STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	594041	A. BUILDING _____ B. WING _____	4/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF CARSON CITY	620 NORTH SECOND STREET CARSON CITY, MI 48811

(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 Laurels of Carson City skilled nursing facility was surveyed for an unannounced annual recertification survey on 04/23/25 to 04/25/25. Intakes: MI00-146112, MI00-146530, MI00-151366, and MI00-151990 Census:77	F0000		
F0550 SS= E	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	F0550	F tag 550 Resident Rights/Exercise of Rights SS=E 1.Residents R50, and R4 have no LTC affects from not having their call lights answered in a timely manner. Resident R11 and R75 no longer reside at the facility. 2. Residents who reside in the facility are at risk of being affected by this deficient practice. Residents in-house were interviewed by the IDT team through Quality Rounds to ensure their needs are addressed timely. Any concerns were addressed through the guest assistance concern process. 3. The QAPI Committee reviewed the Call light Policy and Resident Rights Policy and deemed them appropriate. Facility staff were re-educated by the NHA/Designee on the policies and procedures related to Call lights, and Resident Rights. Staff who have not been educated by Date of Compliance will be re-educated prior to returning to work. 4. The IDT Team will interview 10 residents weekly to ensure that their needs are being met timely through the Quality Rounds Program. These audits will continue weekly times four than monthly x 3 months. The results of these audits will be forwarded to the QAPI Committee for further direction. The NHA is responsible for continued compliance.	5/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/13/2025

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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	interference, coercion, discrimination, and 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 ensure dignified care for four residents (R50, R11, R4, R75) of six reviewed for dignity. Findings include: Review of the Admission Record reflected R50 was admitted to the facility 1/24/25 with diagnoses that included: Debilitating Cardiorespiratory Conditions, Muscle Weakness, History of Stroke and Aphasia (difficulty in speaking). Review of the Minimum Data Set (MDS) dated 1/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the Resident was moderately cognitively impaired. Section GG (Functional Abilities and Goals) reflected R50 was dependent on staff for bed mobility and all transfers. On 4/24/25 at 9:34 AM an interview was conducted with R50 in his room. R50 reported delayed call light response when he needed to get cleaned up after episodes of incontinence, R50 stated delayed care "makes me feel like crap". During a second interview conducted 4/24/25 at 1:28 PM R50 reported during the night staff will respond to his call light but will turn if off, indicate they will return shortly but often fail to return leaving him wet and uncomfortable for extended periods of time. R11			

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	Review of the MDS dated 4/15/25 reflected R11 admitted to the facility 4/10/25 with pertinent diagnoses that included Fractures and Other Multiple Trauma and Unsteadiness on Feet. The MDS reflected a BIMS score of 13 which indicated the Resident was cognitively intact. The Functional Abilities section of the MDS (GG) reflected R11 required moderate assistance with chair and toilet transfer but maximal assist with toilet hygiene. On 4/23/25 at 1:05 PM an interview was conducted with R11 in her room. R11 reported she used to be an Elder Companion and indicated she knows what it takes to provide care to older adults. R11 reported some staff "do well" but others "need to go back and have some more classes on how to care for people". R11 reported some staff are "rough" with transfers, "pulling up in bed", will move legs and then "just drop your feet'. R11 reported night staff are often "crabby" and "ornery' and "will argue with you about little things". R11 reported "I'm one of those people that has to go to the bathroom every half hour". R11 reported she has "peed my pants" because of delayed call light response. R11 reported the delays occur more often during the evenings and nights. R11 reported episodes of delayed response and then after being placed on the toilet another delay in getting off of the toilet. R11 reported "my butt gets real sore" from long waits to be **assisted back to bed.** R4 Review of an "Admission Record" revealed R4 admitted to the facility on 6/3/2024 with pertinent diagnoses which included muscle weakness, unsteadiness of feet, and history of falling. Review of a "Minimum Data Set" (MDS) (a tool used for assessing a resident's care needs)			

