STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	366047	a. building _____ b. wing _____	05/21/2025

name of provider or supplier	street address, city, state, zip code
RAE ANN GENEVA	839 W MAIN STREET GENEVA OH, 44041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED 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
F 0000	INITIAL COMMENTS ANNUAL SURVEY COMPLAINT INVESTIGATION COMPLAINT NUMBER OH00165776 ADMINISTRATOR: Erin Williams, #7430 CERTIFIED BED CAPACITY: 76 CENSUS IN HOUSE: 66 The following deficiencies are based on the annual survey and complaint investigation completed 05/21/25.	F 0000		
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new	F 0580	Resident #9 was immediately assessed and found to have no adverse effects. Open Risk assessments audited by DON to ensure all physicians were notified on 5/22/25. All residents have the ability to be effected. Education on appropriate physician notification for resident change in condition was provided by DON to all staff on 5/22/25. DON/ designee to audit 2 charts a week for 4 weeks to ensure PCP was notified of change in condition. Results to be reviewed in QAPI.	05/22/2025

laboratory director's or provider/supplier representative's signature	title	(x6) date
	ERIN.WILLIAMS4	06/05/2025

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F 0580	Continued From page 1 form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This STANDARD is not met as evidenced by:	F 0580		

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F 0580	Continued From page 2 Based on record review, interview, review of the facility self-reported incident (SRI) and review of the facility policy, the facility failed to ensure Primary Care Physician (PCP) #600 was notified of Resident #9's unknown injury. This affected one (Resident #9) out of one resident reviewed for notification of change in condition. The facility census was 66. Findings included: Review of the medical record for Resident #9 revealed an admission date of 10/10/20 with diagnoses including congestive heart failure, muscle weakness, cirrhosis of liver, diabetes, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated 03/19/25 revealed Resident #9 had impaired cognition. She required substantial to maximum assistance with toileting hygiene and lower dressing. She required partial to moderate assistance with transfers. Review of the nursing note dated 04/28/25 authored by Licensed Practical Nurse (LPN) #404 revealed Resident #9 had scattered discoloration noted during her shower. She had large discoloration to her right side including right forearm, right arm, right inner thigh, and right breast. She also had bruising on the inside of her left arm. The note revealed administration was notified, but there was	F 0580		

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F 0580	Continued From page 3 no documented evidence that PCP #600 was notified of the bruising. Review of the undated care plan revealed Resident #9 had the potential for bleeding and bruising related to antiplatelet medication. Interventions included administering medications as ordered, holding medication as indicated, and monitoring for signs of bleeding/ bruising and reporting to the physician. Review of the May 2025 physician's orders revealed Resident #9 had an order for Plavix (blood thinner) 75 milligram (mg) tablet by mouth one time a day for the prevention of deep vein thrombosis (blood clot). Review of SRI tracking number 259787 with a date of discovery of 04/28/25 revealed the facility filed an incident involving Resident #9 having an injury of unknown source. The SRI revealed on 04/28/25 at 12:23 P.M. Resident #9 was in the shower room and had a large discoloration to her right side including her right forearm, right arm, right breast and right inner thigh. She also had discoloration on the inside of her left arm. Resident #9 was unaware of how the bruises occurred and denied pain. The SRI revealed the bruises were likely from a gait belt and assistance with transfers as well as Resident #9 was on Plavix. The SRI was unsubstantiated for abuse. There was no documented evidence that PCP #600 was notified of the bruising and	F 0580		

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F 0580	Continued From page 4 unknown injury. Review of the incident report dated 04/28/25 and completed by LPN #404 revealed Resident #9 had scattered discoloration noted during her shower. She had large discoloration to her right side including right forearm, right breast and right inner thigh. She also had bruising to her left upper arm. Resident #9 was unaware when it had happened and denied pain. The immediate action indicated that the Director of Nursing (DON) and Administrator were notified. There was no documented evidence that PCP #600 was notified of the bruising. Interview on 05/20/25 at 7:53 A.M. with Resident #9 revealed she denied any abuse or that staff was rough during her care. She had no recollection of the incident on 04/28/25 regarding the bruising but stated, "probably bumped something" as she revealed, "I bruise easy, always have". Interview on 05/20/25 at 4:08 P.M. with the DON verified there was no documented evidence that PCP #600 was notified of Resident #9's unknown injury (bruising to her right side including right forearm, right breast, right inner thigh and bruising to her left upper arm) that was discovered on 04/28/25. She revealed she was unsure why the nurse did not contact PCP #600 as she stated, "it should have been done".	F 0580		

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F 0580	Continued From page 5 Review of the facility policy labeled, "Anticoagulation- Clinical Protocol," dated November 2018, revealed the staff and physician would monitor for possible complications in residents who were being anticoagulated and manage related problems. The policy revealed if a resident showed signs of excessive bruising, hematuria (blood in urine), or other evidence of bleeding the nurse would discuss the situation with the physician before giving the next scheduled dose of medication. The policy also revealed the physician would order measures to address any complications. Review of the facility policy labeled, "Change in a Resident's Condition or Status," dated February 2021, revealed the facility promptly notified the resident, and the resident's physician of changes in the resident's medical/mental condition or status. The policy revealed the nurse would notify the resident's physician when there was an accident or incident involving the resident, discovery of injuries of unknown source, and/or need to alter resident's medical treatment.	F 0580		

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F 0604	Continued From page 6	F 0604		
F 0604 SS=D	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This STANDARD is not met as evidenced by:	F 0604	Resident #3 and #25 were immediately assessed and found to have no adverse effects. All residents who utilize alarms or seatbelts have the ability to be effected. Seatbelt order for resident #25 was DCed immediately by DON on 5/21/25. Alarm for resident #3 was requested to stay in place by resident. Chart was reviewed by DON immediately on 5/21/25 to insure proper documentation was in place. All residents with alarms/ restrictive devices were reviewed by IDT on 5/28/25 to ensure the least restrictive device was in place and that remaining devices were appropriate. Education on appropriate alarm and restrictive device usage and ongoing assessment provided by DON to all staff on 5/22/25. DON/ designee to review 3 residents with an alarm or restrictive device in place weekly for 4 weeks to ensure they are necessary, being routinely reviewed and least restrictive .Results of audit to be reviewed in QAPI.	05/28/2025

