

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

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Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555772                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>11/13/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Joshua Tree Post Acute                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>8515 Cholla Ave<br>Yucca Valley, CA 92284 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                 |
| F 0908<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | Keep all essential equipment working safely.<br><br>Based on observation and interview, the facility failed to ensure the walk-in refrigerator and walk-in freezer were maintained. This failure had the potential for temperatures to fluctuate, putting an already vulnerable population at risk for foodborne illness. During a concurrent observation and interview on 9/15/25 at 8:05 AM, with the Maintenance Supervisor (MS) in the facility's kitchen, the gasket (an airtight seal around the door to keep cold air inside and warm, moist air out, maintaining consistent temperatures for food safety and energy efficiency) for the walk-in refrigerator was loose and held in place with tape. The walk-in freezer door was coated in a layer of ice. The MS stated the freezer door gasket did not create a tight seal which caused the door to shut improperly. The MS stated he needed to melt the ice with a blower every two to three weeks to remove the ice buildup. The MS stated both the walk-in refrigerator and walk-in freezer gaskets needed to be replaced. During a review of the facility's policy and procedure (P&P) titled, Physical Environment, dated 1/2025, the P&P indicated, It is the policy of this facility to establish procedures for routine and non-routine care of equipment and to ensure that it remains in good working order for resident and staff safety. |                                                                                        |                                                 |

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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| <p>F 0578</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide written information concerning the right to formulate an Advance Directive for four of 10 sampled residents (Residents 2, 5, 7, and 9). This failure had the potential for the residents' decisions regarding their healthcare and treatment options not being honored.</p> <p>1. A review of Resident 2's admission Record, (a document showing a summary of the resident's information) dated 9/17/25, indicated Resident 2 was admitted to the facility on [DATE].</p> <p>A review of Resident 2's Advance Directives Checklist, dated 4/18/25, indicated Resident 2 did not possess an Advance Directive (a written document specifying an individual's end- of -life care). The section indicating I was offered and received referral tools to formulate Advance Directive was left blank.</p> <p>A review of Resident 2's History and Physical, dated 4/21/25, indicated Resident 2 did not have the capacity to understand and make decisions.^</p> <p>During a concurrent interview and record review on 9/16/25 at 3:24 PM with the Social Services Director (SSD), Resident 2's Advance Directive Checklist, dated 4/18/25 was reviewed. The SSD stated he documented in the Advance Directive Checklist, form to indicate if the resident or representative was informed of the right formulate an Advance Directive. When asked to show evidence Resident 2 or their representative were offered the right to formulate an Advance Directive, the SSD was unable to show any evidence information about Advance Directives were offered and verified the section was left blank.</p> <p>2. A review of Resident 5's admission Record, dated 9/16/25, indicated Resident 5 was readmitted to the facility on [DATE].</p> <p>A review of Resident 5's POLST, (Physician Orders for Life-Sustaining Treatment - form that documents an individual's preferences for end-of-life care) dated 10/13/24, indicated under Section D Information and Signatures, Resident 5 did not have an Advance Directive.</p> <p>A review of Resident 5's History and Physical, dated 8/22/25, indicated Resident 5 did not have the capacity to understand and make decisions.^</p> <p>During a concurrent interview and record review on 9/16/25 at 3:24 PM with the Social Services Director (SSD), Resident 5's clinical record was reviewed. The SSD stated he was responsible for ensuring the Advance Directives were available in the clinical record or offered to the residents. The SSD stated if the resident did not have an Advance Directive in place, he would follow up with the resident or the representative and offer to formulate one. The SSD stated he documented in the Advance Directive Checklist form to indicate if the resident or representative was informed of the right formulate an Advance Directive. When asked to show Resident 5's Advance Directive Checklist form, the SSD verified there was no documented evidence indicating Resident 5 or their representative was offered the right to formulate an Advance Directive and verified there was no Advance Directive Checklist form completed for Resident 5.^</p> <p>(continued on next page)</p> |                                                                                        |                                                 |

