STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425370	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedgewood Manor Health Care Center	1645 Ridge Road Hopkins, SC 29061

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 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 review of facility policy, observations and staff interviews, the facility failed to properly label and discard expired food items in 1 of 1 main kitchen and 1 of 1 resident nourishment refrigerator. This failure to follow proper food storage protocols presents a potential risk to the health and safety of the 33 residents who consume food prepared in the facility's kitchen.Review of an undated facility policy titled Labeling, Dating, Rotating Foods revealed the following: Food must be rotated while in storage to maintain quality and limit the growth of pathogens. Food items must be rotated so the items with the earliest use-by or expiration dates are used before those listed with later dates. The first in, first out method (FIFO) is used to rotate foods refrigerated, frozen, and/or dry goods so that items dated earlier are used first. Identify food's use-by or expiration date. Identifiers include item name, date entering facility, and date of manufacturer expiration. Dispose of food on the date of expiration. Any food taken out of the original container must have a delivery date, a manufacturer's use-by date, and food identification.During an initial walkthrough of the main kitchen on 07/27/25 at 10:45 AM, the following was revealed,Multi-Tier Shelf: 11 dinner rolls in original packaging dated 04/22/25; label dated for 07/21. 2 hamburger buns in original packaging dated 07/18/25; label dated for 07/25/25. 1 bag of Corn Flakes, opened, not in original box; label dated for 02/14. 1 5 pound (lb.) bag of Quaker Grits, opened, with no open-date label.Freezer: 9 individual pieces of meat in a plastic bag labeled 06/28. 1 Ziplock bag labeled catfish nuggets, dated 07/25. 10 individual pancakes in a plastic bag; no label or date. 1 Ziplock bag containing what appeared to be half a ham, dated 07/20/25, no label. 1 plastic bag containing what appeared to be cinnamon rolls; date on bag: 03/05/25. 1 blue plastic bag containing approximately 12 pieces of flatbread; date of 06/03.Cooler: Three half-gallon containers of buttermilk with a use-by date of 7/22; labels dated for 06/24.During an observation on 07/28/25, at 12:30 PM of the resident refrigerator located behind the nurses' station, 1 bottle of Nutren 1.5 was found with a use-by date of 06/09/25.During an interview on 07/27/25, at 11:29AM, the Facility Administrator (FA) and the Director of Nursing (DON) revealed that the expectation is for all dietary staff to properly label and date food items and to discard any items that are past their use-by date.During an interview on 07/27/25, at 11:52 AM, the Dietary Manager (DM) revealed she has been the DM since 2023, and in addition to dietary duties, has overseen housekeeping for the past 8 to 9 months. She reported that staffing is currently limited, with two cooks and three aides, though she noted that staffing has been worse in the past. Despite this, mealtimes have not been affected. DM explained that the dietary area lacks sufficient storage space to keep items in their original boxes but follows the First-In, First-Out (FIFO) method for inventory management. Inventory is completed on Mondays and Thursdays, during which labeling is also checked. Daily staff meetings are held to ensure expired foods are discarded; however, she admitted this has not been consistently done in recent weeks. Regarding specific items, she stated that bread is received frozen, with a delivery date labeled and a shelf life of seven days from that date. Cereal received in February 25 was not in its original packaging and had no year indicated on the label. In the freezer, pancakes were present, as well as half of a ham that was not properly labeled. Cinnamon rolls dated 03/05/25 were identified and noted as items that should have been removed. She also (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	identified flatbread stored in its original packaging and a second bag containing hamburger patties. The dietary labeling procedures are intended to be followed for all freezer items. One resident nourishment area is located on the unit, containing snacks and drinks for residents, which is restocked as needed by unit staff. Staff are expected to check for proper labeling weekly. The dietary staff are to follow the practice of using the oldest food first and placing newer shipments behind existing stock.