleanse peg tube site daily.<br><br>A resident assessment, dated 04/16/25, showed a BIMS of 5 indicating severely impaired cognition, always incontinent of bladder and bowel, dependent for toileting mobility, and presence of a feeding tube.<br><br>There was no order located for enhanced barrier precautions.<br><br>On 07/23/25 at 9:30 a.m., a laminated EBP sign was observed on the wall next to Resident #13's door.<br><br>On 07/23/25 at 9:39 a.m., Resident #13 was observed in his room, in bed with a tube feeding.<br><br>On 07/23/25 at 9:44 a.m., CNA #2 stated Resident #13 was dependent, incontinent, with an hourly check and change, and was on tube feeding. CNA #2 was unable to state for sure when the resident was last checked. Requested to check resident for incontinence.<br><br>On 07/23/25 at 9:46 a.m., CNA #2 went into Resident #13's room to check if soiled. CNA #2 donned gloves and pulled back the sheet to check brief and observed brief to be wet. CNA #2 stated the resident needed to be changed. Resident #13 was covered back up with sheet, removed gloves, and (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | exited the room to gather supplies.<br><br>There was no observation of hand hygiene performed. EBP sign remained next to the resident's door.<br><br>On 07/23/25 at 9:48 a.m., CNA #2 returned to the room, closed the door and curtain, placed trash bag near the bed, and donned gloves. No gown donned. Has clean brief and wipes ready on the bedside table. Resident #13 has bilateral lower extremity contractures. CNA #2 wiped front to back if the perineum with a wipe. Resident had bowel movement and urine soilage. CNA #2 removed the soiled brief by folding it over itself and wiped the remaining stool from the resident, then wiped the gloved hands with a clean wipe, and then applied the clean brief to the residents' bed, turned the resident over, removed a soiled wipe from between the residents' groin and threw it in the trash. The CNA then wiped the gloved hands with another clean wipe and proceeded to turn the resident over and apply the clean brief. CNA #2 removed the green soiled pad and put it on the floor next to the trash and then continued to snap the brief closed, adjusted the residents' gown, removed their gloves and adjusted the cover and head of bed.<br><br>On 07/23/25 at 9:56 a.m., CNA #2 placed the pad in the bag and the trash in a bag. There was no observation of CNA #2 changing gloves or performing hand hygiene according to standard practice and the standard of care.<br><br>On 07/23/25 at 9:58 a.m., CNA #2 stated the process for hand hygiene during incontinent care was to wash hands first. When asked when they should change gloves or wash their hands, they stated, When start messing with sheets and call lights and before and after incontinent care or when hands are soiled when may cross contaminate. CNA #2 stated, For me it really depends on the person. Some may change more than others, it is up to the person. CNA #2 stated they did not know what kind of wipes they had wiped their gloved hands with.<br><br>On 07/23/25 at 10:00 a.m., CNA #2 stated Resident #13 was on EBP for the feeding tube. CNA #2 stated they did not see any PPE. They stated it was not appropriate to put soiled linen on the floor.<br><br>On 07/23/25 at 10:39 a.m., DON not available. The corporate nurse consultant #1 stated the process for hand hygiene during incontinent care was to wash hands before and after, put on gloves, if soiled ten take off, sanitize and new gloves, then remove gloves and wash hands after. The corporate nurse consultant #1 stated for an incontinent resident on EBP they were expected to wear gown and gloves. They stated the PPE was located on the carts.<br><br>On 07/23/25 at 10:42 a.m., corporate nurse consultant #1 showed the linen cart where the gowns were stored at the bottom. They stated it was not appropriate to put soiled linen on the floor during incontinent care, and it was not appropriate to wipe gloved hands with a clean wipe used for incontinent care instead of changing gloves or performing hand hygiene.<br><br>2. On 07/17/25 at 4:24 p.m., LPN #1 gathered their supplies and prepared a clean area on Resident #7's bedside table. LPN #1 washed their hands and donned a pair of gloves. The LPN did not don a gown per enhanced barrier precautions. LPN #1 used a pair of scissors to remove the old dressing. The LPN placed the scissors back on the clean area prepared. LPN #1 did not clean the scissors. The LPN cleaned the wound with normal saline. LPN #1 used the same scissors used to remove the soiled dressing to cut the collagen strip for the size of the wound. LPN #1 placed an abdominal pad over the collagen and wrapped with a gauze wrap.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A care plan, dated 01/19/21, showed Resident #7 had diagnoses which included schizophrenia, mild protein-calorie malnutrition, abnormal gait and mobility, and diabetes mellitus.<br><br>A physician order, dated 07/17/25, showed the staff was to cleanse the right heel with normal saline, pat dry, apply a collagen sheet and cover with an abdominal pad, and wrap with kerlix and secure with tape daily and as needed.<br><br>On 07/17/25 at 4:55 p.m., LPN #1 stated they forgot to bring in an alcohol wipe to clean the scissors between dirty and clean dressing areas. The LPN stated they should have been wearing a gown and gloves for the wound care per EBP. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the influenza vaccine was offered to a resident for 1 (#4) of 5 sampled residents reviewed for immunization.The administrator identified 62 residents resided in the facility.Findings:The Influenza Vaccine policy, dated 2001, read in part, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.A care plan, revised 06/09/25, showed Resident #4 was admitted on [DATE].There was no documentation Resident #4 had been offered an influenza vaccine.On 07/23/25 at 6:14 p.m., the infection preventionist stated they had no supporting documentation Resident #4 had been offered the influenza vaccine. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the COVID-19 vaccine was offered to residents for 3 (#4, 29, and #61) of 5 sampled residents reviewed for immunization.The administrator identified 62 residents resided in the facilityFindings:The Vaccination of Residents policy, dated 2001, read in part, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated.1. A care plan, revised 06/09/25, showed Resident #4 was admitted on [DATE].2. Resident #29's admission resident assessment, dated 05/23/25, showed the resident was admitted on [DATE].3. A care plan, dated 07/14/25, showed Resident #61 was admitted on [DATE].There was no documentation the residents above had been offered the COVID-19 vaccine.On 07/23/25 at 6:14 p.m., the infection preventionist stated they had no supporting documentation the residents above had been offered the COVID-19 vaccine. |