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| <p>F 0578</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>3. A review of Resident 7's admission Record, dated 9/16/25, indicated Resident 7 was first admitted to the facility 3/19/22.</p> <p>A review of Resident 7's POLST, dated 3/19/22, indicated under Section D Information and Signatures, Resident 7 did not have an Advance Directive.</p> <p>A review of Resident 7's History and Physical, dated 6/11/25, indicated Resident 7 did not have the capacity to understand and make decisions. Further review of Resident 7's clinical record indicated no documented evidence that the resident or the representative was provided with written information concerning the right to formulate an Advance Directive.</p> <p>During a concurrent interview and record review on 9/16/25 at 3:24 PM with the SSD, Resident 7's clinical record and POLST dated 3/19/22 were reviewed. The SSD stated that he was responsible for ensuring the Advance Directives were available in the clinical record or offered to the residents. If the resident did not have an Advance Directive in place, he would follow up with the resident or the representative and offer to formulate one. The SSD stated he documented in the Advance Directive Checklist form to indicate if the resident or representative was informed of the right formulate an Advance Directive. When asked to show Resident 7's Advance Directive Checklist form, the SSD verified there was no documented evidence indicating Resident 7 or her representative was offered the right to formulate an Advance Directive and verified there was no Advance Directive Checklist form completed for Resident 7.</p> <p>4. A review of Resident 9's admission Record, dated 9/16/25, indicated Resident 9 was readmitted to the facility on [DATE].</p> <p>A review of Resident 9's POLST, dated 7/6/24, indicated under Section D Information and Signatures, Resident 9 did not have an Advance Directive.</p> <p>A review of Resident 9's History and Physical, dated 11/26/24, indicated Resident 9 did not have the capacity to understand and make decisions. Further review of Resident 9's clinical record indicated no documented evidence that the resident or the representative was provided with written information concerning the right to formulate an Advance Directive.</p> <p>During a concurrent interview and record review on 9/16/25 at 3:24 PM with the SSD, Resident 9's clinical record and POLST dated 7/6/24 were reviewed. The SSD verified there was no documented evidence indicating Resident 9 or her representative was offered the right to formulate an Advance Directive. The SSD verified there was no Advance Directive Checklist form completed for Resident 9. The SSD stated the facility had a difficult time contacting the family and verified Resident 9 did not have an Advance Directive in place since admission.</p> <p>A review of the facility's policy and procedures titled Advance Directives, dated 1/25/25, indicated It is the policy of this facility that a resident's choice about advance directives will be recognized and respected. Further, it is the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment, and at the resident's option, formulate an advance directive.5. The care plan team will periodically, at least quarterly, annually, and on a change of condition, review the advance directive and/or preferences regarding treatment options with the resident or his/her representative his/her advance directives to ensure that they are still the wishes of the resident.</p> |                                                                                        |                                                 |

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| F 0552<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to obtain informed consent (a process in which a healthcare professional educates a resident/patient about the risks, benefits, and alternatives of a given procedure or intervention so the resident/patient can make an educated decision) before administration of Ativan ([lorazepam] a psychotropic medication that affects a person's mental state and used to treat anxiety) for one of five sampled residents (Resident 1). This failure resulted in Resident 1 being administered Ativan without Resident 1 understanding or agreeing to the risks and benefits of the medication. A review of Resident 1's admission Record, (a document showing a summary of the resident's information) dated 9/18/25, indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses including major depressive disorder and anxiety. A review of Resident 1's Order Summary Report, (a report that contains medication orders) dated 9/19/25 indicated Resident 1 had a physician's order dated 9/9/25 for Ativan Oral Tablet 0.5 mg (milligrams - unit of measurement) (Lorazepam) Give 1 tablet by mouth every 8 hours as need for Anxiety . During a concurrent interview and record review on 9/19/25 at 4:45 PM with the Director of Nursing (DON), the DON reviewed Resident 1's medical record and verified there was no documentation Resident 1 received informed consent prior to the administration of Ativan. The DON verified Resident 1 received Ativan without a signed informed consent. The DON reviewed the facility's policy and procedure (P&amp;P) titled, Psychotropic Drug Use, dated 1/2025 which indicated, .6 .f. Informed consent was obtained prior to use . The DON verified the facility did not follow their policy for psychotropic drug use.</p> |                                                                                        |                                                 |