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interviews, the facility failed to ensure that an allegation of abuse was immediately reported to the abuse coordinator for 1 of 3 residents, Resident (R) 31 reviewed for abuse. This failure had the potential to expose the victim to ongoing harm and allow harmful behavior to continue without intervention.Review of the undated facility policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revealed, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations withing prescribed timeframes.Review of R31's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to: type 2 diabetes mellitus, schizoaffective disorder, chronic kidney disease, anxiety disorder, and muscle weakness.Review of R31's quarterly Minimum Data Set (MDS) with an Annual Reference Date (ARD) of 07/16/25 revealed R31 had a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating she has moderate cognitive impairment.Review of R31's progress notes dated 07/27/25 at 4:20 PM, revealed, I woke this resident by saying hello this am and asking her how she was. R31stated that a few days ago some girl sprayed air freshener in my face. I asked her if she had reported it to anyone and she replied no, I just thought about it. No eye irritation or redness noted. I offered her a cool wet cloth for her eyes and she said not right now. Encouraged resident to let me know if she changed her mind.During an interview on 07/27/25 at 12:05 PM, R31 stated that a nurse had allegedly sprayed aerosol in her eyes a couple of weeks ago, but she does not remember who the nurse was. She stated she reported to the Activities Director around supper time the day that it happened, but no one has come to talk with her about it. During an interview with the Facility Administrator (FA) on 07/27/25 at 2:30PM, the surveyor reported the allegation of abuse. FA stated he was not aware of an abuse allegation, and this is the first that he has heard of it. He included that there are no aerosol cans in the building and to his knowledge, no one in the facility has been treated for eye care due to irritants being sprayed or getting into their eyes. The FA provided the surveyor with the two-hour state reportable dated 07/27/25 at 2:55PM.During an interview on 07/27/25 at 2:40 PM, the Activities Director revealed that R31 had never reported anything to her about someone doing anything offensive to her. She states R31 is always pleasant to her, and she had not made any complaints about anything.During an interview on 07/28/25 at 4:07PM, Licensed Practical Nurse (LPN)5 revealed she was waking up R31 yesterday morning and speaking to her as normal and she asked her how she was doing and R31 responded stating that a girl sprayed air freshener in her eyes a couple of days ago. She includes she did not do anything with this information because she usually says weird things in the morning, and she thought that this was again the same case. LPN5 states that she should have immediately called her Director of Nursing (DON), she knows that she should report any signs of abuse or any sort of odd occurrence. She also states she spoke to R31 a lot and looked at her eyes to make sure there were no spots on her face. LPN5 also includes that she did not bring the situation back up to the resident and she did not report it, she wrote a progress note after the FA approached her about the incident and they asked her to write a statement.During an interview with the DON on 07/29/25 at 9:42 AM, she stated that staff should notify her and/or the FA of any allegation of abuse that should occur. An incident form should also be completed in the computer. The staff is educated to report anything from death, falls, altercations, just anything. The FA is the abuse coordinator, and all things should be reported to him immediately, all staff should be aware of this, and they train the staff annually for abuse.During an interview with the FA on 07/29/25 at 9:56 AM, he revealed that all staff are trained annually through Relias and periodically when thing come about. He includes he is (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the coordinator, and staff are aware that any allegations or cases of abuse should be reported to me or their immediate supervisor. All forms of abuse should be reported, and I then have two hours of being informed to report to the state agency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 review of facility policy, record review, observations, and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for Resident (R4), 1 of 3 residents reviewed for ADL care. Specifically, staff failed to provide showers and nail care for R4, who was dependent on staff for assistance with ADLs.Review of the facility's undated policy titled Activities of Daily Living (ADLs) revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to: cerebral infarction due to thrombosis of the right middle cerebral artery, morbid (severe) obesity due to excess calories, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and unsteadiness on feet.Review of R4's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/02/25, revealed R4's Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. R4 is dependent on staff assistance for personal hygiene and showering/bathing and had no refusals of care during the look-back period.During an observation and interview on 07/27/25 at 1:34 PM, R4 revealed that she has impairment on her left side. R4's fingernails were long with dried dirt and brown matter underneath. R4 had food crumbs on her face and gown. R4 stated that she requires assistance with personal hygiene due to her left-side impairment. She reported repeatedly asking staff to clean her nails, but they have not done