STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	554020	A. BUILDING _____ B. WING _____	**6/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUBAL CARE AND REHAB CENTER	**N 306 MAPLE STREET STEPHENSON, MI 49887**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Roubal Care and Rehab Center was surveyed for a Recertification survey on 6/26/2025. Intakes: MI00148996, MI00151127 and MI00153700 Census: 36	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F0550		

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

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.

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	reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: **Based on observation, interview and record review, the facility failed to provide dignified care for two Residents (#31 and #14) of two residents reviewed for dignity, resulting in R31 expressing feelings of humiliation and helplessness.** **Findings include:** **All times recorded in Eastern Daylight Time (EDT), unless otherwise noted.** **Resident #31 (R31)** **Review of the Minimum Data Set (MDS) assessment for R31, dated 5/22/2025, revealed admission to facility on 8/14/2024 with diagnoses including obstructive uropathy, peripheral vascular disease, morbid obesity, and depression. Section "H" of the MDS revealed R31 had an indwelling urinary catheter and was always incontinent of bowel. Section "GG" revealed R31 required substantial/maximal staff assistance for toileting hygiene and bathing, and was dependent on staff for all transfers and mobility. R31 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating cognition was intact.** **On 6/25/25 at 8:59 a.m., an observation in the 300 Hall revealed the door to R31's room was closed. Upon entering, R31 was**			

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	observed lying in bed covered by a white sheet from his torso to his shins, with his upper body and both lower legs and feet visible. Urinary catheter tubing was observed leading from under the right side of the sheet to a dependent drainage bag attached to the right side of R31's bed frame. The drainage bag was not covered with a urinary drainage bag cover. The drainage bag was observed with approximately 600 milliliters (ml) of dark yellow urine and urine was visible in the tubing leading from the resident to the bag. During an interview at the time of this observation, R31 reported he preferred to have the door to his room closed for privacy, but staff often walked into the room without knocking while care was being provided. R31 reported he did not often get out of bed and all care, including incontinence care and bathing were completed in his room. R31 expressed embarrassment that he was completely dependent on staff and that he felt "helpless." On 6/25/2025 at 10:55 a.m., R31's morning care was observed being performed by Certified Nursing Assistant (CNA) "K" and CNA "N". CNA "N" was observed emptying R31's urinary catheter drainage bag after which she performed hand hygiene in R31's bathroom. R31's bathroom was noted to be directly across from the end of the Resident's bed. CNA "N" then re-entered R31's room and left the bathroom door open. Continuing with care, CNA "K" pulled the sheet from R31, and was observed being incontinent of bowel. Dried feces was observed on the white fitted sheet covering the mattress and feces was pooled on the absorbent pad positioned underneath R31. CNA "K" washed R31's genitals then CNA "N" assisted R31 to lay on his left side while CNA "K" washed the			

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	stool from the resident buttocks and groin area. While CNA "K" was cleansing stool from R31's buttocks, Resident #14 (R14), a female resident, was observed entering the shared bathroom from the adjoining room. R31 was not covered with his exposed body was in full view of R14. Upon noticing R14 through the open bathroom door, R31 sighed and stated, "See, no privacy, this happens all the time, every time they start cleaning me up someone walks in." CNA "N" confirmed R14 resided in the adjoining room and shared the bathroom with R31. CNA "K" closed the bathroom door and left to assist R14. CNA "K" and CNA "N" never offered or assisted R31 with covering at any time during the care observation. On 6/25/2025 at 3:33 p.m., CNA "K" and CNA "M" were observed preparing R31 for a transfer from his bed to his recliner. Initial observation revealed R31 lying in bed wearing a disposable incontinence brief and his shorts pulled down to his mid-thighs, no other covering was present. R31 was rolled to the left then right as the CNAs pulled R31's shorts over his hips and buttocks then positioned the lift sling underneath R31, who was then transferred to the reclining chair. R31's bathroom door was observed ajar during the entire observation. During an interview on 6/26/2025 at 3:08 p.m., the Director of Nursing (DON) was informed of the observations involving R31. The DON confirmed R14 did share an adjoining bathroom with R31. The DON reported R31 did not physically use the bathroom as he was incontinent and had an indwelling urinary catheter, but staff did use the bathroom during his care provision. The DON reported it was important for staff to be			

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	sure the door is closed during R31's care to ensure his privacy and promote dignity for both R31 and R14. **Review of the Michigan Long Term Care Ombudsman Program's, "My Rights as a Resident of a Nursing Home" accessed 6/26/2025, revealed the following: "My right to dignity - I have a right to privacy when receiving care."**			
F0577 SS= C	Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: .	F0577		

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	Based on observation, interview, and record review, the facility failed to honor the residents' rights to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect. This deficient practice affected all 36 residents residing in the facility. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. On 6/25/25 at 11:00 AM, a confidential group meeting was held with six interested residents in attendance. The annual survey process was explained whereby a report would be sent to the facility with issues and concerns discovered by the State Agency. The facility would then respond in writing with a plan to correct the noted concerns. The entire report of both concerns and corrections would be public knowledge and must be posted in an easily accessible place in the building where the residents and others have the opportunity to read and review it. The residents in attendance did not know of this procedure and were unaware of the report's availability. The resident council president R3 stated agreed she did not know where the results of the last survey were posted. After the meeting on 6/25/25 at 11:27 AM, the public posting was sought out with R3. There was a binder with survey results hanging on the wall. However, the last survey of 5/14/24 was displayed with large print stamped "Not Final" on each page. There was not a plan of correction included.			