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F 0604	Continued From page 7 Based on observation, interviews, record review and facility policy review, the facility failed to routinely assess seat belts and alarms for necessity, appropriateness and least restrictive. This affected two (Residents #3 and #25) out of two residents reviewed for restraints. The facility identified 13 residents (#4, #5, #9, #11, #16, #25, #26, #29, #33, #38, #52, #64 and #135) who had seat belts or alarms as restrictive devices. The facility census was 66. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 08/28/03 with diagnoses of hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, speech and language deficits following cerebrovascular disease, chronic kidney disease and vascular dementia. Review of a physician order dated 09/17/24 indicated Resident #3 had a Velcro seat belt to the wheelchair for positioning and safety. Additional medical record review for Resident #3 revealed there were no assessments completed upon application of the seat belt on 09/17/24 or thereafter for necessity, appropriateness or least restrictive. Review of the quarterly Minimum Data	F 0604		

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F 0604	Continued From page 8 Set (MDS) assessment completed 03/19/25 revealed Resident #3 had moderate cognitive impairment. Review of the care plan updated on 04/18/25 indicated Resident #3 had impaired cognition with fluctuation including poor decision making, poor impulse control and a communication problem so staff had to anticipate needs. Resident #3 also had potential for falls related to limited mobility, impaired balance and coordination due to right-sided hemiplegia. Staff were to anticipate Resident #3's needs, be sure a call light was in reach and apply a Velcro seat belt to the wheelchair for positioning and safety. There was no plan of care to monitor the seat belt as necessary, appropriate or least restrictive. Observation on 05/18/25 at 9:50 A.M. revealed Resident #3 sitting in a wheelchair watching television with a seat belt secured with Velcro at the waist. The resident was unable to explain why a seat belt was in place, but when encouraged, pulled the seat belt apart with the left hand due to the right sided paralysis. Review of progress notes from September 2024 to May 2025 revealed no documentation to justify the use of or monitoring of the seat belt for Resident #3. Review of the Treatment Administration Record (TAR) from April 2025 to May	F 0604		

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F 0604	Continued From page 9 2025 revealed Resident #3's seat belt was in place each shift. Review of the nursing assistant Kardex (summary of resident information) effective 05/19/25 indicated to apply a Velcro seat belt in the wheelchair for safety. Interview on 05/19/25 at 4:35 P.M. with Director of Nursing (DON) verified Resident #3 had a Velcro seat belt ordered without any assessments to ensure it was not a restraint, necessary, appropriate and least restrictive. The care plan only referenced the seat belt as a fall intervention without any plan for monitoring or assessing the device to determine when or if the resident was able to self-release the seat belt. During the interview, the DON wrote a physician order for the nurses to monitor Resident #3's seat belt once every quarter to ensure it was not a restraint by checking to see if the resident could self-release it on command. The DON confirmed restrictive devices such as seat belts were to be assessed when applied and at least quarterly to ensure it was not a restraint. Review of the physician order written by the DON on 05/19/25 specified Resident #3 was able to release the seat belt on command and if not, it was to be reported. This check was to be completed daily every three months on the first of the month for three days, and it was to begin on 06/01/25.	F 0604		

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F 0604	Continued From page 10 Interview on 05/20/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #364 confirmed Resident #3 wore a seat belt daily while up in the wheelchair and had for several months, and it was used to prevent the resident from getting up unassisted. 2. Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus type two, dementia, major depressive disorder recurrent, generalized anxiety disorder and post-traumatic stress disorder. Review of a physician order dated 09/17/24 indicated Resident #25 had an alarming Velcro seat belt to the wheelchair for positioning and safety. Another physician order dated 03/17/25 specified an additional pressure alarm was applied to the wheelchair for safety. Review of the Quarterly MDS assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment. Additional medical record review for Resident #25 revealed there were no assessments completed upon application of either the alarming seat belt on 09/17/24 or the pressure alarm on 03/17/25, and none thereafter for necessity, appropriateness or least restrictive.	F 0604		

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F 0604	Continued From page 11 Review of progress notes from September 2024 to May 2025 revealed no documentation to justify the use of either the alarming seat belt or pressure alarm for Resident #25 or to monitor those devices. Review of the TAR from April 2025 to May 2025 revealed Resident #25's seat belt and additional pressure alarm was in place each shift. Review of the care plan updated on 04/18/25 indicated Resident #25 had impaired cognition including poor memory and poor choices. Resident #25 also had potential for falls related to limited range of motion of the right lower extremity, poor balance and poor safety awareness. Staff were to be sure a call light was in reach and maintain a pressure alarm to the wheelchair to alert staff to unassisted rising. The alarming Velcro seat belt was not addressed in the plan of care, and there was no plan to monitor either the seat belt or pressure alarm as necessary, appropriate or least restrictive. Review of the nursing assistant Kardex for Resident #25 effective 05/19/25 indicated to maintain a pressure alarm to the wheelchair to alert staff to unassisted rising. The physician ordered seat belt was not noted on the Kardex. Interview on 05/19/25 at 4:35 P.M. with the DON verified Resident #25 had an	F 0604		

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F 0604	Continued From page 12 alarming Velcro seat belt and pressure alarm ordered without any assessments to ensure it was not a restraint, necessary, appropriate and least restrictive. The care plan did not address these devices with any plan for monitoring or assessments. During the interview the DON was in the process of adding physician orders for nurses to monitor Resident #25's seat belt once every quarter to ensure it was not a restraint by checking to see if the resident could self-release it on command. The DON stated restrictive devices such as seat belts and alarms were to be assessed when applied and at least quarterly to ensure it was not a restraint. Review of the physician order written by the DON on 05/19/25 specified Resident #25 was able to release the seat belt on command and if not, it was to be reported. This check was to be completed daily every three months on the first of the month for three days, and it was to begin on 06/01/25. Observation on 05/20/25 at 1:37 P.M. with CNA #364 of Resident #25 verified there was no physician ordered seatbelt or pressure alarm in place for safety or positioning. Interview at the time of the observation with CNA #364 could not state when or why the devices were not in place. An interview on 05/20/25 at 1:52 P.M. with Resident #25 denied remembering when	F 0604		