so. R4 also expressed that she does not receive showers as often as she should and could not remember the last time she had an actual shower. While she acknowledged receiving good bed baths, it had been nearly a week since her last one. R4 shared that she has voiced her concerns to the Director of Nursing (DON) regarding staff not assisting her with showers and has also discussed this issue with her spouse. She emphasized that she does not want to seem like she is bothering the staff but simply wants the help she needs.During observations 07/28/25 8:36 AM and 07/29/2025 at 9:49AM, R4's fingernails remained long with dried dirt and brown matter underneath. R4 states that her aide told her they didn't have the supplies to cut or clean her nails. Review of the Resident Shower Book Log documented R4 received either a shower or a bed bath on the following dates: 03/14/25, 03/21/25, and 04/11/25. These dates were confirmed by the Assistant Director of Nursing (ADON).During an interview on 07/28/25, at 10:35 AM, the DON confirmed that R4 is compliant with care, including assistance with ADLs. She stated that R4 has a contracture in her left arm and is dependent with all ADL's. She stated that as far as nailcare, Certified Nursing Assistants (CNA's) are to cut and trim resident nails, during AM care or during a shower, if a resident requests.During a phone interview on 07/28/25 at 12:50 PM, R4's spouse confirmed that he is the primary contact for the facility and stated that R4 was admitted last year following a stroke. He reported that he has not observed his wife refusing care; however, he expressed concern that she tells him she does not receive showers on her scheduled shower days. He stated that he has observed her receiving bed baths rather than showers. He typically visits her after work, around 5:00 PM to 6:00 PM, before dinner. He also mentioned that R4 recently complained to him that her nails are not being cleaned. R4 is fully dependent on staff for all care and is bedridden.During an interview on 07/28/25 at 2:41 PM, in the presence of the DON and Facility Administrator (FA). The ADON stated that both nurses currently assigned to the unit are new, and this was their first day on the floor. She explained that ADL charting is completed in the electronic health record (EHR), except for showers, which are documented in a shower book maintained on the unit. Regarding R4, it was noted that the resident is scheduled to receive showers on Tuesdays and Fridays. CNAs are responsible for documenting each time a resident receives a shower or bed bath, and if a resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refuses, the refusal should be recorded on the shower sheet for that day or in a progress note. Additionally, a shower task is available in the EHR system. The ADON emphasized the expectation that CNAs honor resident preferences and document all care provided. She also added that CNAs are responsible for cleaning residents' nails as needed. When invited to observe the resident's nails, the ADON, DON, and FA declined.During an interview on 07/29/25 at 11:48 AM, the Activities Director (AD) revealed that CNAs are responsible for cleaning and cutting residents' fingernails upon request. The AD also stated that she will assist with nail polishing if the resident requests it.During an interview on 07/29/25 at 12:00 PM, CNA1 revealed that showers are supposed to be documented in the shower book, which is kept at the nurses' station. She acknowledged that she has been providing residents with showers but has not been documenting them in the book, which is why it appears empty. She also states she is not R4's CNA. She stated that moving forward, she will improve her documentation practices.During an interview on 07/29/2025 at 12:16 PM, CNA2 confirmed that she is R4's assigned CNA. She stated she would need to check with other staff and refer to the shower book to determine when R4 last had a shower, as she could not recall the dates offhand. CNA2 confirmed that R4's nails needed to be cleaned and cut. CNA2 acknowledged that R4 had been asking her for several days to attend to them. CNA2 stated she had informed the nurse about R4's nails because she did not feel comfortable cutting them herself.During an interview on 07/29/2025 at 4:26 PM, the FA revealed that his expectation regarding residents' personal hygiene including showers and nail care is that it should be provided both on scheduled days and as needed. He stated that this expectation is strongly emphasized with the DON and ADON. The FA also emphasized that if it's not documented, it's not done, and this applies to nail care as well if a resident requests it, staff are expected to complete it and ensure it is properly documented.