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	On 6/25/25 at 11:30 AM, the Nursing Home Administrator looked through the binder and confirmed there was not a final copy of the results of the last annual survey, and there was not a plan of correction for the concerns posted. .			
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F0584		

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	Based on interview and record review, the facility failed to maintain facility living areas odor free and with comfortable temperatures for two Residents #7 and #31 (R7 and R31) of 16 residents reviewed for a safe, clean, comfortable environment. This deficient practice resulted in resident dissatisfaction with unbearably hot living conditions and the smell of urine in R7's room. Findings include: All times noted are Eastern Daylight Savings Time, unless otherwise noted. Resident #7 (R7) Review of R7's Minimum Data Set (MDS) assessment, dated 4/1/25, revealed R7 was admitted to the facility on 12/28/24, with diagnoses that included the following, in part: hypertension, end-stage renal disease, diabetes mellitus, dementia, and chronic obstructive pulmonary disease (COPD). R7 did not complete the Brief Interview for Mental Status (BIMS) but was documented with severely impaired cognition. R7 required "Setup or clean-up assistance" with upper body dressing, lower body dressing, putting on/taking off footwear (including socks), and personal hygiene. Review of R7's Progress Notes revealed the following, in part: 6/22/24 18:00 Central Daylight Savings Times (CDST)] "LATE ENTRY: Writer continued to monitor resident and kept cooling washcloth to keep on head, resident			

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	was responding appropriately to writer stating she (R7) felt better but was still pale in color and was 'tired'. She was able to sip on OJ (orange juice and ice water at this time. POA (Power of Attorney) at bedside and states resident often doesn't drink enough water/fluids and has overheated before like this. She went to buy a resident a fan tonight for her room and states she feels comfortable with continuing to monitor and updating PCP (primary care provider) to see her this week at facility. Nursing staff to continue to monitor. Update was sent to PCP. 6/22/25 18:06 (6:06 CDST) "Resident was lowered to the floor by CNA's (Certified Nurse Aides), she was walking in the hallway and began to faint ... resident was transferred to her bed, she was changed into cooler clothing and a cool rag placed on her head. Resident's POA was called and she stated she is on her way here. Resident is responsive at this time but appears weak/exhausted." 6/24/25 13:52 (1:52 p.m. CDST) "Residents room had a strong foul urine odor. She had a wet brief on the floor. She is weak today and required a wheelchair to get to the dining room. She was confused this morning at times." During a telephone interview on 6/25/25 at 3:05 p.m., Confidential Complainant "C" detailed the following information: "One of the nurses called and told me [R7] had an episode ... I said that you have to keep her cool because she has dementia and she will put on a million layers of clothes ... I did not say that she had episodes like this before. When I arrived, they had her in bed. They had taken the multiple layers of clothing off.			

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	They told me she was wearing a long sleeve shirt, ted hose, long pants, a sweater, and thick socks ... They had her in her bed with no pants, a brief, and a shirt ... and a wet wash cloth draped over her forehead. I tried to wake her up, she tried to talk, and she would fall back asleep. I squeezed her finger tips trying to get her to open her eyes. Her door was open, when I arrived, The DON (Director of Nursing) had asked if we could purchase a fan for her. I had my spouse go to the dollar store and purchase the fan for her room ... They said it is just the heat and when her body temperature cools, she will be okay. When I went in two days ago, she was still extremely tired, couldn't stay awake very long ... Now she is much weaker. I had to have them give her a wheelchair because she can't walk without one ... The only thing I have had a constant complaint about is that I will go in there and her room will smell like pee. Then they will come in and clean. I will go and she will have a pad with dry patches of circles of urine on it - there was one on her chair yesterday. That has been a constant. I told the social worker that either your aides have poor judgement, or they are just lazy ... It was very hot in the facility, while we were in the room, there was sweat beading off of us just putting a fan together. In my opinion it was egregiously hot. [The DON] asked me to buy a fan. I didn't ask about having a fan ... [The DON] said she did not believe they have fans for the resident rooms ..." During an observation and interview on 6/26/25 at 9:12 a.m. Certified Nurse Aide (CNA) "E" was asked to observe R7's chair and bedding. The odor of urine was clearly present in the room. The bed sheet was wet with urine. The sheets had not been removed after getting the resident up from bed to eat			

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	breakfast. When CNA "E" was asked if the odor of urine was present to her, CNA "E" stated, "Oh yeah!" and commented that the bed sheet was wet while the bed pad had been folder over with the blue water repellent side toward the resident. During an interview on 6/26/25 at 9:57 a.m., the DON said she was training a nurse on the other side of the facility when a resident came up and said my friend is not feeling good ... She (R7) was pale, and it was hot that day (92-degree outdoor temperature) and she was dressed with thick compression stockings on, some tight leggings, her fuzzy socks on and a t shirt and a sweater on ... I knew she was probably over heating - we got her into the wheelchair, some clothes off, got a cool cloth on her. I don't remember if her temperature was assessed. Her back was sweaty when we were putting her into the chair. I didn't take her temperature. She was not my resident ... At that time, we knew we had to get the layers off..." During an interview on 6/26/25 at 9:41 a.m., Environmental Services Director (ESD) "G" said he did not have any written documentation to show monitoring of facility temperatures on hot days in the facility. When asked how he would know if the temperature rose above 81 degrees in Resident rooms, ESD "G" stated, "I would not know." The ESD "G" did acknowledged the outdoor temperature was 92 degrees on the day R7 required removal of clothing and cooling by facility staff. During an interview on 6/26/25 at 10:06 a.m., when asked if urine saturated bed sheets in R7's room should have been changed upon identification that they were wet, and the			

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	room smelled of urine, the DON stated, "Absolutely they should be changed." Review of the Maintenance Director's Job Description, copyright 2023, signed on 9/19/24, revealed the following, in part: "Position Purpose: Directs the day-to-day activities of the Maintenance Department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility, and to assure the facility is maintained in a safe and comfortable manner." Resident #31 (R31) Review of the Minimum Data Set (MDS) assessment, dated 5/22/2025, revealed R31 was admitted to facility on 8/14/2024 and had diagnoses including obstructive uropathy, peripheral vascular disease, morbid obesity, and depression. Section "GG" indicated R31 required substantial/maximal staff assistance for toileting hygiene and bathing, and was dependent on staff for all transfers and mobility. R31 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating cognition was intact. On 6/25/25 at 8:59 a.m., an observation in the 300 Hall revealed the door to R31's room was closed. Upon entering, R31 was observed lying in bed covered by a white sheet from his torso to his shins, with his upper body and both lower legs and feet visible. When asked if he had any concerns regarding his stay in the facility, R31stated, "Well, my current concern is with the heat." Resident stated, "Over the past week there were a couple days where it (temperature) was unbearable" in the facility. R31 reported the temperature in his room was			