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	assessment for R4, with a reference date of 3/23/2025 revealed a "Brief Interview for Mental Status" (BIMS) (a scale used to determine a resident's cognitive status) score of 10, out of a total possible score of 15, which indicated R4 was moderately cognitively impaired. Further review of same MDS assessment revealed R4 was dependent on staff assistance with toileting and transferring. In an interview on 4/23/2025 at 2:25 PM in R4's room, R4 reported staff answered her call light promptly when her family was there, but she frequently waited for 30 minutes or longer after pressing her call light for toileting assistance when her family was not visiting. R4 reported she was often continent but about once a week she would have an accident in her brief because of the extended wait for her call light to be answered. R4 reported staff often turned her call light off and left the room without helping her. R4 reported the facility put a sign on her wall to prevent staff from doing this. R4 reported urinating in her brief while waiting extended periods of time for her call light to be answered made her feel "unwanted." In an interview on 4/24/2025 at 4:16 PM, R4 reported a certified nursing assistant (CNA) turned her call light off earlier that morning and left her room without assisting her. R4 reported staff returned approximately 15 minutes later to assist her to the toilet. In an interview on 4/25/2025 at 11:45 AM, CNA "C" reported staff are not to turn resident's call lights off until they met the need of the resident. CNA "C" reported she saw some staff turning call lights off and leaving the room without meeting the resident's need, but this should not be done. R75			

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	Review of an "Admission Record" revealed R75 admitted to the facility on 3/31/2025 with pertinent diagnoses which included muscle weakness, unsteadiness on his feet, and falls. Review of a "Minimum Data Set" (MDS) (a tool used for assessing a resident's care needs) assessment for R75, with a reference date of 4/1/2025 revealed a "Brief Interview for Mental Status" (BIMS) (a scale used to determine a resident's cognitive status) score of 11, out of a total possible score of 15, which indicated R75 was moderately cognitively impaired. Further review of same MDS assessment revealed R75 required assistance with toileting and transferring. In an observation and interview on 4/24/2025 at 8:17 AM in R75's room, R75's call light was activated, and he was leaning forward in his bedside chair. R75 stated, "I have to go number two." In an observation on 4/24/2025 at 8:25 AM in the hall outside R75's room, a Registered Nurse walked to the end of the hallway outside R75's door, looked in the direction of R75's door with activated call light, and walked back down the hall away from R75's door without answering the call light. At 8:31 AM a CNA entered R75's room and answered his call light. In an interview on 4/24/2025 at 11:35 AM, R75 reported he remembered he had turned his call light on at 08:00 AM that morning. R75 reported he was barely able to hold his stool prior to his call light being answered approximately 30 minutes after he turned it on. R75 reported he frequently waited 30 to 60 minutes for his call light to be answered. R75 reported waiting extended periods of time for his call light to be answered frequently caused him to lose control of his bowel and bladder. R75 reported losing			

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	control in his brief made him feel embarrassed and stated, "a young girl has to come and clean me up." Review of facility policy/procedure "Resident Dignity & Personal Privacy", revised 3/28/2024, revealed " ...The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy ... Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth ..." Review of facility policy/procedure "Call Lights", revised 3/12/2025, revealed " ...Call lights will be placed within the resident's reach and answered in a timely manner ... turn off the call light if you are able to meet the resident request ... When finished, turn the call light off ..."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to hold blood pressure medication according to the physician's order for 1 resident (R69) of 18 residents reviewed. Findings include: Review of an "Admission Record" revealed R69 admitted to the facility on 3/19/2025 with	F0658	F tag 658 Services Provided Meet Professional Standards SS=D 1. Resident R69 no longer resides at the facility. On 4/24 The DON notified the Nurse Practioner of the findings. Patients chart and vitals were reviewed. Patient was assessed and showed no signs of distress. Education was initiated. Resident discharged home with her spouse on 5/4/2025. 2. Residents residing in the facility receiving blood pressure medications are at risk of being affected by this deficient practice. Residents receiving BP meds with parameters were reviewed by the DON to ensure that medications were held if the BP was not within parameters. Any concerns were addressed. 3. The QAPI Committee reviewed the Medication Administration Policy and deemed	5/15/2025