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility policy, record reviews, observations, and interviews, the facility failed to provide an ongoing resident-centered program designed to meet the resident's interests, hobbies, and cultural preferences in order to promote physical, mental, and psychosocial well-being for 1 of 2 residents reviewed for activities, Resident (R)35.Review of an undated facility policy titled, Activities states, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. Activities may be conducted in different ways: One-to-One Programs, Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. Program of Activities - to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend. All staff will assist residents to and from activities when necessary. Activities can occur at any time and are not limited to formal activities provided by the activities staff and can include other facility staff members, volunteers, visitors, residents, and family members.Review of R35's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes mellitus, unspecified dementia, major depressive disorder, and episodes of syncope and collapse. Review of R35's Quarterly- Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/25, revealed R35 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating that she is cognitively intact. Additionally, no rejection of care was exhibited during the lookback period.Review of R35's Care Plan revealed, Focus- The resident will continue to be encourage to attend oor (out of room) activities that meet the emotional, intellectual, physical, and social needs r/t past and present interest. She is also the resident council president she enjoys spending time with peers/staff and sitting outside on front porch. Interventions- Invite the resident to scheduled activities. The resident needs assistance/escort to activity functions.Review of R35's progress notes documented by the Activities Department revealed the following:06/30/25 3:09PM Resident Preferences Evaluation Resident Preferences Evaluation: How important is it to you to choose what clothes you wear: Somewhat important. How important is it to you to take care of your personal belongings or things: Somewhat important. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath: Somewhat important. It is somewhat important to the Resident to have snacks available between meals. It is somewhat important for Resident to choose their own bedtime. It is very important for the Resident to have their family, or a close friend involved in discussion about their care. It is somehow important for Resident to be able to use the phone in private. It is somewhat important to Resident to have a place to lock their things to keep them safe. Primary respondent for Daily and Activity: Resident. It is somewhat important for Resident to have books, newspapers and magazines to read. It is somewhat important for the Resident to keep up with the news. It is somewhat important to Resident to listen to music they like. It is not very important for the Resident to be around animals such as pets. It is somewhat important for Resident to do things with groups of people. It is somewhat important for Resident to do their favorite activities. It is somewhat important to Resident to go outside to get fresh air when the weather is good. It is somewhat important for Resident to participate in religious services or practices.07/08/25 3:35PM Quarterly note: Resident alert and oriented, able to make most needs known. Resident continue on a mech soft diet. Resident is very pleasant and nice. Ms. [NAME] continues to require a w/c for ambulation around unit. Ms. [NAME] has calendar in room for review but is informed of daily activities of interest by staff. Resident attends oor activities that of interest to her such as bingo and social events at times or sitting on (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	front porch. Continues as Resident council President. Resident interact with others well. Resident has good family support. Well follow plan of care at this time.Review of the facilities activity calendar located on the unit in front of the main double doors revealed the following scheduled events: On Sunday, 07/27/25 at 10:00 AM, a worship service was scheduled. On Monday 07/28/25, at 10:00 AM, sittercise was scheduled, followed by finger painting at 2:00 PM. On Tuesday, 07/29/25, I-Spy was scheduled for 10:30 AM, and Bingo was scheduled for 2:00 PM.Observation on 07/27/25 from 9:58AM though 10:30 AM did not reveal any activities occurring during this time. During an interview on 07/27/25 at 2:14 PM, R35 revealed that she is dependent on staff for transfers and most of her Activities of Daily Living (ADLs). She stated that she typically receives an activity calendar from the AD at the beginning of each month; however, activities had not been provided for the past couple of days, and she was unsure why. She further reported that on other occasions, staff members have entered her room and told her they would return to escort her to activities, but they never followed through. R35 stated she would love to participate more in activities if staff came and got her.Observation on 07/28/25 at 10:27 AM, of activities held in the facility's main dining room, revealed five residents participating in group exercises along with the Activities Director (AD). Resident R35 was not observed in attendance.During an interview on 07/29/25 at 11:48 AM, The AD revealed that she has been employed at the facility for 13 years. She stated that all residents receive an activity calendar at the beginning