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	overwhelming and that when he asked for a fan or for air conditioning to be turned on, was told the facility had neither available for use in resident rooms. When asked if it helped to have the door of his room open, R31 reported he preferred to have the door to his room closed for privacy. R31 reported he ordered a window air conditioner for his room, "But, I'm not sure they'll let me use it."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: **Based on observation, interview and record review, the facility failed to ensure timely ADL (Activities of Daily Living) care was provided for two Residents (#31 and #25) of two residents reviewed for ADL care.** **Findings include:** **All times recorded in Eastern Daylight Time (EDT), unless otherwise noted.** **Resident #31 (R31)** **Review of the Minimum Data Set (MDS) assessment, dated 5/22/2025, revealed R31 was admitted to facility on 8/14/2024 and had diagnoses including diabetes, obstructive uropathy, peripheral vascular disease, morbid obesity, and depression. Section "H" of the MDS assessment revealed R31 had an indwelling urinary catheter, was always**	F0677		

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ROUBAL CARE AND REHAB CENTER	N 306 MAPLE STREET STEPHENSON, MI 49887

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	incontinent of bowel. Section "GG" of the MDS revealed R31 required substantial/maximal staff assistance for toileting hygiene and bathing, and was dependent on staff for all transfers and mobility. R31 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. On 6/25/2025 at 8:59 a.m., an observation in the 300 Hall revealed the door to R31's room was closed. Upon entering, R31 was observed lying in bed covered by a white sheet from his torso to his shins, with his upper body and both lower legs and feet visible. It was noted R31's toenails were overgrown past the tip of the toes. Further observation revealed the nails of R31's great toes were grown out approximately one-half inch (in.) past the tip of the Resident's toes. Urinary catheter tubing was observed leading from under the right side of the sheet into a dependent drainage bag attached to the right side of R31's bed frame. The drainage bag was not covered with a urinary drainage bag cover. It was noted that the drainage bag contained approximately 600 milliliters (ml) of dark, yellow urine and urine was visible in the tubing leading from the resident to the bag. There was an unpleasant fecal odor noted while standing near R31's bed. On 6/25/2025 at 10:55 a.m., R31's morning care was observed performed by Certified Nursing Assistant (CNA) "K" and CNA "N". CNA "N" was observed preparing to empty R31's urinary catheter drainage bag into a clear, graduated cylinder. It was noted the drainage bag appeared heavy and nearly full of dark, yellow urine. Further observation revealed CNA "N" filled the cylinder with urine from the bag, emptied the urine into the			

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	toilet in the Resident's bathroom, then returned to empty the remaining urine from the bag. CNA "N" reported she emptied 1,150 milliliters (ml) of urine from the drainage bag. After CNA "N" emptied the drainage bag, CNA "K" removed the sheet covering R31, and it was noted the Resident had been incontinent of bowel. Dried feces was observed on the white fitted sheet covering the mattress and feces was pooled on the absorbent pad positioned underneath the resident. CNA "K" washed R31's genitals then CNA "N" assisted R31 to lay on his left side while CNA "K" washed the stool from R31's buttocks and groin area. Further observation revealed areas of dried stool on the back of R31's upper thighs and buttocks. When asked when the last time the Resident was checked for incontinence and/or changed, CNA "N" reported R31 requested not to be disturbed between 10:00 p.m. and 6:00 a.m. When asked to clarify whether R31 had been checked and changed since 10:00 p.m. the previous evening, CNA "N" confirmed R31 had not been checked since he went to bed the previous evening. When asked about R31's toenail care, CNA "N" reported since the Resident was a diabetic, the CNA staff would alert the licensed nursing staff of the care needed and the licensed nurses would provide nail care. During an interview at the time of the observation, R31 reported he did not have control of his bowels and due to neuropathy, could not always feel when he was incontinent. R31 confirmed he did not like to be awakened in the middle of the night. When asked if anyone had been in to check this day after 6:00 a.m., R31 reported he received his breakfast, but no one checked to see if he was incontinent or if his catheter			

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	bag was full. R31 was asked when the last time staff trimmed his toes, he reported he was unsure but, "More than a month ago." During an interview on 6/26/25 at 10:03 a.m., Licensed Practical Nurse (LPN) "A" was asked about the process for ensuring nail care for residents is provided as needed. LPN "A" reported the licensed nursing staff was responsible for nail care as the facility had no visiting podiatrist. When asked how often nail care is provided, LPN "A" stated the CNA staff "are really good about letting us know it needs to be done ... and we (licensed nurses) do it." Review of R31's comprehensive care plan revealed the following: "I have diabetes mellitus ... Inspect my feet daily ... Date Initiated: 8/14/2024." It was noted in review, R31's care plan did not include a focus area or interventions related to R31's bowel incontinence, including how often the Resident needed to be checked or changed. There was no focus area or interventions related to nail care for R31 related to the diagnosis of diabetes. On 6/26/25 at 2:51 p.m., the Director of Nursing (DON) was alerted to the observations of R31 and R25. The DON reported she expected staff to check for resident care needed at the beginning of each shift or as soon as possible. The DON reported she was aware of R31's request not to be disturbed in the middle of the night. When asked if R31 should be checked at the beginning of the morning shift due to not being checked all night and having a catheter and being incontinent. The DON reported it			

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	was important for staff to check on R31 early in the shift as he does not have control of his bowels and does not know when he has had a bowel movement. Resident #25 (R25) Review of the MDS assessment, dated 3/26/2025, revealed R25 was admitted to the facility on 2/04/2025 and had diagnoses including prostate cancer, anemia and arthritis. Section "GG" of the MDS assessment revealed R25 required substantial/maximal assistance with bathing and personal hygiene and had mild cognitive impairment. On 6/25/2025 at 8:40 a.m., R25 was observed in his room eating his morning meal. Further observation revealed R25's fingernails and nail beds to be visibly soiled with dark coloring under his nails and nail beds. His nails were noted to be unkempt, with jagged edges and the length of the nails grown out approximately one-half centimeter (cm) past the tip of his fingers. On 6/26/2025 at 3:02 p.m., R25 was observed seated in a recliner in his room. R25's fingernails were observed as previous. R25's nails were overgrown, and his right thumbnail was observed to be jagged with a sharp appearance. When asked if he would prefer to have his fingernails cleaned and trimmed, R25 stated, "What can I do about it?" Review of R25's comprehensive care plan revealed the following: "I have an ADL self-care performance deficit ... Personal hygiene/Oral care: Assist."			