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| F 0584<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation and interview, the facility failed to clean and disinfect the shared toilet of two sampled residents (Resident 32 and Resident 53) after completing plumbing work. This failure violated the residents' right to a safe and sanitary living environment. During a concurrent observation and interview on 9/15/25, at 9:25 AM with Resident 53, in the resident's room, the door to the restroom had a red banner that read, Stop do not enter. Resident 53 stated the toilet was broken. During an interview on 9/15/25, at 4:19 PM with Resident 32, Resident 32 stated the toilet in their room was still broken and was not usable. During an observation on 9/15/25, at 11:13 AM in Residents 32 and 53 shared restroom, the top ring of the toilet bowl had multiple brown rings and stains. A review of the Maintenance Work Order Log, dated from 8/7/25 - 8/29/25 indicated an entry dated 8/16/25, that Resident's 32 and 53's shared toilet was clogged. During a concurrent observation and interview on 9/17/25 at 3:10 PM with the Director of Nursing (DON), in Residents 32 and 53's shared restroom, the DON confirmed the shared toilet was stained and unsanitary for resident use. During a concurrent interview and record review on 9/18/25 at 9:20 AM with DON, the facility's policy and procedure (P&amp;P) titled, Housekeeping Services dated 1/2025 was reviewed. The P&amp;P indicated, The policy of this facility is to promote a sanitary environment. The DON confirmed the toilet was left in an unsanitary condition and did not adhere to this housekeeping policy.</p> |                                                                                        |                                                 |

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| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide the required documentation or notification related to the resident's needs, appeal rights, or<br>bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on<br>interview and record review, the facility failed to notify the Office of the State Long-Term Care<br>Ombudsman (an advocate for residents in nursing homes) prior to the transfer or as soon as<br>practicable when one of three sampled residents (Resident 3) was discharged to the hospital. This<br>failure had the potential to leave Resident 3 unprotected from improper discharge and limit Resident<br>3's rights to advocacy and representation. 1. A review of Resident 3's admission Record, (a document<br>showing a summary of the resident's information) dated 9/18/25, indicated Resident 3 was admitted<br>to the facility on [DATE].A review of Resident 3's Order Details, dated 6/4/25, indicated a<br>physician's order to transfer the resident to the hospital for a psychiatric evaluation.A review of<br>Resident 3's eINTERACT Transfer Form V4.0, dated 6/4/25, indicated the resident had a planned<br>transfer to the hospital on 6/4/25 due to behavioral symptoms.A review of Resident 3's Progress<br>Notes, dated 6/27/25, indicated Resident 3 was readmitted to the facility.Further review of Resident<br>3's clinical record indicated no documented evidence that the Ombudsman was notified of Resident<br>3's discharge to the hospital. During a concurrent interview and record review on 9/17/25 at 3:39 PM<br>with the Medical Records Director (MRD), Resident 3's clinical record was reviewed. The MRD stated<br>part of her responsibilities was to fax a notification to the Ombudsman regarding resident transfers<br>and discharges. The MRD explained she faxed the notification immediately and kept a copy of the fax<br>transmittal. When asked to show the Ombudsman Notification regarding Resident 3's discharge to the<br>hospital on 6/4/25, the MRD was unable to find the documentation. The MRD verified that the<br>notification regarding Resident 3's discharge was overlooked and should have been sent to the<br>Ombudsman. |                                                                                        |                                                 |