of each month. Each morning, she conducts rounds to notify residents of the activities scheduled for that day. According to the AD, both she and the Certified Nursing Aides (CNAs) are responsible for assisting dependent residents if they choose to participate in activities. She explained that she is responsible for maintaining a participation log to document resident attendance and refusals. However, she acknowledged that she has not been documenting attendance for any of the residents and, therefore, could not produce a record for Resident R35. The AD also stated that church services are supposed to be held on Sundays, but she has not heard from the reverend in some time and is unsure whether he continues to come, as she is not present on weekends.Observation of the main dining room on 07/29/25 at 2:19 PM revealed that no residents were present or participating in the scheduled Bingo activity, which was confirmed by the AD. During an interview on 07/29/25 at 4:26 PM, the Facility Administrator revealed that his expectation is for staff to assist residents in getting up and participating in scheduled activities. He stated that activities should be conducted as outlined in the activity schedule. If, for any reason, an activity is canceled, residents are to be notified. Additionally, he emphasized that documentation is always expected, stating, If it's not documented, it's not done.

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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, interviews, record review, and review of facility policy, the facility failed to follow physician orders for changing oxygen tubing and nasal cannulas for 3 of 3 residents (R) R7, R32 and R42 reviewed for respiratory care. This failure has the potential for harm due to increased risk of infection. Review of the undated facility policy titled Oxygen Administration revealed, 5b. Change Oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Review of R7's face sheet showed she was admitted to the facility on [DATE]. Her diagnoses included but were not limited to: chronic obstructive respiratory disease (COPD; a lung disease causing shortness of breath), chronic respiratory failure, generalized anxiety disorder, and muscle weakness. Review of R7's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/25 showed she has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she has no cognitive deficit. Her MDS indicated she receives continuous oxygen therapy. Review of R7's care plan revealed a focus on her diagnosis of COPD. Interventions included adjusting the head of bed and body positioning to assist with ease of respirations as able; assessing hydration status if indicated; encouraging rest periods if indicated, medications as ordered; labs if indicated; monitoring lung sounds, pallor (paleness), character of sputum (secretions), and cough; monitoring resident's anxiety and providing support and assistance as needed; monitoring respiratory rate, depth, and effort; reporting any abnormalities to Medical Director if indicated; and notifying Medical Director and family of change in condition if indicated. Review of R7's Order Summary Report noted the following order with a start date of 07/06/25, Cleansing oxygen concentrator filter with warm water, letting the filter dry and replacing weekly every Sunday and as needed; changing oxygen concentrator tubing and water bottle (and date) weekly on Sunday and as needed; and oxygen via nasal cannula at two liters per minute (LPM) continuously. Review of R7's Treatment Administration Record (TAR) for 07/01/25-07/31/25 revealed a blank/unsigned space for 07/27/25 indicating R7's tubing and nasal cannula were not changed. During an observation on 07/27/25 at 12:05 PM, R7's oxygen level was set at 2 liters per minute (LPM). R7 was wearing a dark green nasal cannula with dark green tubing. No label indicating the date the tubing and nasal cannula were changed was found on the tubing. During an interview with R7 on 07/27/25 at 12:05 PM, she revealed she uses oxygen continuously. She stated she liked a particular type of nasal cannula from Lincare. When asked the last time her oxygen tubing and nasal cannula had been changed, she revealed, It has not been changed. This is the one I came to the facility with. I use mouthwash to clean the nostril prongs. During an observation on 07/28/25 at 11:15 AM, R7 was wearing oxygen via nasal cannula. R7's oxygen level was set at 2LPM. No label was found on the tubing indicating the date and time of change. No label was found on the oxygen concentrator indicating the date and time of the tubing and nasal cannula change. During an interview with R7 on 07/28/25 at 11:15 AM, she was asked again if her oxygen tubing had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been changed since admission, and she stated, No, it hasn't. This is the one I brought from home. I like the way it feels. When asked if she ever refused to have her oxygen tubing changed when staff offered or said they were going to, she stated, They never have told me they were going to change it, so no, I have never refused. During a phone interview with Licensed Practical Nurse (LPN)4 on 