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	Review of the facility policy titled, "Activities of Daily Living (ADLs)," last revised 7/15/2024, revealed the following: **"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."**			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently implement a bowel protocol program for one Resident (R32) of 2 Residents reviewed for bowel function in a total sample of 12 residents. This deficient practice resulted in extended periods of time when R32 had no documented bowel movement, with increased risk for pain and discomfort and/or the risk for medical complications such as bowel impaction. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. A review of the medical record revealed that Resident #32 (R32) was admitted to the facility	F0684		

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	on 2/7/25 with diagnoses including chronic systolic congestive heart failure, protein-calorie malnutrition and encounter for palliative care. Review of R32's Minimum Data Set assessment, dated 5/22/25, revealed Section O (Special Treatments and Programs) noted R32 was on hospice care. The physician's orders for R32 included Fentanyl (a pain medication with known side effects of constipation). A review was conducted of R32's "Task List for Bowel Continence" for 5/28/25 through 6/26/25. The report revealed: - 5+ days (from 6/8/25 at 9:31 until 6/14/25 at 1:11 AM) without a recorded bowel movement - 4 days (from 6/16/25 at 1:59 PM until 6/20/25 at 9:24 PM) without a recorded bowel movement. - 5+ days (from 6/21/25 at 1:58 PM through today 6/26/25) without a recorded bowel movement. A review of Resident #32's Medication Administration Record (MAR) for the month of June 2025 revealed an order for "Miralax, one packet ... Give 1 packet by mouth every 24 hours as needed for constipation add to 4-8 ounces fluid Order date: 2/20/2025". The MAR had no documentation this medication for constipation was given in the month of June 2025. An interview was conducted with the Director of Nursing (DON) on 6/26/25 at 12:48 PM. The DON confirmed that there was no documentation on the June 2025 MAR for R32 getting Miralax for absence of bowel movements and constipation. The DON stated ,"After 3 days without a BM (bowel movement) we would implement our bowel protocol." When asked for a copy of the bowel protocol one could not be			

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	presented. All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. During an interview on 6/26/25 at 1:00 PM, the Nursing Home Administrator (NHA) and the DON stated there was protocol the Medical Director "D" used, but they had not implemented it at the time of the interview. The protocol was reviewed at that time, but the NHA and DON could not explain it and could not interpret the abbreviations ("1 PR prn" was thought to be a typographical error but was later explained by the Medical Director "D" as "1 per rectal as needed"). During a follow up interview on 6/26/25 at 12:53 PM, the NHA confirmed there was "not a current bowel policy in place in the facility at this time." During an interview on 6/26/25 at 1:12 PM, Medical Director "D" described the expectations for constipation in residents stating, "The facility should call me to alert me when residents have not had a BM in 3 days. They should be giving Miralax per my order and then I will generally follow the protocol I gave to the facility." At this time, Medical Director "D" reviewed the medical record for R32, noting constipation of 5 days at the end of today. Medical Director "D" agreed the order for Miralax should have been followed as it had not been given as ordered all month. Medical Director "D" also noted R32 was on pain medications which frequently caused constipation. Medical Director "D" explained the expectation would be that the nurse would call her if any resident had not had a BM in three days and the resident did not have an order for measures to take. During an interview on 6/26/25 at 1:43 PM, Registered Nurse (RN) "B" stated if a resident did			

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	not have a BM in 3 days, she would follow the bowel protocol which involved Miralax, an enema and a suppository. RN "B" was not certain of the order of the actions to take. RN "B" stated, "The protocol would indicate the order of these treatments." When asked to produce the protocol, RN "B" looked on the computer and could not locate it. RN "B" began to look through binders and papers at the nursing station. RN "B" did not locate a bowel protocol. When asked to check R32's last BM, RN "B" noted the last BM was 6/21/25, which was five days ago and RN "B" noted no action had been taken.			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate supervision and proper use of assistive devices (gait belt and wheelchair) to prevent a fall with major injury (fractured femur) for one Resident #37 (R37) out of one resident reviewed for falls. This deficient practice resulted in harm when R37 fell while ambulating with staff and subsequently fractured his femur requiring a surgical hip repair. Findings include: All times noted are in Eastern Daylight-Saving Time (EDST), unless otherwise noted. Resident #37 (R37)	F0689		

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	Review of R37's Progress Notes revealed the following, in part: "1/12/2025 15:44 ([:44 Central Standard Time (CST)]: "Resident ambulating in hall with staff assistance, utilizing walker, wheelchair to follow. Stopped to sit in WC (wheelchair) lost balance and fell from standing position into wall on right side of body head hitting cement wall ...Resident complains of right hip pain, unable to lift right leg. Appears misaligned..." "1/12/25 16:01 (4:01 p.m. CST); Resident left with paramedics at this time..." "1/12/25 18:35 (6:35 p.m. CST); "...resident is being admitted with hip fracture ... POC (plan of care) was being followed as in gait belt on, resident pushing walker and staff had WC follow..." "1/13/25 11:18 CST: Imaging showed an acute intertrochanteric and subtrochanteric fracture of the right femur. Plan: To OR (operating room) tomorrow for ... nailing of right hip fracture." "1/13/25 21:11 (9:11 p.m. CST); Team (IDT) discussed this fall - education will be provided to CNAs." Review of R37's Incident Report, dated 1/12/2025 at 15:36 (3:36 p.m. CST) revealed the following, in part: "Nursing Description: Resident ambulating in hall with staff assistance with gait belt on, utilizing walker with wheelchair to follow. Stopped as wanted to sit in WC feeling weak, lot balance and fell sideways from standing position into wall on right side of body, also hitting head on cement wall." Resident Taken to Hospital? Y (yes), No injuries observed at time of incident ... Injuries Report Post Incident: No			