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F 0604	Continued From page 13 the alarm or seat belt was last used or whether being able to release the seat belt when it was in place. Interview on 05/20/25 at 1:54 P.M. with Registered Nursing (RN) #431 confirmed both the seat belt and pressure alarm devices were not in place as ordered and were signed off on the TAR as being checked and in place as safety interventions. RN #431 indicated the devices were removed some time ago but could not identify when but remembered it was because Resident #25 was no longer trying to get up without assistance. A second review of the progress notes from September 2024 to May 2025 revealed no documentation to identify the removal of the alarming seat belt or pressure alarm for Resident #25. Observation on 05/21/25 at 12:13 P.M. of Resident #25 being transported to the dining room via wheelchair revealed no visible seat belt or alarming device in place. Review of the facility policy, "Use of Restraints," revised April 2017, revealed prior to placing a resident in restraints there will be a pre-restraining assessment and review to determine the need. The assessment will be used to determine possible underlying causes of the problematic medical symptoms and if there are less restrictive interventions that may improve the symptoms. Physical	F 0604		

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F 0604	Continued From page 14 restraints include devices that a resident cannot remove. When indicated the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation of the need will be documented. Review of the facility policy, "Managing Falls and Fall Risk," revised March 2018, revealed position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy, and staff will document each resident's response to interventions intended to reduce falls or the risks of falling. If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether the measures were still needed.	F 0604		
F 0605 SS=D	483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 0605	Resident #33 was immediately assessed and found to have no adverse effects. All residents on a PRN antipsychotic medication have the ability to be effected. All residents on PRN antipsychotic orders were immediately audited by DON/ designee to ensure all had stop dates in place. Education on antipsychotic usage, GDR process and appropriate orders provided by DON to all nursing staff on 5/22/25. DON/ designee to audit all PRN antipsychotic orders for stop date weekly for 4 week. Results to be reviewed in QAPI.	05/22/2025

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F 0605	Continued From page 15 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 0605		

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F 0605	Continued From page 16 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond	F 0605		

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F 0605	Continued From page 17 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This STANDARD is not met as evidenced by: Based on record review, interview and facility policy review, the facility failed to ensure as needed (PRN) psychotropic medication was reviewed by a practitioner after 14 days for necessity and appropriateness. This affected one (Resident #33) out of five residents reviewed for psychotropic medications. The facility census was 66. Findings include: Review of the medical record for Resident #33 revealed an admission date of 03/20/19 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, major depressive disorder recurrent, adjustment disorder with anxiety, and vascular dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated 02/27/25 indicated Resident #33 had severe cognitive impairment.	F 0605		

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F 0605	Continued From page 18 Review of the care plan last reviewed on 03/12/25 revealed Resident #33 had potential for adverse effects from antianxiety medications and used PRN antianxiety medications for anxiety. Interventions included administering medications as ordered by a physician and monitoring/documenting side effects and effectiveness. Review of the physician orders for Resident #33 revealed a routine order dated 09/23/24 for Vistaril (a sedative/hypnotic which is a psychotropic) 25 milligrams (mg) twice daily for anxiety or agitation. Another order was added on 04/01/25 for Vistaril 25 mg every six hours PRN for anxiety or agitation. There was no duration ordered for the psychotropic. Review of the pharmacy recommendation dated 04/07/25 revealed a pharmacist requested Resident #33's PRN order for Vistaril 25 mg every six hours for anxiety be reviewed by a practitioner after 14 days as required for psychotropics. The physician did not review the medication as recommended until 05/08/25 when the physician ordered the medication to continue for three months due to anxiety. Review of the Medication Administration Record (MAR) for April 2025 indicated the PRN Vistaril order was administered on 04/07/25 and 04/29/25. Further review of the physician orders for	F 0605		

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F 0605	Continued From page 19 Resident #33 revealed the PRN Vistaril order dated 04/01/25 which had no duration was changed on 05/09/25 to Vistaril 25 mg every six hours PRN for anxiety or agitation for a duration of three months. Review of the physician progress notes from 04/01/25 to 05/08/25 revealed no review of the PRN psychotropic after 14 days as required. Interview on 05/21/25 at 12:17 P.M. with Director of Nursing (DON) verified Resident #33's PRN psychotropic medication (Vistaril) was not reviewed by the physician within 14 days as required. The DON confirmed the pharmacist recommendation on 04/07/25 was not addressed timely until 05/08/25 in which the psychotropic medication continued until then. Review of the facility policy, "Antipsychotic Medication Use," revised December 2016, revealed residents would not receive PRN doses of psychotropic medications unless the medication was necessary to treat a specific condition documented in the clinical record. The need to continue PRN orders for psychotropic medications beyond 14 days required the practitioner to document the rationale for the extended order, and the duration of the PRN order would be indicated within the order.	F 0605		

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F 0636	Continued From page 20	F 0636		
F 0636 SS=D	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional	F 0636	Resident #22 was immediately assessed and found to have no adverse effects. All residents have the ability to be effected. MDS reviewed all residents for open annual MDS Assessments on 5/22/25 to ensure they were complete. Resident #22 annual MDS Assessments immediately reviewed and complete on 5/29/25 by MDS. Admin immediately provided MDS Coordinator education MDS Assessments policy and timely submission. DON/ designee to audit 2 residents with annual MDS assessments due weekly for 4 weeks. Results to be reviewed in QAPI.	05/29/2025

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F 0636	Continued From page 21 assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This STANDARD is not met as evidenced by: Based on record review, interview and facility policy review, the facility failed to complete an annual Minimum Data Set (MDS) assessment in the required timeframe (within 366 days from the previous comprehensive assessment) for Resident #22. This affected one	F 0636		