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	pertinent diagnoses which included sepsis, congestive heart failure, and endocarditis (an infection of the heart's inner lining usually involving the heart valves). Review of R69's "Physician's Orders" active 4/30/2025 revealed an order to give hydralazine (a medication used to treat high blood pressure) HCI 25 milligrams by mouth twice a day, hold for systolic blood pressure (the top number in a blood pressure reading, representing the pressure in your arteries when your heart beats and pumps blood) less than 140. Review of R69's April 2025 Medication Administration Record (MAR) revealed hydralazine given with the systolic blood pressure (SBP) less than 140 at the following times by different nurses: -on 4/3/2025 at 12:00 PM with SBP of 138 -on 4/6/2025 at 12:00 AM with SBP of 122 -on 4/6/2025 at 06:00 AM with SBP of 129 -on 4/8/2025 at 12:00 AM with SBP of 132 -on 4/8/2025 at 06:00 AM with SBP of 134 -on 4/9/2025 at 12:00 AM with SBP of 132 -on 4/13/2025 at 6:00 PM with SBP of 106 -on 4/18/2025 at 12:00 AM with SBP of 115 -on 4/18/2025 at 06:00 AM with SBP of 123 -on 4/20/2025 at 06:00 AM with SBP of 116 -on 4/21/2025 at 6:00 PM with SBP of 122		it appropriate. Nursing staff were re-educated by the DON/Designee on the policies and procedures related to Medication Administration specific to medications with parameters. Staff who have not been educated by Date of Compliance will be re-educated prior to returning to work. 4. The DON/Designee will review 5 residents weekly times four to ensure that physician orders are followed regarding medication parameters then monthly x 3 months. The results of these audits will be forwarded to the QA Committee for further guidance and direction. The NHA is responsible for continued compliance.	

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	In an interview on 4/24/2025 at 11:00 AM, the Director of Nursing (DON) confirmed hydralazine was documented as given to R69 in April of 2025 with a SBP of less than 140 several times and the medication should have been held per the physician's order. The DON reported she would review the Electronic Medical Record (EMR) to determine if there was any further documentation showing the medication had been held appropriately on the dates in question. In an interview on 4/24/2025 at 1:47 PM, the DON reported she reviewed R69's EMR and could find no documentation that hydralazine was held in accordance with the physician's order on the dates in question. Review of the facility policy/procedure "Medication Administration", revised 10/17/2023, revealed " ...Medications are administered in accordance with written orders of the attending physician ..."			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F0688	F tag 688 Increase/Prevent/Decrease in ROM/Mobility SS=D 1. Resident #25 was evaluated to determine if the resident had any new discomfort, or worsening of contracture due to the staff's failure to offer and utilize her right-hand splint. The care plan was reviewed and updated as needed. 2. Residents residing in the facility with splints or other contractual devices have the potential to be affected by the deficient practice. The nursing team reviewed patients with contractual devices to ensure devices were being offered and utilized by physician order. Any refusals were documented, and care plans were updated to reflect preferences. 3. The Qapi Committee reviewed the Brace	5/14/2025

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to utilize an intervention to enhance the comfort and functionality for one of three residents (Resident #25) reviewed for range of motion. Findings: Resident #25 (R25) Review of an "Admission Record" revealed R25 was a 79 year-old female, last admitted to the facility on 01/06/16 with pertinent diagnoses of dementia and right sided weakness and paralysis following a stroke. During an observation on 04/23/25 at 11:07 AM, R25 laid in bed resting with her eyes closed. R25's right hand was contracted into a bent fist position and R25 did not have a splint on her right hand. A splint sat on the bedside table in R25's room. During an observation on 04/24/25 at 9:15 AM, R25 laid in bed and did not have a splint on her right hand. The splint sat on the bedside table in the resident's room. During an interview at the same time, R25 stated "no" staff had not asked her today if they could put the splint on her. During an observation on 04/24/25 at 11:54 AM, staff assisted R25, who sat in a wheelchair, to the dining room. R25 did not have a splint on the right hand. During an observation on 04/24/25 at 1:54 PM, R25 sat in her wheelchair in the dining room and played bingo. R25 did not have a splint on her		and Splint Program and deemed it appropriate. Nursing staff were re-educated by the DON/Designee on the Brace and Splint Program. Staff who have not been educated by Date of Compliance will be re-educated prior to returning to work. 4. The DON/Designee will review 5 residents weekly times four weeks to ensure that their devices are being utilized by physician order, then monthly x 3 months. The results of these audits will be forwarded to the QAPI Committee for further guidance and direction. The NHA is responsible for continued compliance.	