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	Injuries Observed Post Incident ... Level of Pain: Blank ... Statements: Staff (Certified Nurse Aide (CNA) "P": [R37] had been wanting to go for a walk, so I went to take him for a walk. I put his gait belt on and gripper socks on and then we went for the walk. As he pushed his walker down the hall, I had one hand on his gait belt and had WC follow with the other hand. He was walking along nice and strong then all of a sudden he said he needed to sit and as I went to hold his arm and push WC up, he just collapsed over." Review of a "Therapy Recommendations - PT (Physical Therapy)" document provided by the facility on 6/26/25 at 11:40 a.m., revealed the following PT recommendations as of 1/3/2025: "Resident [R37], Recommendations: Please amb (ambulate) pt (patient) with FWW (front wheeled walker) with CGA [(contact guard assist requires a hand on the client (such as with a gait belt)] and W/C (wheel chair) follow 60 ft or as tolerates X1-2 a day, room to desk." Review of a "Therapy Recommendation - OT (Occupational Therapy) document provided by the facility on 6/26/25 at 3:43 p.m., revealed the following OT recommendation: "[R37] Recommendations: Contact guard - Min. (minimum Assist X 1 for functional transfers." During an interview on 6/26/25 at 3:42 p.m., CNA "P" who was walking R37 at the time of his fall on 1/12/25, reported R37 was walking well and then said that he wanted to sit down, he was getting tired and wanted to sit down. I initially had my right hand on the back of his gait belt, and my left hand reaching behind and pulling along his wheelchair. I went to grab his arm and turned to pull the w/c up so that he could sit in it and he went down. When asked what hand she used to grab his arm, she initially said her right hand - that had been on his gait belt and then used			

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	her left hand to pull the wheelchair behind him. Then she stated that she doesn't really recall because it was quite a while ago. When asked if she had been re-educated, CNA "P" said that they told her that she did everything right, but the next time she should keep her hand on the gait belt, stay facing the resident's back, and get someone else to help pull the wheelchair. When asked if she was aware that R37 was a CGA contact guard assist, CNA "P" said she was not aware of that, but thought he was an assist of one during ambulation.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to maintain sanitary oxygen tubing for three Residents (R6, R32 and R34) of four Residents reviewed for respiratory care. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted.	F0695		

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	Resident #6 (R6) A review of R6's electronic medical record (EMR) revealed an initial admission to the facility on 4/24/25 with diagnoses including chronic diastolic congestive heart failure. A review of R6's Minimum Data Set (MDS) assessment, dated 5/5/25, revealed Section O (Special Treatments and Programs) reported while residing in the facility R6 required the use of oxygen. A Physician's order was written for R6 "Change oxygen tubing weekly, date and initial tubing with each change." On 6/26/25 at 3:24 PM, R6 was observed in her room with an oxygen concentrator. The oxygen tubing was dated as last changed on 6/16/25. Resident #32 (R32) A review of R32's EMR revealed initial admission to the facility on 2/7/25 with diagnoses including chronic systolic congestive heart failure. A review of R32's MDS assessment, dated 5/22/25, revealed Section O (Special Treatments and Programs) reported while residing in the facility R32 required the use of oxygen. A Physician's order was written "Change oxygen tubing, date and initial tubing Start Date 4/20/2025." On 6/24/25 at 12:59 PM, R32 was observed receiving oxygen via tubing from a concentrator. The tubing was dated as last			

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	changed on 6/16/25. On 6/26/25 at 11:47 AM, R32's room was observed with an oxygen concentrator. The oxygen tubing was dated as last changed on 6/16/25. Resident #34 (R34) A review of R34's EMR revealed initial admission to the facility on 4/11/2025 with diagnoses including chronic systolic congestive heart failure. A review of R34's assessment, dated 4/17/25, revealed Section O (Special Treatments and Programs) reported while residing in the facility R34 required the use of oxygen. The EMR included a Physician's order written for R34, "Change oxygen tubing weekly, date and initial tubing with each change." On 6/26/25 at 3:31 PM, R34's room was observed with an oxygen concentrator. The oxygen tubing was dated as last changed on 6/16/25. During an interview on 6/26/25 at 11:50 AM, the Director of Nursing (DON) stated oxygen tubing is changed weekly. The facility policy titled "Oxygen Administration" dated as revised 8/2/2024 read in part, "Oxygen is administered to resident who need it, consistent with professional standards of practice, comprehensive person-centered care plans,			

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	554020	A. BUILDING _____ B. WING _____	6/26/2025

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	and the resident's goals and preferences ... 6. Cleaning and care of equipment shall be in accordance with facility policies for such equipment." There were no specifications in the policy as to when to change the oxygen tubing. .			
F0732 SS= C	Posted Nurse Staffing Information §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F0732		

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to post the actual hours worked by licensed and unlicensed nursing staff on the daily Staff Posting Information. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise noted. On 6/24/25 at 12:37 p.m., the Nurse Staffing Sheet was observed posted on the wall outside of the Social Workers office and across from the main nurses' station. A copy of the Nurse Staffing Sheet was requested and received from Activity Director "O" on 6/24/25 at 12:39 p.m. Review of Nurse Staffing Sheets dated 6/24, 6/25, and 6/26/25 revealed all columns for "RN (Registered Nurse) Hours Actually Worked", "LPN (Licensed Practical Nurse) Hours Actually Worked", and CNA (Certified Nurse Aide) Hours Actually Worked" were blank: absent any documentation for all shifts. During an interview on 6/26/25 at approximately 3:30 p.m., the Nursing Home Administrator (NHA) was asked if she understood this Surveyor's concerns related to completion and posting of the Nurse Staffing Sheets. The Director of Nursing (DON) who was also present during the interview, asked the NHA what was wrong with the Nurse Staff Postings. The NHA stated, "The actual hours worked (columns for all shifts) are blank." Review of the "Nurse Staffing Posting Information" policy, reviewed/revised 8/10/24,			