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F 0636	Continued From page 22 (Resident #22) out of 11 residents reviewed for comprehensive MDS assessments. The facility census was 66. Findings include: Review of the medical record for Resident #22 revealed an admission date of 05/13/20 with diagnoses including chronic obstructive pulmonary disease and diabetes mellitus type two. Review of the MDS assessments for Resident #33 revealed the last comprehensive assessment completed was an annual MDS assessment dated 04/01/24. There was no comprehensive assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #22 had no comprehensive assessment completed since 04/01/24 within the required timeframe. Review of the facility policy, "Comprehensive Assessments," revised March 2022, revealed comprehensive assessments were conducted in accordance with criteria and timeframes establish in the Resident Assessment Instrument (RAI) User Manual, and Annual assessments were completed at least every 366 days.	F 0636		

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F 0638	Continued From page 23	F 0638		
F 0638 SS=E	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments in the required timeframe (within 92 days from the previous assessment). This affected nine (Residents #11, #20, #21, #22, #26, #29, #41, #42 and #60) out of 11 residents reviewed for quarterly MDS assessments. The facility census was 66. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 07/31/11 and diagnoses included Parkinsonism, dementia and diabetes mellitus (DM) type two. Review of the MDS assessments for Resident #11 revealed the last quarterly assessment completed was dated 12/31/24. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #11 had no quarterly assessment completed after 12/31/24 within the	F 0638	Residents #11, 20, 21, 22, 26, 29, 41, 42, and 60 were immediately assessed and found to have no adverse effects. All residents have the ability to be effected. Resident #11, 20, 21, 22, 26, 29, 41, 42, and 60 quarterly mds assessments immediately reviewed By MDS. Residents #11, 22, 26, 29 quarterly assessments complete immediately and residents #20, 21, 41, 42, and 60 quarterly assessments were complete on 5/29/25 by MDS. MDS reviewed all quarterly mds assessments On 5/21/25 Admin provided MDS Coordinator education on quarterly MDS Assessment policy and timely submission. DON/ designee to audit 3 residents charts weekly to ensure quarterly MDS Assessments we submitted timely for 4 week. Results to be reviewed in QAPI.	05/29/2025

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F 0638	Continued From page 24 required timeframe. 2. Review of the medical record for Resident #20 revealed an admission date of 01/09/16 and diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and hypertensive heart disease. Review of MDS assessments for Resident #20 revealed an annual assessment was completed dated 01/03/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #20 had no quarterly assessment completed after 01/03/25 within the required timeframe. 3. Review of the medical record for Resident #21 revealed an admission date of 09/03/15 and diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left dominant side, COPD and chronic pain syndrome. Review of MDS assessments for Resident #21 revealed a significant change assessment was completed dated 01/03/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with	F 0638		

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F 0638	Continued From page 25 MDS Coordinator #333 verified Resident #21 had no quarterly assessment completed after 01/03/25 within the required timeframe. 4. Review of the medical record for Resident #22 revealed an admission date of 05/13/20 and diagnoses included COPD and DM type two. Review of MDS assessments for Resident #22 revealed the last quarterly assessment completed was dated 01/02/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #22 had no quarterly assessment completed after 01/02/25 within the required timeframe. 5. Review of the medical record for Resident #26 revealed an admission date of 01/09/22 and diagnoses included hypertensive heart disease, dementia and Alzheimer's disease. Review of MDS assessments for Resident #26 revealed an annual assessment was completed dated 12/31/24. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident	F 0638		

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F 0638	Continued From page 26 #26 had no quarterly assessment completed after 12/31/24 within the required timeframe. 6. Review of the medical record for Resident #29 revealed an admission date of 05/10/23 and diagnoses included degeneration of nervous system due to alcohol, COPD and hypertensive heart disease. Review of MDS assessments for Resident #29 revealed the last quarterly assessment completed was dated 12/31/24. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #29 had no quarterly assessment completed after 12/31/24 within the required timeframe. 7. Review of the medical record for Resident #41 revealed an admission date of 12/30/20 and diagnoses included epilepsy, dementia, DM type two and congestive heart failure. Review of MDS assessments for Resident #41 revealed the last quarterly assessment completed was dated 01/03/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with	F 0638		

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F 0638	Continued From page 27 MDS Coordinator #333 verified Resident #41 had no quarterly assessment completed after 01/03/25 within the required timeframe. 8. Review of the medical record for Resident #42 revealed an admission date of 12/26/23 and discharge date of 05/05/25. Diagnoses included hypertensive heart disease and dementia. Review of MDS assessments for Resident #42 revealed an annual assessment was completed dated 01/02/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #42 had no quarterly assessment completed after 01/02/25 within the required timeframe. 9. Review of the medical record for Resident #60 revealed an admission date of 09/06/24 and diagnoses included hypertensive heart disease, chronic pain syndrome and asthma. Review of MDS assessments for Resident #60 revealed the last quarterly assessment completed was dated 01/08/25. There was no quarterly assessment completed thereafter as required. Interview on 05/19/25 at 10:26 A.M. with	F 0638		

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F 0638	Continued From page 28 MDS Coordinator #333 verified Resident #60 had no quarterly assessment completed after 01/08/25 within the required timeframe.	F 0638		
F 0640 SS=E	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must	F 0640	Residents #11, 20, 21, 22, 26, 29, 41, 42, 62, 70 and 60 were immediately assessed and found to have no adverse effects. All residents have the ability to be effected. Resident #11, 20, 21, 22, 26, 29, 41, 42, and 60 assessments immediately reviewed By MDS. Residents #11, 22, 26, 29, 62, and 70 assessments complete immediately and residents #20, 21, 41, 42, and 60 quarterly assessments were complete on 5/29/25 by MDS. All resident MDS assessments were reviewed by MDS on 5/22/25. Admin provided MDS Coordinator education on MDS Assessment policy and timely submission on 5/21/25. Random Weekly audits of comprehensive care plans to be complete by: DON/ Designee for 4 week. Results to be reviewed in QAPI.	05/29/2025