07/29/25 at 11:55 AM, he revealed, I must have missed changing R7's tubing and nasal cannula. I do it in the dark, so I guess I missed it. I had a lot of oxygen tubing to change out. When asked if R7 ever refused to have her oxygen tubing and nasal cannula changed, he stated, No, she has never refused. During an interview with Director of Nursing (DON) on 07/29/25 at 09:25 AM, she revealed, The tubing R7 is wearing came from when she was transported from the hospital. She has had it on since she has been here. She is refusing to change it. I am going to ask her to change it today. Review of R32's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses including, but not limited to: hypoxemia, chronic obstructive pulmonary disease and anxiety disorder. Review of R32's five-day MDS with an ARD of 07/03/25 reveals he had a BIMS score of 8 out of 15, indicating he has moderate cognitive impairment. Review of R32's Physician Orders revealed an order dated 06/26/25, Keep Nebulizer mask/tubing covered when not in use every shift for protocol. Another order dated 06/29/25, Change [Oxygen] O2 concentrator tubing and [water] H2O bottle and date weekly on Sunday and [as needed] PRN every night shift every Sun for protocol and change O2 concentrator filter with warm water, let air dry and replace weekly on Sunday and PRN. Review of R32's Care Plan with an initiation date of 07/15/25, revealed a Focus of a diagnosis of COPD, with interventions including, Change nebulizer mask and tubing weekly on Sunday. Ensure to Record date of change, Cleanse O2 concentrator filter with warm water, let air dry and replace weekly on Sunday and PRN, and Change O2 concentrator tubing and H20 bottle and date weekly on Sunday and PRN. During an observation on 07/27/25 at 11:35 AM, R32's O2 concentrator and tubing did not have any labels or dates. During an observation on 07/28/25 at 8:53AM and 1:55PM, revealed the R32's O2 concentrator and tubing did not have any labels or dates. Also, R32's nebulizer face mask was exposed with no covering on the nightstand. Review of R42's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including, but not limited to: acute respiratory failure with hypoxia, generalized anxiety disorder, muscle spasm, and traumatic brain injury. Review of R42's Physician Orders revealed an order dated 07/27/25, Change Oxygen Concentrator tubing and H2O bottle (and date) weekly on Sunday and PRN, every night shift every Sun for Oxygen therapy and Cleanse O2 concentrator filter with warm water, let air dry and replace weekly on Sunday and PRN, every night shift every Sun for Oxygen therapy. Review of R42's Baseline Care Plan indicates special treatments of oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/27/25 at 12:11 PM, R42 was sitting in the day room with oxygen nasal cannula on, there were no dates or labels on the tubing or the O2 concentrator. During an observation on 07/28/25 at 8:57AM and at 1:58 PM, R42 was observed lying in bed with oxygen nasal cannula on, there were no dates or labels on the tubing or the O2 concentrator. During an observation on 07/29/25 at 9:10 AM, revealed no labels or dating on R32's tubing or O2 concentrator. During an interview on 07/29/25 at 9:15 AM, LPN2 confirmed there were no dates on the tubing and concentrator. She states she is unsure if the facility is supposed to date tubing and concentrators, because some facilities do and some do not. During an interview on 07/29/25 at 9:20AM, LPN3 revealed this is her first day working here and she is not sure if the dates should be on oxygen tubing and/or O2 concentrators. During an interview on 7/29/25 at 9:38AM, the DON revealed that oxygen tubing and concentrators should be labeled and changed every Sunday night, and she wasn't aware that there were no dates on the machines and tubing, but she could find out why and get them labeled. The DON includes that face masks for nebulizers should be placed in a plastic bag when not in use. She further reveals that the nursing staff is responsible for ensuring that the items are properly labeled. She includes there is a staff member that is responsible for labeling oxygen tubing and concentrators on Sundays, and she just didn't check behind him. During an interview on 07/29/25 at 9:59AM, the facility Administrator revealed, he is aware that the tubing and concentrators should be changed out and dated and the Assistant Director of Nursing (ADON) and DON should oversee that task. He is unsure of who would be responsible on a daily basis. The Administrator states his expectation is that staff follow all orders, as written, for each resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interviews, and employee record reviews, the facility failed to provide yearly performance evaluations for Certified Nursing Assistants (CNAs), for 3 of 5 CNAs reviewed for yearly performance evaluations; CNA3, CNA4,and CNA5. Review of CNA3's employee record revealed she has a hire date of 04/20/23. She received her last performance review on 05/10/24. She received a rating of Excellent in all areas except one. Her 2025 performance review had not yet been completed as of 07/28/25. Review of CNA4's employee record