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	revealed the following, in part: "Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time ...1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility Name, b. The current date, c. Facility's current resident census, d. The total number of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses, ii. Licensed Practical Nurses/Licensed Vocational Nurses ... 4. A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current. A. The information shall reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated to reflect such. b. Staffing shall include all nursing staff who are paid by the facility (including contract staff) ..."			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% for three Residents (R6, R7 & R 21) of 9 residents reviewed for medication administration. This deficient practice resulted in a medication administration error rate of 12.00%, based on 3 medication errors in 25 opportunities for error. Findings include: All times noted are Eastern Daylight Savings	F0759		

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	Times (EDST) unless otherwise noted. Resident #21 (R21) On 6/26/25 at 9:18 a.m., Registered Nurse (RN) "A" was observed preparing and administering medications on the 300 Hall medication cart. When preparing medications for R21, RN "A" punched out one 88 mcg (microgram) tablet of Levothyroxine that landed on top of the medication cart which had not been disinfected, nor was a barrier in place. RN "A" donned clean gloves without the performance of hand hygiene, picked up the tablet and placed it into R21's plastic medication cup for administration to the Resident. During an interview on 6/26/25 at 9:31 a.m., when asked if the top of the 300 Hall medication cart was clean or dirty, RN "A" stated, "It is dirty." When asked what should have happened with the pill for R21, that was dropped onto the top of the medication cart, RN "A" stated, "It should have been thrown away." RN "A" acknowledged a new pill should have been popped from the Levothyroxine blister pack and administered to R21. Resident R6 On 6/26/25 at 12:09 p.m., RN "B" prepared Diclofenac Sodium (Voltaren) gel for application to R6's bilateral knees. RN "B" squeezed an undetermined amount in a 30 cc (cubic centimeter) medication cup. When asked what the Voltaren dosage was, RN "B" stated, "1 %" When asked how much of the Voltaren gel was to be used. RN "B" said 4 grams. When asked if the amount in the medication cup was 4 grams, RN "B" was unsure. This Surveyor asked about the availability of a Dosing Card for the Voltaren. RN "B" said she had always placed the gel in the			

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	cup and was unaware of a dosing card, but said she would look for one. RN "B" examined the medication cart drawers, and did fine a Voltaren Dosing Card, which required review and education prior to proper application of the gel onto the card. Review of "Voltaren Gel Dosage (Diclofenac Sodium 10 mg(milligrams) in 1 gram, last updated 8/22/24, revealed the following dosage instructions: "...Dosing Care: The dosing card can be found attached to the inside of the carton. The proper amount of Voltaren Gel should be measured using the dosing card supplied in the drug product carton. The dosing card is made of clear polypropylene. The dosing card should be used for each application of drug product. The get should be applied with in the rectangular area of the dosing card up to the 2 gram or 4-gram line (2g for each elbow, wrist, or hand, and 4g for each knee, ankle, or foot) ... The 4g line is 4.5 inches long. The dosing card containing Voltaren Gel can be used to apply the gel. The hands should then be used to gently rub the gel into the skin. After using the dosing card, hold with fingertips, rinse, and dry." Retrieved on 6/26/25 at 1:11 p.m. from drugs.com/dosage/voltaren-gel.html. Resident R7 On 6/26/25 at 12:33 p.m., RN "B" prepared a Novolog Flexpen for administration of fast-acting insulin to R7. RN "B" primed the pen with 2 units of insulin, removed the needle, applied a clean needle and placed the insulin pen down on top of the medication cart. When asked why the needle had been changed on the insulin pen after priming, RN "B" stated, "I don't know. I thought I was supposed to do that." RN "B" continued to look at this Surveyor, who then asked what RN "B" was going to do next. RN "B" asked, "Prime			

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	the pen again?" On 6/26/25 at approximately 12:35 p.m., RN "B" used the Novolog Flexpen to administer insulin into R7's right abdomen. RN "B" held the insulin pen in R7's abdominal skin [subcutaneously (SQ)] for 1-2 seconds; removing the pen quickly from the Resident. Review of the Novolog "Instructions for Use", copyright 2023, revealed the following Novolog Flexpen insulin administration instructions: "...Step 13: Press and hold down the dose button until the dose counter shows "0". Keep the needle in your skin after the dose counter has returned to ")" and slowly count to 6. When the dose counter returns to "0" you will not get your full dose until 6 seconds later. If the needle is removed before you count to 6, you may see a stream of insulin coming from the needle tip..." Document retrieved on 6/26/25 at 1:30 p.m., from novo-pi.com/novolog.pdf. During an interview on 6/26/25 at approximately 3:30 p.m., and 4:10 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were informed of the above medication preparation and administration errors. Both the NHA and DON expressed understanding of the deficiency concern related to the failure to maintain an error rate of less than 5%.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using	F0812		

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	produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain best practices in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During a tour of the walk-in cooler, at 7:58 AM on 6/25/25, it was observed that storage racks in the walk-in cooler were found with an accumulation of debris on the open wire rack shelving. Observation of the floor in the walk-in cooler found a dried yellow spill on the floor as well as an accumulation of debris and paper trash under racks and alongside the perimeter of the floor. During a tour of the walk-in freezer, at 8:00 AM on 6/25/25, it was observed that the floor of the walk-in cooler was full of paper trash debris from date marking stickers. During an observation of the clean utensil drawer, at 8:38 AM on 6/25/25, it was observed that an accumulation of crumbs were found along the back wall of the drawer. When asked how often this area gets cleaned out, Dietary Manager (DM)			

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	"I" was unsure. During an interview with DM "I", at 8:40 AM on 6/25/25, it was found that the stand-up mixer gets used a few times a week for mashed potatoes. When asked what the plastic bag covering the mixer meant, DM "I" stated it was to keep the mixer clean. Observation of the mixer found white dried food debris smeared on the under arm of the unit. During a tour of the cook line, at 8:48 AM on 6/25/25, observation of the manual can opener at the end of the cook line found increased accumulation of rust and pitting on the can opener bar and inside mechanism for turning the can opener. When asked if the can opener gets used much, DM "I" stated that staff typically used the electric can opener. Observation of the electric can opener found a dark black accumulation of debris behind the blade. When asked if the electric can opener had been used today, DM "I" asked staff and stated it was not. During an observation of the pantry microwave, at 9:06 AM on 6/25/25, there was observed increased accumulation of food debris evident on the inside top of the unit. When asked about the microwave, DM "I" stated she will have to add it to the cleaning list for her staff. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue,			