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F 0640	Continued From page 29 electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This STANDARD is not met as evidenced by: Based on record reviews, interviews and facility policy review, the facility failed to complete and submit Minimum Data Set (MDS) assessments within the required timeframes. This affected 11 (Residents #11, #20, #21, #22, #26, #29, #41, #42, #60, #62 and #70) out of 11 residents reviewed for MDS assessments. The facility census was 66. Findings include:	F 0640		

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F 0640	Continued From page 30 1. Review of the medical record for Resident #11 revealed an admission date of 07/31/11 and diagnoses included Parkinsonism, dementia and diabetes mellitus (DM) type two. Review of the quarterly MDS assessment for Resident #11 with an ARD (assessment reference date) of 12/31/24 revealed it was completed on 02/13/25. The assessment was not completed within the required timeframe, which was 14 days after the ARD of 12/31/24. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #11's assessment was not completed timely. 2. Review of the medical record for Resident #20 revealed an admission date of 01/09/16 and diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and hypertensive heart disease. Review of the annual MDS assessment for Resident #20 with an ARD date of 01/30/25 revealed it was completed on 03/06/25 and the CAA (care area assessment) completed on 03/06/25. The assessment and CAA were not completed within the required timeframe which was within 14 days after the ARD on 01/30/25. Interview on 05/19/25 at 10:26 A.M. with	F 0640		

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F 0640	Continued From page 31 MDS Coordinator #333 verified Resident #20's assessment and CAA were not completed timely. 3. Review of the medical record for Resident #21 revealed an admission date of 09/03/15 and diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left dominant side, COPD and chronic pain syndrome. Review of the significant change MDS assessment for Resident #21 with an ARD date of 01/03/25 revealed it was completed on 02/04/25 and the CAA completed on 02/04/25. The assessment and CAA were not completed within the required timeframe which was within 14 days after determination of change in resident status on 01/03/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #21's assessment and CAA were not completed timely. 4. Review of the medical record for Resident #22 revealed an admission date of 05/13/20 and diagnoses included COPD and DM type two. Review of the quarterly MDS assessment for Resident #22 with an ARD date of 01/02/25 revealed it was completed on 02/26/25. The assessment was not completed within the required timeframe, which was 14 days after the ARD of	F 0640		

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F 0640	Continued From page 32 01/02/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #22's assessment was not completed timely. 5. Review of the medical record for Resident #26 revealed an admission date of 01/09/22 and diagnoses included hypertensive heart disease, dementia and Alzheimer's disease. Review of the annual MDS assessment for Resident #26 with an ARD date of 12/31/24 revealed it was completed on 02/14/25 and the CAA completed on 02/14/25. The assessment and CAA were not completed within the required timeframe which was within 14 days after the ARD on 12/31/24. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #26's assessment and CAA were not completed timely. 6. Review of the medical record for Resident #29 revealed an admission date of 05/10/23 and diagnoses included degeneration of nervous system due to alcohol, COPD and hypertensive heart disease. Review of the significant change assessment with an ARD date of 11/25/24 revealed it was completed on 01/15/25 and the CAA completed on 01/15/25. The	F 0640		

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F 0640	Continued From page 33 assessment and CAA were not completed within the required timeframe which was within 14 days after determination of change in resident status on 11/25/24. Review of the quarterly MDS assessment for Resident #29 with an ARD date of 12/31/24 revealed it was completed on 02/14/25. The assessment was not completed within the required timeframe, which was 14 days after the ARD of 12/31/24. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #29's assessments and CAA were not completed timely. 7. Review of the medical record for Resident #41 revealed an admission date of 12/30/20 and diagnoses included epilepsy, dementia, DM type two and congestive heart failure. Review of the quarterly MDS assessment for Resident #41 with an ARD date of 01/03/25 revealed it was completed on 02/03/25 and submitted on 03/20/25. The assessment was not completed within the required timeframe which was within 14 days after the ARD of 01/03/25, and it was not submitted timely which was within 14 days after completion on 02/03/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #41's assessment was not completed or submitted timely.	F 0640		

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F 0640	Continued From page 34 8. Review of the medical record for Resident #42 revealed an admission date of 12/26/23 and discharge date of 05/05/25. Diagnoses included hypertensive heart disease and dementia. Review of the annual MDS assessment for Resident #42 with an ARD date of 01/02/25 revealed it was completed on 02/19/25 and the CAA completed on 02/19/25. The assessment and CAA were not completed within the required timeframe which was within 14 days after the ARD of 01/02/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #42's assessment and CAA were not completed timely. 9. Review of the medical record for Resident #60 revealed an admission date of 09/06/24 and diagnoses included hypertensive heart disease, chronic pain syndrome and asthma. Review of the admission MDS assessment for Resident #60 with an ARD date of 09/12/24 revealed it was completed on 10/04/24 and the CAA completed on 10/04/24. The assessment and CAA were not completed within the required timeframe which was within 14 calendar days after admission on 09/06/24. Review of the quarterly MDS assessment	F 0640		

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F 0640	Continued From page 35 for Resident #60 with an ARD date of 01/08/25 revealed it was completed on 03/13/25. The assessment was not completed within the required timeframe, which was 14 days after the ARD of 01/08/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #60's assessments were not completed timely. 10. Review of the medical record for Resident #62 revealed an admission date of 12/29/24 and discharge date of 02/04/25. Diagnoses included metabolic encephalopathy and COPD. Review of the admission MDS assessment for Resident #62 with an ARD date of 01/05/25 revealed it was completed on 01/13/25 and the CAA completed on 01/13/25. The assessment and CAA were not completed within the required timeframe which was within 14 calendar days after admission on 12/29/24. Review of the discharge return not anticipated MDS assessment for Resident #62 dated 01/30/25 revealed it was completed on 03/26/25. The assessment was not completed within the required timeframe which was within 14 days after discharge on 02/04/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident	F 0640		