revealed she has a hire date of 02/24/16. She received her last performance review on 02/28/24. She was rated Excellent and Good in all areas. When Surveyor initially asked for her file on 07/28/25, Human Resources (HR) revealed CNA4's 2025 review was not yet completed. Later in the day on 07/28/25, HR informed Surveyor CNA4's 2025 was completed. She was rated Good in all areas.Review of CNA5's employee record revealed she has a hire date of 04/25/24. When Surveyor initially asked for CNA5's employee record, HR revealed CNA5's 2025 review was not yet completed. On 07/28/25, HR informed Surveyor CNA5's 2025 review was now completed. During an interview on 07/28/25 at approximately 3:40 PM with HR about the missing evaluations, she revealed, I should have had them done. I need to have them (the supervisors) get them done. With regards specifically to CNA5, she stated, We are going to have to pro-rate her. I am going to give them the form to do.During an interview with HR on 07/28/25 at 4:28 PM, she revealed, I want to show you they now have CNA5's review done.During an interview with Regional Consultant on 07/28/25 at approximately 3:30 PM, he stated, Why are you asking for employee reviews? We've never been asked for those. In all my years of doing this, this is the first time someone has asked. It's not in the regulations, so I don't know why you want them. Surveyor informed Regional Director that yearly reviews for CNA staff are in the regulations. Additionally, he stated, I dislike the whole review process. It really doesn't mean anything. I have never had a performance evaluation in my 26 years of doing this.During an interview with Regional Consultant on 07/28/25 at 5:40 PM, he stated, I found the regulation about the performance reviews. I didn't know that it was a regulation.On 07/29/24 at 11:48 AM, Surveyor attempted to do a phone interview with CNA4 to confirm she had not had a performance evaluation this year. Voice mail message with call back number left. On 07/29/25 at 11:49 AM, Surveyor attempted to do a phone interview with CNA3 to confirm she had not had a performance evaluation this year. Voice mail message with call back number left. During a phone interview with CNA5 on 07/29/25 at 12:17 PM, she stated, No, I have not had an evaluation this year. It has been over a year since I have had one. I do get verbal feedback from the Director of Nursing (DON), but when I requested to get a formal evaluation so that I could get a raise, she replied, Good luck with that.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations, interviews, and Daily Nursing Hours sheet reviews, the facility failed to visibly post the Daily Nursing Hours sheets on a daily basis where residents, staff, and visitors could visibly access them. During an observation on 07/27/25 at 9:59 AM, the Daily Nursing Hours sheets were posted in one of two resident hallways outside the Director of Nursing (DON) office. The office was located within the facility and was not readily accessible to visitors as they entered the facility. The date on the sheet that was visible was 07/24/25. Under the Daily Nursing Hours sheet dated 07/24/25 was a Daily Nursing Hours sheet dated 07/21/25. During an interview with Regional Consultant on 07/27/25 at 4:30 PM, he revealed, We do not post the Daily Nursing Hours sheets in the front of the building. We have always posted these at the nurses' station. I do not know if the sheet would be visible to others that don't go to the nurses' station or past it if the resident's room is not down that hallway. He then agreed that all visitors would not actually see the Daily Nursing Hours sheets but reiterated that is where the sheet is posted in every building he oversees. During an interview with the DON on 07/28/25 at approximately 3:30 PM, she confirmed, We only post the Daily Nursing Hours sheets by my office. We do not have it posted anywhere else in the building.On 07/29/25, Surveyor requested the Daily Nursing Hours sheets for 01/01/25 through 03/31/25. During an observation on 07/29/25 at 4:28 PM, DON was in the business office and was observed writing the Daily Nursing Hours sheets. Surveyor asked if she was writing the sheets for Quarter 1. She responded, No. I'm just gathering them together. When surveyor questioned why there was an unfinished Daily Nursing Hours sheet with the date of 03/12/25 on it, she stated, There were some that were missing. Surveyor informed DON not to write up the missing ones. DON then gave surveyor a stack of Daily Nursing Hours sheets from 01/01/25 - 03/11/25.