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	and other debris." According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. "(A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean ..." During an interview with DM "I", at 8:11 AM on 6/25/25, it was found that staff get their sanitizer from the janitors sink daily and fill up spray bottles to use with wiping cloths. Observation of the facility provided test trips found expiration dates of March 15th, 2020, and October 5th, 2021. Further review found a sanitizer spray bottle located on a table near the back dish machine area entrance. At this time, the spray bottle was tested and found to be 0 to 50 parts per million (ppm). A sanitizer bucket was poured from the janitors sink, by DM "I" and was found to be well over 500 ppm when tested. When asked about the inconsistency in sanitizer level, DM "I" was unsure and stated she would get a hold of the vendor. According to the 2022 FDA Food Code section 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L (milligrams/Liter) of SANITIZING solutions shall be provided. According to the 2022 FDA Food Code section 7-204.11 Sanitizers, Criteria. Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall: "(A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)P, or (B) Meet the requirements as specified in 40 CFR			

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	180.2020 Pesticide Chemicals Not Requiring a Tolerance or Exemption from Tolerance-Non-food determinations." During a tour of the facility kitchen, at 8:43 AM on 6/25/25, while in the clean pots and pans storage area, two full pans and two half pans were noted having been stored wet, without proper air drying having occurred prior to stacking. Upon interview with DM "I", it was agreed that the pots and pans are to be properly air dried before being stacked and stored According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD ..."			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F0880		

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	facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two Deficient Practice			

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	Statements. Based on observation, interview and record review, the facility failed to ensure the use of infection control measures according to current guidelines and professional standards of practice for two Residents (#31 and #13) of 11 residents reviewed for infection control practices. All time recorded in Eastern Daylight Time (EDT), unless otherwise noted. Resident #31 (R31) Review of the Minimum Data Set (MDS) assessment, dated 5/22/2025, revealed R31 was admitted to facility on 8/14/2024 and had diagnoses including obstructive uropathy, peripheral vascular disease, morbid obesity, and depression. Section "H" of the MDS assessment revealed R31 had an indwelling urinary catheter, was always incontinent of bowel. Section "GG" revealed R31 required substantial/maximal staff assistance for toileting hygiene and bathing, and was dependent on staff for all transfers and mobility. R31 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he was cognitively intact. On 6/25/25 at 8:59 a.m., an observation in the 300 Hall revealed the door to R31's room was closed. A Centers for Disease Control and Prevention (CDC) sign was observed on the outside of the door indicating the use of Enhanced Barrier Precautions (the use of gowns and gloves during high-contact resident care to reduce the spread of multidrug-resistant organisms [MDROs]) in the care of R31. Further review of the sign revealed the following:			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Enhanced Barrier Precautions. Everyone Must ... Wear gloves and gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting. Device care or use: central line, urinary catheter ... Wound care ..." On 6/25/2025 at 10:55 a.m., R31's morning care was observed being provided by Certified Nursing Assistant (CNA) "K" and CNA "N". CNA "N" was observed preparing to empty R31's urinary catheter drainage bag into a clear, graduated cylinder while CNA "K" donned a protective gown and gloves. Further observation revealed CNA "N" with gloved hands and no protective gown filling the cylinder with urine from the bag. CNA "N" then walked toward the bathroom with the cylinder of urine at which time she noticed CNA "K" wearing a protective gown. CNA "N" stated, "Oops, that's my first mistake," then proceeded to empty the urine in the toilet and returned to empty the remaining urine from the bag into the cylinder then into the toilet, without donning a protective gown. On 6/25/2025 at 3:33 p.m., CNA "K" and CNA "M" were observed preparing R31 for a transfer from his bed to his recliner. Initial observation revealed R31 lying in bed wearing a disposable incontinence brief and his shorts pulled down to his mid-thighs with no other covering was present. R31's urinary catheter drainage bag was attached to the right side of the bed frame with dark, yellow urine was observed to be present in the tubing. R31 was rolled to the left then right as the CNAs, wearing gloves and no protective gowns, pulled R31's shorts over his hips and			

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	554020	A. BUILDING _____ B. WING _____	6/26/2025

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	buttocks then positioned the lift sling underneath R31. CNA "K" was observed positing the catheter drainage bag on the lift in preparation for the transfer. R31 was then transferred to the reclining chair with CNA "M" supporting R31 while CNA "K" operated the lift. It was noted neither CNA "K" or CNA "M" wore protective gowns during the care or transfer of R31. During an interview immediately after the observation, the CNAs were queried regarding the use of EBP (Enhanced Barrier Precautions) in the care of R31. CNA "M" reported they did not provide catheter care, therefore EBP was not indicated. When asked to clarify in what instances EBP was warranted for use in the care of R31, CNA "M" stated, "only direct care of the catheter." When asked how they knew what cares call for the use of EBP, both CNA "M" and CNA "K" reported they referred to the care plan and the signage of the Resident's door. Review of R31's comprehensive care plan revealed no intervention listed related to the use of EBP in the care of R31. On 6/26/2025 at 1:30 p.m., the Assistant Director of Nursing (ADON)/Infection Preventionist reported EBP was to be utilized in all high contact care of residents with indwelling medical devices, such as indwelling urinary catheters and residents with open wounds. The ADON was queried as to what constituted high contact care activities and confirmed transfers and catheter care warranted the use of EBP. Review of the facility policy titled, "Infection Prevention and Control Program," last revised 6/05/2024, revealed procedures for			

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	the use of Standard Precautions and Transmission-Based Precautions (TBP). Further review revealed no procedure listed for the use of EBP. Review of the CDC guidance titled, "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant organisms (MDROs), dated 4/02/2025, revealed the following: "Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce the transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities ... more than 50% of nursing home residents may be colonized with an MDRO, nursing homes have been the setting for MDRO outbreaks, and when these MDROs result in resident infections, limited treatment options are available ..." Resident #13 (R13) Review of R13's MDS assessment, dated 5/14/25, revealed admission to facility on 4/1/23 with diagnoses that included: End-Stage Renal Disease (ESRD) and dementia. Further review of the MDS assessment revealed R13 had one unstageable, suspected deep tissue injury that was not present upon admission. R13 did not complete the BIMS but was documented with severely impaired cognition. On 6/25/25 at 10:01 a.m., RN "A" was observed as she prepared the room and R13 for wound care. Neither RN "A" or IP/RN "H" (also present during the observation) donned gowns for enhanced barrier precautions prior to performing/assisting with wound care for R13.			