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F 0640	Continued From page 36 #62's assessments were not completed timely. 11. Review of the medical record for Resident #70 revealed an admission date of 04/01/25 and diagnoses included intraspinal abscess and granuloma, DM type two and chronic pain syndrome. Review of the admission MDS assessment for Resident #70 with an ARD date of 04/08/25 revealed it was completed on 04/29/25 and the CAA completed on 04/29/25. The assessment and CAA were not completed within the required timeframe which was within 14 calendar days after admission on 04/01/25. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Resident #70's assessment was not completed timely. Review of the facility policy, "Comprehensive Assessments," revised March 2022 revealed comprehensive assessment were conducted in accordance with criteria and timeframes establish in the Resident Assessment Instrument (RAI) User Manual including admission assessments which must be completed by day 14.	F 0640		

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F 0655	Continued From page 37	F 0655		
F 0655 SS=D	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that	F 0655	All residents have the ability to be effected. All baseline care plans reviewed by DON, MDS/ designee to ensure they are in place on 5/22/25 and residents received a copy. Admin provided MDS Coordinator education on base line care plan policy and importance of timely patient review and acknowledgment immediately on 5/21/25. DON provided all nursing staff education on baseline care plan policy and importance of timely patient review and acknowledgment on 5/22/25. DON/ designee to audit 3 new admissions baseline care weekly to ensure timely receipt of baseline care plans for 4 week. Results to be reviewed in QAPI.	05/22/2025

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F 0655	Continued From page 38 includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This STANDARD is not met as evidenced by: Based on record reviews, interviews and facility policy review, the facility failed to provide residents and representatives with a written summary of the baseline care plan. This affected two (Residents #76 and #77) of two residents reviewed for baseline care plans. The facility census was 66. Findings include: 1. Review of the medical record for Resident #76 revealed an admission date of 02/18/25 and discharge date of 03/07/25. Diagnoses included nonrheumatic aortic valve stenosis, nonrheumatic mitral valve insufficiency, pulmonary hypertension, nonrheumatic tricuspid valve insufficiency, chronic obstructive pulmonary disease, atrial fibrillation, and congestive heart failure (CHF). Review of the Admission Minimum Data Set (MDS) assessment dated 02/25/25 revealed Resident #76 was rarely or	F 0655		

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F 0655	Continued From page 39 never understood. The baseline care plan dated 02/18/25 included Resident #76's use of antibiotics for a urinary tract infection, diuretics due to CHF, cognitive status and needs for activities of daily living assistance. Review of the family conference form dated 02/21/25 revealed there was a conference held with Resident #76's family to discuss the resident's care. However, there was no evidence Resident #76, and the resident's representative received a written summary of the baseline care plan. Review of the nursing progress notes from February 2025 to March 2025 revealed no indication Resident #76 and the resident's representative received a written summary of the baseline care plan. Interview on 05/20/25 at 4:03 P.M. with MDS Coordinator #333 verified Resident #76 and the resident's representative did not receive a written summary of the baseline care plan. 2. Review of the medical record for Resident #77 revealed an admission date of 02/04/25 and discharge date of 02/21/25. Diagnoses included myocardial infarction type two, malignant neoplasm of prostate, severe protein-calorie malnutrition, pulmonary fibrosis, and chronic kidney disease stage two.	F 0655		

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F 0655	Continued From page 40 Review of the Admission MDS assessment dated 02/11/25 revealed Resident #77 had moderate cognitive impairment. The baseline care plan dated 02/05/25 included Resident #77's fall risk, plan for discharge, advanced care planning, wound prevention, cognitive status and needs for activities of daily living assistance. Review of the family conference form dated 02/06/25 revealed there was a conference held with Resident #77's family to discuss the resident's care. However, there was no evidence Resident #77, and the resident's representative received a written summary of the baseline care plan. Review of the nursing progress notes for February 2025 revealed no indication Resident #77 and the resident's representative received a written summary of the baseline care plan. Interview on 05/21/25 at 10:04 A.M. with MDS Coordinator #333 verified Resident #77 and the resident's representative did not receive a written summary of the baseline care plan. Review of the facility policy, "Care Plans - Baseline," revised March 2022, revealed residents and/or representatives are provided a written summary of the	F 0655		

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F 0655	Continued From page 41 baseline care plan in a language the resident/representative can understand.	F 0655		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and	F 0656	All residents have the ability to be effected. Social Services and all staff educated by DON on Trauma informed care 5/22/25. PCC trauma informed care assessment put in place and complete by social services on 5/22/25 for #25, #140 and on all appropriate residents. DON/ designee to audit trauma informed assessments on new admissions weekly for 4 weeks. Results to be reviewed in QAPI.	05/22/2025

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F 0656	Continued From page 42 the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This STANDARD is not met as evidenced by: Based on record reviews, interviews and facility policy review, the facility failed to implement a comprehensive care plan to include trauma-informed care for Residents #25 and #140. This affected two (Residents #25 and #140) out of two residents reviewed for trauma-informed care. The facility reported two (Residents #25 and #140) who had trauma related diagnoses. The facility census was 66. Findings include: 1. Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of dementia, major depressive disorder recurrent,	F 0656		

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F 0656	Continued From page 43 generalized anxiety disorder and post-traumatic stress disorder (PTSD). Review of the quarterly MDS assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment. Review of the physician orders effective May 2025 revealed no orders related to trauma-informed care other than to consult psychotherapies. Review of the assessments for Resident #25 revealed no trauma screening or assessments completed since admission. Review of the nursing progress notes from May 2024 to May 2025 revealed no documentation relevant to Resident #25's trauma or trauma-informed care. Review of the physician progress notes from psychiatric services on 11/18/24, 12/09/24, 01/14/25, 02/10/25, 03/10/25 and 05/05/25 revealed no documentation relevant to Resident #25's trauma or trauma-informed care. Review of the care plan dated 02/18/17 and last updated on 04/18/25 indicated Resident #25 had impaired cognition including poor memory and poor choices. The resident had depression, anxiety, and a history of alcohol abuse, who demonstrated behaviors related to maintaining personal space. There was no reference in the care plan relevant to Resident #25's trauma including triggers	F 0656		