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	right hand. During an observation on 04/24/25 at 3:56 PM, R25 laid in bed resting with her eyes open. There was not a splint on her right hand and the splint sat on the bedside table. R25 stated "no" staff had not asked her today if they could put the splint on her. R25 stated "yes" that sometimes staff do ask her if she wanted to have the splint on. During an observation on 04/25/25 at 8:24 AM, R25 laid in her bed resting with her eyes closed. The splint was not on her right hand and it sat on the bedside table. During an observation on 04/25/25 at 9:30 AM, staff entered R25's room and provided peri-care. Staff did not ask R25 if the hand splint could be placed. Review of a "Care Plan" for R25 revealed the intervention: wear right hand resting splint from morning (am) to bedtime (hs).			

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F0689 SS= B	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 observation and record review, the facility failed to follow a safety intervention for one of three resident's (Resident #25) reviewed for falls and accidents. Findings: Resident #25 (R25) Review of an "Admission Record" revealed R25 was a 79 year-old female, last admitted to the facility on 01/06/16 with pertinent diagnoses of dementia, morbid obesity, and right sided weakness and paralysis following a stroke. During an observation on 04/25/25 at 9:30 AM, certified nurse aide (CNA) "A" provided peri-care to R25. During the care, CNA "A" instructed R25 to roll onto her right side and then over onto her left side. Only one staff person was present to assist with bed mobility. Review of a "Care Plan" for R25 revealed the following safety intervention: resident is dependent on two staff assist with bed mobility. (Initiated 01/19/24)	F0689	F tag 689 Accidents SS=B Accidents 1. Resident #25 was evaluated to determine if any injuries were sustained due to staff's failure to follow the care plan/Kardex during repositioning the resident. No injuries noted due to deficient practice. The CNA involved received 1:1 education 2. Residents who reside in-house are at risk due to the deficient practice. Residents in-house who sustained an accident in the last 10 days were reviewed by the nursing team to ensure that the care plan was followed and that the accident didn't occur based on failure to follow the care plan. Any concerns will be addressed. 3. The QAPI Committee reviewed the Standards of CNA/STNA Practice and deemed it appropriate. CNA's were re-educated by the DON/Designee on the Standards of CNA/STNA Practice. Staff who have not been educated by Date of Compliance will be re-educated prior to returning to work. 4. The DON/Designee will review residents with accidents weekly times four to ensure that their care plans are being followed, then monthly x 3 months. The results of these audits will be forwarded to the QAPI Committee for ongoing direction and further guidance. The NHA is responsible for continued compliance.	5/14/2025
F0880	Infection Prevention & Control §483.80 Infection Control The facility must establish	F0880	F tag 880 Infection Prevention and Control SS=F	5/14/2025

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SS= F	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 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		1.Staff member involved was immediately educated on the use of PPE for all residents in isolation. Soiled washcloths were immediately bagged and placed in the soiled utility room for laundering and the bedside stand disinfected. The water management meeting was held on 5/6/25. The following depts. attended the meeting, Environmental Service Director, Maintenance, Infection Control (IC), Nursing, and NHA. 2. Residents residing in house are at risk related to the deficient practice. Residents in house were reviewed by the nursing team to ensure there was no spread of infection for failure to follow proper IC protocols when entering a room without proper PPE, no s/sx of legionella and lack of proper handling of linen. The city's water department was contacted regarding the chlorine levels that were noted to be outside of parameters. A visit is scheduled for the week of 5/12 to test the facilities' chlorine levels, using their device. If it is determined that the results are not within parameters, we will work with the water dept to regulate chlorine levels to appropriate parameters. 3. The QAPI Committee reviewed the policies and procedures related to Multi Route Transmission Based Precautions, Infection Control, and the Water Management Program and deemed it appropriate. Facility staff were re-educated by the DON/Designee on Multi Route Transmission Based Precautions, and Infection Control. Staff who have not been educated by Date of Complinace will be re-educated prior to returning to work. The Maintenance Director and ICP were re-educated on water management program and the requirement of monthly meetings. The Maintenance Director was educated that if levels are not within parameters, that an	

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	594041	A. BUILDING _____ B. WING _____	4/25/2025