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	RN "A" performed hand hygiene and donned clean gloves prior to pulling the Resident's privacy curtain closed with her gloved hands. RN "A" with the same gloves placed an absorbent barrier pad underneath R13's right ankle. RN "A" removed the old, soiled dressing, dated 6/24/25, on R13's right lateral ankle bone. RN "A" opened a package of sterile gauze 4x4's with her contaminated gloves, touching the interior and exterior of the sterile gauze pads. Normal saline was applied to the now contaminated gauze pads, and the wound was cleansed using the same dirty gloves. Another sterile 4x4 gauze pad was saturated with normal saline, and the wound was cleansed again. RN "A" took the tube of Medi honey, placed ointment on a sterile tongue depressor and applied it to the wound bed. RN "A" removed her gloves and washed her hands in the Resident's bathroom. She then placed her clean left hand into her scrub top left pocket and donned the gloves retrieved from her scrub top pocket. The dressing was dated 6/25/25, and the Mepilex dressing was applied to R13's wound with potentially contaminated gloved hands. During an interview on 6/26/25 at 9:30 a.m., RN "A" was asked when hand hygiene should be performed after touching environmental surfaces during wound care. RN "A" stated, "After I touched all those things (privacy curtain, dirty bed linens, and other environmental surfaces)." RN "A" said she knew that after she did the wound care yesterday, but she was already done with the care so there was nothing she could do about it then. When asked if the inside of her scrub top pocket was clean or dirty, RN "A" said "Dirty." RN "A" acknowledged she should not have reached into her scrub top for the gloves with clean hands. RN "A" confirmed the observation did not demonstrate appropriate infection control practices during wound care. On 6/25/25 at 10:00 a.m., observation on the 200			

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	Hall revealed the door to R13's room was closed. A Centers for Disease Control and Prevention (CDC) sign was observed on the outside of the door indicating the use of Enhanced Barrier Precautions (the use of gowns and gloves during high-contact resident care to reduce the spread of multidrug-resistant organisms [MDROs]) in the care of R13. Further review of the sign revealed the following: "Enhanced Barrier Precautions. Everyone Must ... Wear gloves and gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting. Device care or use: central line, urinary catheter ... Wound care ..." DPS B Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During a follow up tour of the kitchen, starting at 7:50 AM on 6/25/25, it was observed that water lines were protruding from behind the cook line and found not attached to any pieces of equipment. Further observation found a mop sink faucet under and off to the right of the three-compartment sink. An interview with Dietary Manager "I" found that staff never use the faucet and were unaware that it was there. The faucet was found still hooked up to the facilities			

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	domestic water as water would dispense onto the floor when turned on. These fixtures indicated stagnant water lines in the facility. During a tour of the 100-hall soiled utility room, at 11:31 AM on 6/25/25, observation of the cold water, coming from the mop sink faucet over the hopper, found discolored water dispensed out of the faucet and that gave a yellow tinge to the water in the basin. When asked if staff use the hoppers, Housekeeping Lead (HL) "J", stated that staff do use the hoppers, but typically just the hot water. During a tour of the 100-hall bath, at 11:37 AM on 6/25/25, an interview with HL "J" found that staff don't use the tub in this room. Observation of the tub found an accumulation of dust and debris, indicating minimal use and a possible stagnant water line. During a tour of the 200-hall soiled utility, at 11:54 AM on 6/25/25, it was observed that the water line for the spray hose on the hopper was turned off at the source. Using a plumbing key, the spray was turned on and found to dispense discolored yellow tinged water into the basin of the hopper. During an interview with the Director of Nursing, at 1:40 PM on 6/25/25, it was found that she has not been part of the Water Management Team and questions should be directed to Environmental Services Director (ESD) "G". During a record review of the facility provided document, entitled "Water Management Program", reviewed / revised on 1/7/25, found under the heading "Policy Explanation and Compliance Guidelines" the first requirement states that ..."A water management team has been established to develop and implement the			

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	facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. During a tour of the 400 hall, with HL "J", starting at 1:52 PM on 6/25/25, it was found that the beds in the hall have been decertified, and this area has not been used for residents since before HL "J" started a couple years ago. When asked if housekeeping has any responsibility in this hall. HL "J" stated that she makes sure that water is in the basins of the sinks and toilets so that sewer gas doesn't escape and create odors. When asked if any of the water fixtures get flushed regularly, HL "J" stated that she didn't believe the water was on in these rooms and that's why she must carry a bucket down to fill them. Observation of the shared bathroom for rooms 405 and 407, at 1:55 PM on 6/25/25, found that the commode water was low in the bowl and was able to be flushed, indicating the water was active on this hall with numerous stagnant lines not being regularly flushed. An interview with ESD "G", at 2:34 PM on 6/25/25, found that the facility does not take any water samples, such as for disinfection, as a part of their water management plan. When asked about flushing water in the facility to remove stagnation from minimum use or unused water fixtures, ESD "G" stated once a month we check the commodes to make sure they have water in them, but there is not a routine flushing schedule for water fixtures. When asked if the facility has any control measures to reduce the risk of Legionella or OPPP, such as implementing a kill step in their hot water system at 140 F, ESD "G" was unsure and stated the hot water system for domestic use is set at 117 F.			

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	During a further record review of the facility provided document, entitled "Water Management Program", reviewed / revised on 1/7/25, found "Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual controls, or environmental testing for pathogens. The measures shall be specified in the water management program action plan ...When control limits are not maintained, corrective action will be taken and documented accordingly."			