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F 0656	Continued From page 44 and trauma-informed care. Review of the nursing assistant Kardex for Resident #25 effective 05/19/25 indicated no information relevant to trauma-informed care. Interview on 05/19/25 at 4:26 P.M. with the Director of Nursing (DON) verified there were no assessments used for trauma informed care and no information on Resident #25's trauma, triggers or needed interventions to care for the resident's PTSD which included in the care plan, Kardex and progress notes. Interview on 05/20/25 at 1:52 P.M. with Resident #25 denied any staff had discussed or asked questions related to the PTSD or trauma. Interview on 05/20/25 2:24 P.M. with Social Services Director (SSD) #318 verified there was no trauma assessment completed for Resident #25 to contribute to trauma-informed care. SSD #318 indicated a trauma assessment should have been completed within 48 hours after admission so it would reflect on the baseline care plan and then into the comprehensive care plan thereafter. Resident #25 had no trauma assessment completed upon admission and none afterwards so therefore it was not included in the care plan. Review of the facility policy, "Trauma Informed Care," revised March 2019,	F 0656		

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F 0656	Continued From page 45 revealed trauma-informed care was culturally sensitive and person-centered. Review of the facility policy, "Using the Care Plan," revised August 2006, revealed the care plan would be used in developing the resident's daily care routines and available to staff who have responsibility for providing care or services to the resident. 2. Review of the medical record revealed Resident #140 was admitted to the facility on 05/13/25 with diagnoses including PTSD, recurrent major depressive disorder, generalized anxiety disorder, congestive heart failure, chronic obstructive pulmonary disease, and alcohol dependence with unspecified alcohol use disorder. Review of the baseline care plan dated 05/13/25 revealed Resident #140 was new to the nursing facility, had adjustment issues related to admission, had the potential for bleeding, was ordered physical therapy (PT) and occupational therapy (OT), had the potential for skin impaired skin integrity, had skin impairments noted on admission, was admitted on a regular diet, was admitted with anti-anxiety medications, was dependent on the facility's activities staff for activities and social interaction, was at risk for falls, and was at risk for nutritional problems related to class three morbid obesity.	F 0656		

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F 0656	Continued From page 46 There was no information found in the baseline care plan related to Resident #140's diagnosis of PTSD. Interview with the Director of Nursing (DON) on 05/19/25 at 4:26 P.M. verified there were no care plans used for trauma informed care, to obtain information on the resident's triggers, and confirmed there was no information on Resident #140's Kardex. Interview on 05/20/25 at 2:24 P.M. revealed SSD #318 will be doing a brief trauma assessment for residents with PTSD/trauma going forward, did not complete one until yesterday 05/19/25 for Resident #140 and had a meeting with the resident and the resident's family, but typically the assessments should be completed within 48 hours of admission so it could be reflected on the baseline care plan, but in this case, that did not get done prior to the baseline care plan being completed, so trauma care was not on the residents baseline care plan, but should have been. Review of Residents 140's Brief Trauma Questionnaire revealed it was completed on 05/19/25 at 3:59 P.M. Interview with the MDS Coordinator #333 on 05/20/25 at 4:03 P.M. confirmed that the resident did not have a baseline care plan in place within the first 48 hours for PTSD. The care plan was initiated on 05/16/25.	F 0656		

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F 0656	Continued From page 47	F 0656		
F 0657 SS=E	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This STANDARD is not met as evidenced	F 0657	Resident #3 and #25 were immediately assessed and found to have no adverse effects. All residents with restrictive devices and alarms have the ability to be effected. Seatbelt for resident #25 was DCed immediately by DON on 5/21/25. Seatbelt for resident #3 was requested to stay in place by resident. Chart was reviewed by DON immediately on 5/21/25 to insure proper documentation was in place. Resident #3 and #25 comprehensive care plan immediately reviewed and updated by MDS on 5/21/25. Admin immediately provided MDS Coordinator education on comprehensive care plan policy and timely submission. Education on appropriate alarm and restrictive device usage and documentation provided by DON to all staff on 5/22/25. All residents alarms/ restrictive devices were reviewed by IDT on 5/28/25 to ensure appropriateness an supporting documentation in place. Weekly audits of three alarms/ restrictive devices to be complete by DON/ designee to ensure the care plan is accurate and the device in place are appropriate as the least restrictive option with proper monitoring for 4 weeks. Results to be reviewed in QAPI.	05/28/2025

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F 0657	Continued From page 48 by: Based on record reviews, observations, interviews and facility policy review, the facility failed to revise care plans for Residents #3 and #25 to include the use and monitoring of seat belts and alarms as restrictive devices and failed to complete comprehensive care plans within the required timeframe (within 21 days after admission) for Residents #60 and #70. This affected four (Residents #3, #25, #60 and #70) out of four residents reviewed for comprehensive care plan completion and revision. The facility census was 66. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 08/28/03 with diagnoses of hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, speech and language deficits following cerebrovascular disease, chronic kidney disease and vascular dementia. Review of a physician order dated 09/17/24 indicated Resident #3 had a Velcro seat belt to the wheelchair for positioning and safety. Review of the quarterly Minimum Data Set (MDS) assessment completed 03/19/25 revealed Resident #3 had moderate cognitive impairment.	F 0657		

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F 0657	Continued From page 49 Review of the care plan updated on 04/18/25 indicated Resident #3 had impaired cognition with fluctuation including poor decision making, poor impulse control and a communication problem so staff had to anticipate needs. Resident #3 also had potential for falls related to limited mobility, impaired balance and coordination due to right-sided hemiplegia. Staff were to anticipate Resident #3's needs, be sure a call light was in reach and apply a Velcro seat belt to the wheelchair for positioning and safety. There was no plan of care to monitor the seat belt as necessary, appropriate or least restrictive. Observation on 05/18/25 at 9:50 A.M. revealed Resident #3 sitting in a wheelchair watching television with a seat belt secured with Velcro at the waist. Review of the Treatment Administration Record (TAR) from April 2025 to May 2025 revealed Resident #3's seat belt was in place each shift. Interview on 05/19/25 at 4:35 P.M. with the Director of Nursing (DON) verified Resident #3 had a Velcro seat belt ordered, and the care plan only referenced the seat belt as a fall intervention without any plan for monitoring or assessing the device as necessary, appropriate or least restrictive. Interview on 05/20/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #364	F 0657		