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| F 0644<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow up on one of four residents (Resident 6) Level II (two) Preadmission Screening and Resident Review ([PASRR] a mandatory screening process to ensure that individuals with a serious mental illness or an intellectual disability are not improperly placed in a nursing home) to determine the resident's need for specialized services and appropriate placement. This failure placed Resident 6 at risk for unmet behavioral health needs and inappropriate care planning. A review of Resident 6's admission Record, (a document showing a summary of the resident's information), indicated Resident 6 was readmitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia (a severe brain disorder in which people interpret reality abnormally) and a mood disorder). A review of Resident 6's Preadmission Screening and Resident Review (PASSR) Level 1 Screening, dated 8/13/24, indicated a level one screening was completed following a change in condition. Further review indicated under Section III -Serious Mental Illness, Resident 6's PASSR Level 1 screening was marked Yes to a diagnosed serious mental illness and the specified diagnoses included schizoaffective disorder, depressive type, major depressive disorder. A review of Resident 6's Notice of Attempted Evaluation, dated 8/13/24, indicated facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the level one screening, therefore California Department of Health Care Services was unable to complete a level two evaluation for serious mental illness to determine if the individual could benefit from specialized services. During a concurrent interview and record review on 9/16/25 at 3:50 PM, with the Medical Records Director (MRD), Resident 6's clinical record was reviewed. The MRD reviewed Resident 6's Preadmission Screening and Resident Review PASSR - Level 1 Screening, dated 8/13/24, and Resident 6's Notice of Attempted Evaluation, dated 8/13/24. The MR stated she was responsible to complete and follow up the PASRR for the residents in the facility. The MRD stated the process of PASSR determines if residents require special services or if the residents are not appropriate to stay in the facility. The MRD was asked to provide documented evidence the facility followed up on the attempted PASSR Level II Screening. The MRD was unable to provide such evidence and stated it must have been missed. During a concurrent interview and record review on 9/17/25 at 3:18 PM, the facility's policy and procedure (P&amp;P) titled PASSR Completion Policy, dated 1/25, was reviewed with the Administrator and the Administrator verified the PASSR Completion Policy, dated 1/25 indicated, The center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. 1. Center Administrator will designate the medical records to make sure that the PASRR and/or level of care (LOC) is done on all potential residents .4. Administrator is accountable for monitoring the process of completing the necessary paperwork for the admission. The Administrator stated he delegated the responsibility of the PASRR to Medical Records. The Administrator stated the completion and follow through of a resident's PASRR was important and necessary to ensure services and placement at the facility was appropriate for the resident.</p> |                                                                                        |                                                 |

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| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to ensure that wound treatment supplies were maintained in a sanitary manner when a red-pink colored dried substance and an expired treatment wipe were found inside the facility's Wound Treatment Cart. This failure had the potential to result in unsafe or ineffective resident treatments. During a concurrent Wound Treatment Cart inspection and interview on [DATE], at 11:33 AM with Director of Nursing (DON), an expired (passed the use by date printed on the package and can no longer be clean or effective) SurePrep (skin protectant wipe that prevents irritation) and red-pink dried substance were found inside the treatment cart drawer. The DON verified that the SurePrep expired on [DATE] and that there was a red-pink colored dried substance in the top drawer of the treatment cart that had spilled onto other medications. During an interview on [DATE] at 11:10 AM with the Infection Preventionist (IP), the IP stated that there should not be expired supplies on the cart and spills are an infection control issue and should have been cleaned up immediately. During an interview on [DATE] at 11:20 AM with the DON, the DON stated, there should not be expired wipes on the cart and spills in the treatment cart should be cleaned up immediately.</p> |                                                                                        |                                                 |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the lunch menu was followed when: The recipe was not followed during preparation of the pureed starch 2. The portion size for the ginger carrots was not followed during tray line These failures had the potential to put the residents at risk for choking hazards and malnutrition. 1. A review of the Fall Menus, dated 9/16/25, indicated that rice pilaf was on the menu for lunch. During a concurrent observation, interview, and record review on 9/16/25 at 11:01 AM, with the Cook, in the presence of the Registered Dietician (RD) and Dietary Services Supervisor (DSS), the [NAME] began to make the [NAME] Pilaf for 12 residents who were ordered a pureed diet. The [NAME] measured out 12 servings, placed them into the blender, and blended. The [NAME] then added approximately one cup of chicken stock and blended again until the right consistency was reached. The RD and DSS reviewed the facility's Recipe: Pureed (IDDSI Level #4) Starch (Rice, Pasta, Polenta, Potatoes, etc.), dated 2025, indicated, .1. Complete the regular recipe. Measure out the total number of portions .for pureed diets. 2. Puree on low speed to a paste consistency before adding any liquid. 3. Gradually add warm milk . The RD and DSS verified the recipe required the use of warm milk, and not chicken stock. The [NAME] verified chicken stock was used instead of warm milk for the puree preparation for lunch. When asked if the nutritional value could be changed by not following the recipe, the RD stated, Yes. The RD and DSS stated the puree recipe should be followed. 2. A review of the facility's therapeutic spreadsheets titled, Fall Menus [NAME] Spreadsheet Week 3 Tuesday dated 9/16/25, indicated that ginger carrots were on the menu for lunch, and the regular serving size was one half cup. During an observation of tray line on 9/16/25 at 12:29 PM, the [NAME] was observed plating for Resident 23 in the presence of the RD and DSS. He placed one third cup scoop of carrots on the plate. At 12:51 PM, The [NAME] was observed plating for Resident 53 in the presence of the RD and DSS. He placed one third cup scoop of carrots on the plate. During a concurrent observation and interview on 9/16/25 at 1:15 PM, with the DSS, the DSS was asked how they determine serving sizes. The DSS stated they followed the therapeutic spreadsheet that listed the serving size. The DSS stated the serving size for the ginger carrots was one half cup and verified the [NAME] incorrectly served one third cup of the ginger carrots to Residents 23 and 53. The DSS stated Residents 23 and 53 should have received one half cup of the ginger carrots for lunch. During an interview with the RD on 9/16/25 at 1:16 PM, the RD stated staff should use the serving sizes listed on the therapeutic spreadsheet. The RD acknowledged using the wrong size scoop meant the residents received a smaller serving than they were supposed to get.</p> |                                                                                        |                                                 |