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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 review of facility policy, record reviews, observations and staff interviews, the facility failed to ensure a medication error rate below 5% during medication administration for 2 of 25 opportunities for error; the error rate was 8 percent. Specifically, Resident (R) 30 did not receive two medications for which there were active physician orders, resulting in a medication omission error. Review of the undated facility policy titled, Medication Administration, states, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician.Observation of medication pass on 06/28/25 at 8:34 AM, Licensed Practical Nurse (LPN)1 was observed preparing to administer medications to R30. R30 had active physician orders for the following medications: Calcitriol Oral Capsule 0.25 mcg, to be administered by mouth once daily at 9:00 AM for renal disease and Sensipar (Cinacalcet HCl) Oral Tablet 30 mg, to be administered by mouth once daily at 9:00 AM for renal disease. At the time of observation, LPN1 confirmed that neither medication was available in the facility, and therefore they were not administered as ordered. Constituting an omission error due to unavailability.Interview with LPN 1 on 06/28/25 at 8:34 AM following a medication administration observation. LPN 1 reported that she is new to the facility and has been employed for only a few days. She stated she is not yet familiar with R30 or R30's medication regimen. LPN 1 confirmed she was unaware that R30 had run out of Sensipar (Cinacalcet HCl) and Calcitriol. She also reported that she does not know how long it will take for the pharmacy to replenish the missing medications. LPN #1 stated she planned to notify the Director of Nursing for assistance with ordering the missing medications.Interview on 07/29/25 at 10:35 AM, with the Director of Nursing (DON) and Associate Director of Nursing (ADON) revealed, The resident was admitted to the facility on a Friday following a hospitalization. The transition of care followed a continuum from home to the hospital and subsequently to the facility. The resident is a dialysis patient with a scheduled dialysis regimen on Tuesdays, Thursdays, and Saturdays. Upon admission, a medication reconciliation was completed. Calcitriol and Sensipar were among the medications the hospital provider intended to continue post-discharge. The resident was sent to dialysis the day after admission; however, the nephrologist did not evaluate the resident during that session. The DON and ADON reported they were under the impression that the resident should not receive certain medications until evaluated by the nephrologist. At this time, no documentation has been provided to support that claim. It was confirmed by both the DON and ADON that there are active orders for Calcitriol and Sensipar. However, these medications were not administered, as they had not yet been delivered by the pharmacy.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations and interviews, the facility failed to failed to provide appropriate assistive devices for 1 of 2 Residents (R) reviewed for food. Specifically, R22 did not receive an ordered cup with two handles and lid during meals. This failure has the potential for harm due the potential loss of independence with feeding self.Review of the undated policy titled, Use of Assistive Devices revealed, Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities . Assistive devices include . g. Eating utensils. The policy also stated, The facility will provide assistive devices for residents who need them.Review of R22's face sheet showed she was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to: anxiety, dementia and dysphagia (trouble swallowing).Review of R22's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/25 showed she has a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating she has severe cognitive deficit. Her MDS indicated she had no complaints of difficulty swallowing, no choking during meals or when swallowing medications, and no special treatments.Review of R22's care plan revealed R22 Patient needs a cup with two handles and a lid with each meal. Review of R22's orders revealed that a order for a cup with two handles and lid with each meal was entered on 07/31/24.During an observation on 07/29/25at 08:50 AM, a 2-handled cup with lid was not present on R22's breakfast tray.During an interview with R22 on 07/29/25 at 8:50 AM, she stated, No, I've never had a special cup. I don't know what you are talking about. I've never seen anything like that.During an interview on 07/29/25 at 9:58 AM, when asked about the 2-handled cup with lid on R22's care plan, Dietary Manager revealed, The 2-handle cup would have to be in the orders. If I get an order for that, we will put the cup on her tray when it is set up. I usually get two for each resident who needs one. A two-handled cup is for adaptive purposes if they have a hard time grasping a cup. It allows her to be independent with dining and not have to rely on others to help her.During an interview on 07/29/25 at 10:08 AM with Certified Nursing Assistant (CNA) 2, she revealed, I've never noticed a 2-handle cup on R22's tray. I've never served her anything in that type of cup.During an interview on 07/29/25 at 09:58 AM, Director of Nursing (DON) revealed, R22 does have an order for a 2-handled cup with lid. She should have the cup. DON showed the order for a 2-handled cup with lid dated 07/31/24 to Surveyor.During an interview on 07/29/25 at 11:07 AM, Surveyor informed Dietary Manager of the order for a 2-handled cup with lid for R22 dated 07/31/24. She stated, Yes, I know that now. I've sent a message to the speech therapist to see what exact model she needs.