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	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: Based on observation, interview, and record review the facility failed to 1) use Personal Protective Equipment (PPE) according to Transmission Based Precaution (TBP) orders for 1 resident (R61) of two residents reviewed for TBP, 2) implement the facility water management policy/procedure, and 3) dispose of soiled linens in a sanitary manner for 1 resident (R25) of 18 residents reviewed. Findings include: PPE- R61 Review of an "Admission Record" revealed R61 admitted to the facility on 6/13/2023 with pertinent diagnoses which included dementia and muscle weakness. Review of R61's "Physician's Orders", initiated 4/23/2025, revealed an order for contact precautions related to suspected Methicillin-resistant Staphylococcus aureus (MRSA) in his heel wound. In an observation on 4/23/2025 in the hallway outside R61's room, contact precaution signage		action plan needs to be developed and implemented to include rechecks on the levels. 4. The Infection Control Preventionist/Designee will observe 5 residents on isolation weekly times four weeks to ensure that staff are adhering to all IC protocols including Donning and Doffing PPE, handling of linen, water management program then monthly x 3 months. The results of these audits will be forwarded to the QAPI Committee for further direction and guidance. The IC Preventionist is responsible for ongoing compliance. The NHA will review the monthly Water Management meetings to ensure that chlorine levels are within perimeters. The NHA is responsible for ongoing compliance of the Water Management Program.	

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	was on the outside of his door directing staff to don gloves and a gown prior to entering his room. In an observation on 4/24/2025 at 7:57 AM in the hallway outside R61's room, Certified Nursing Assistant (CNA) "D" entered R61's room with his breakfast tray without donning gloves or a gown. Contact precautions signage directing staff to don gloves and a gown prior to entering the room was visible on R61's door. In an interview on 4/24/2025 at 8:04 AM, Infection Preventionist (IP) "B" reported R61 recently changed from Enhanced Barrier Precautions to Contact Precautions due to pending MRSA concerns. IP "B" reported gloves and gown were required to be donned prior to room entry. Water Management Program Review of a blank "Water Management Team Meeting Minutes" form provided by the facility, undated, revealed attendance verification, space to document control limits for chlorine levels, pH range, and water temperatures throughout the building, and direction that testing outside of the documented acceptable limits required intervention to be documented on the form in the comment section. The control limit for an acceptable chlorine level was documented as 0.2 to 4.0 ppm. Review of facility chlorine level testing revealed the following tests outside of documented acceptable parameters- -0.07 on 5/16/2024 -0.10 on 5/22/2024 -0.16 on 6/5/2024			

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	-0.13 on 6/19/2024 -0.18 on 6/28/2024 -0.12 on 7/2/2024 -0.15 on 7/11/2024 -0.17 on 7/18/2024 -0.12 on 7/30/2024 -0.02 on 8/8/2024 -0.19 on 8/16/2024 -0.18 on 8/22/2024 -0.16 on 9/13/2024 -0.18 on 9/20/2024 -0.14 on 10/30/2024 -0.19 on 11/7/2024 -0.10 on 11/26/2024 -0.17 on 12/12/2024 -0.15 on 2/14/2025 -0.15 on 4/3/2025 -0.19 on 4/23/2025 In an interview on 4/25/2025 at 10:00 AM, Regional Consultant "E" reported she could find no documentation that the facility had been using the "Water Management Team Meeting Minutes"			

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	form or that the facility had intervened when chlorine levels were documented to be outside of the acceptable parameters. Regional Consultant "E" reported the form should be used at least quarterly and each time testing is found to be outside of acceptable parameters. Regional Consultant "E" reported the facility should have documented interventions taken for each chlorine level below 0.2 ppm on the "Water Management Team Meeting Minutes" form. Review of facility policy/procedure "Water Management Program", revised 2/1/2024, revealed " ...Water management programs identify hazardous conditions and take steps to minimize the growth and spread of Legionella and other waterborne pathogens in building water systems ... Control measures may include visible inspections, use of disinfectant, and temperature ... Monitoring such controls include testing protocols for control measures, acceptable ranges, and documenting the results of testing ... Interventions will be implemented when control limits are not met ..." Resident #25 (R25) Review of an "Admission Record" revealed R25 was a 79 year-old female, last admitted to the facility on 01/06/16 with pertinent diagnoses of dementia and right sided weakness and paralysis following a stroke. During an observation on 04/25/25 at 9:29 AM certified nurse aide (CNA) "A" provided peri-care to R25. CNA "A" used three wash clothes to wipe the resident's skin clean of urine and fecal matter. Once finished cleaning R25, CNA "A" placed all three contaminated wash clothes on top of R25's over bed table. CNA "A" did not clean and sanitize R25's over bed table prior to leaving R25's room.			

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