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| F 0842<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure the medical record was accurate for one of 14 sampled residents (Resident 12) when the facility incorrectly assessed and documented Resident 12 as a good candidate for a bowel and bladder retraining program. This failure had the potential for Resident 12 to receive a delay in incontinence (involuntary loss and control of urine from the bladder and/or stool from the rectum) care, have an increased risk of skin breakdown and urinary tract infections (an infection in any part of the urinary system, such as the bladder, kidneys, or urethra). A review of Resident 12's admission Record, (a document showing a summary of the resident's information) dated 9/17/25, indicated Resident 12 was admitted to the facility on [DATE]. During an interview on 9/17/25 at 2:39 PM with Resident 12, Resident 12 stated using a bedpan to urinate was difficult and preferred using incontinence briefs because of the loss of control of the bladder. Resident 12 also stated the use of the bedside commode and walking to the bathroom was not feasible because Resident 12 could not stand. During an interview on 9/17/25 at 2:41 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 12 required Hoyer lift (a mechanical device with a boom, mast, base, and a sling to lift and transfer individuals who are unable to move themselves) for transfers, was incontinent of urine, and CNA 1 provided urinary incontinence care after Resident 12 had an incontinence episode. During a concurrent interview and record review on 9/17/25 at 3:22 PM, with the Director of Nursing (DON), Resident 12's SSL-Bowel and Bladder Program Program Screener, dated 9/5/25, was reviewed. The SSL-Bowel and Bladder Program Screener under section A indicated Resident 12 voided appropriately without incontinence at least daily, and was alert and oriented. The DON reviewed Resident 12's Tasks - Bladder Continence dated 8/19/25 through 9/17/25, and verified Resident 12 had only one episode of bladder continence in the prior 30 days. The DON stated the SSL-Bowel and Bladder Program Screener was incorrect.</p> |                                                                                        |                                                 |

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| F 0577<br><br>Level of Harm - Potential for<br>minimal harm<br><br>Residents Affected - Many                                       | <p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation and interview, the facility failed to ensure the most recent survey results, and the corresponding plan of corrections were readily accessible to the residents, family, and visitors. This failure had the potential to limit the residents' and the public's ability to stay informed about the facility's quality of care and efforts to address the identified deficiencies.1. During an interview on 9/16/25 at 10:05 AM at the Resident Council meeting, the residents were asked if they were able to review the results of the state survey without having to ask a staff. All four residents (Residents 4, 35, 52, and 57) who attended the meeting stated they had not seen the survey results and did not know where they were located. During a concurrent observation and interview on 9/16/25 at 10:39 AM with the Administrator (ADM), the ADM was asked to locate the facility's survey binder (a binder containing the results of the most recent survey which includes the Statement of Deficiencies (Form CMS-2567) which contains any deficiencies resulting from a complaint investigation or recertification survey). The ADM then retrieved the survey binder from a locked room that cannot be accessed without a staff's assistance. When asked to show any facility signage indicating where the survey binder was kept, the ADM verified the facility did not have any signs posted. The ADM explained that the facility previously kept the survey binder in the lobby; however, it was often removed and misplaced, so it was relocated to a locked room. A review of the facility's policy and procedures titled Resident Rights, dated 1/25/25, indicated .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .w. examine survey results.</p> |                                                                                        |                                                 |