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F 0657	Continued From page 50 verified Resident #3 wore a seat belt daily while up in the wheelchair and had it for several months, and it was used to prevent the resident from getting up unassisted. 2. Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus type two, dementia, major depressive disorder recurrent, generalized anxiety disorder and post-traumatic stress disorder (PTSD). Review of a physician order dated 09/17/24 indicated Resident #25 had an alarming Velcro seat belt to the wheelchair for positioning and safety. Another physician order dated 03/17/25 specified an additional pressure alarm was applied to the wheelchair for safety. Review of the Quarterly MDS assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment. Review of the care plan updated on 04/18/25 indicated Resident #25 had impaired cognition including poor memory and poor choices. Resident #25 also had potential for falls related to limited range of motion of the right lower extremity, poor balance and poor safety awareness. Staff were to be sure a call light was in reach and maintain a pressure alarm to the wheelchair to alert staff to unassisted rising. The alarming Velcro seat belt was	F 0657		

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F 0657	Continued From page 51 not addressed in the plan of care, and there was no plan to monitor either the seat belt or pressure alarm as necessary, appropriate or least restrictive. Review of the TAR from April 2025 to May 2025 revealed Resident #25's seat belt and additional pressure alarm was in place each shift. Interview on 05/19/25 at 4:35 P.M. with the DON verified Resident #25 had an alarming Velcro seat belt and pressure alarm ordered, and the care plan did not address these devices as being in place or removed, nor any plan for monitoring or assessments. Observation on 05/20/25 at 1:37 P.M. with CNA #364 of Resident #25 verified there was no physician ordered seatbelt or pressure alarm in place for safety or positioning. Interview at the time of the observation with CNA #364 could not state when or why the devices were not in place. An interview on 05/20/25 at 1:52 P.M. with Resident #25 denied remembering when the alarm or seat belt was last used or whether being able to release the seat belt when it was in place. Interview on 05/20/25 at 1:54 P.M. with Registered Nursing (RN) #431 confirmed both the seat belt and pressure alarm devices were not in place as ordered and were signed off on the TAR as being	F 0657		

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F 0657	Continued From page 52 checked and in place as safety interventions. RN #431 indicated the devices were removed some time ago but could not identify when but remembered it was because Resident #25 was no longer trying to get up without assistance. Review of the progress notes from September 2024 to May 2025 revealed no documentation to identify the removal of the alarming seat belt or pressure alarm for Resident #25. Observation on 05/21/25 at 12:13 P.M. of Resident #25 being transported to the dining room via wheelchair revealed no visible seat belt or alarming device in place. 3. Review of the medical record for Resident #60 revealed an admission date of 09/06/24 with diagnoses including hypertensive heart disease, chronic pain syndrome and asthma. Review of the admission MDS assessment dated 09/12/24 revealed it was completed on 10/04/24. The care area assessment and care plan were completed on 10/04/24. This was outside of the required timeframe for completing comprehensive care plans. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Residents #60's care plan was completed late, outside of the required 21 days after admission timeframe.	F 0657		

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F 0657	Continued From page 53 4. Review of the medical record for Resident #70 revealed an admission date of 04/01/25 with diagnoses including intraspinal abscess and granuloma, diabetes mellitus type two and chronic pain syndrome. Review of the admission MDS assessment dated 04/08/25 revealed it was completed on 04/29/25. The care area assessment and care plan were completed on 04/29/25. This was outside of the required timeframe for completing comprehensive care plans. Interview on 05/19/25 at 10:26 A.M. with MDS Coordinator #333 verified Residents #70's care plan was completed late, outside of the required 21 days after admission timeframe. Review of the facility policy, "Using the Care Plan," revised August 2006, revealed the care plan was used in developing the resident's daily care routines and was available to staff who have responsibility for providing care or services to residents.	F 0657		

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F 0689	Continued From page 54	F 0689		
F 0689 SS=D	483.25(d)(1)(2) 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 STANDARD is not met as evidenced by: Based on record review, observation, interviews and facility policy review, the facility failed to properly monitor and maintain safety interventions which were in place for Resident #25. This affected one (Resident #25) out of two residents reviewed for safety interventions. The facility census was 66. Findings include: Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus type two, dementia, major depressive disorder recurrent, generalized anxiety disorder and post-traumatic stress disorder. Review of the quarterly Minimum Data Set (MDS) assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment.	F 0689	Resident #25 was immediately assessed and found to have no adverse effects. All residents with safety interventions have the ability to be effected. Resident #25 seatbelt immediately DCed by DON. Education provided to all staff by DON on 5/22/25 regarding alarm/ restrictive device policy. All residents with orders for restrictive devices/ alarms were audited by IDT team on 5/22/25 to ensure they are appropriate, in place, and have required documentation. Don/ Designee to audit 2 residents weekly ensuring that proper documentation is in place for their safety interventions for 4 weeks to ensure compliance. Results to be reviewed in QAPI.-	05/22/2025

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F 0689	Continued From page 55 Review of a physician order dated 09/17/24 indicated Resident #25 had an alarming Velcro seat belt to the wheelchair for positioning and safety. Another physician order dated 03/17/25 specified an additional pressure alarm was applied to the wheelchair for safety. Review of the assessments for Resident #25 revealed there were none completed for either the alarming seat belt on 09/17/24 or the pressure alarm on 03/17/25, and none thereafter to determine necessity and appropriateness. Review of the care plan updated on 04/18/25 indicated Resident #25 had impaired cognition including poor memory and poor choices. Resident #25 also had potential for falls related to limited range of motion of the right lower extremity, poor balance, poor safety awareness, and a history of falls. Staff were to be sure a call light was in reach and maintain a pressure alarm to the wheelchair to alert staff to unassisted rising. The alarming Velcro seat belt was not addressed in the care plan. Review of the progress notes from September 2024 to May 2025 revealed no documentation to justify the use of either the alarming seat belt or pressure alarm for Resident #25 or to monitor those devices. Review of the Treatment Administration Record (TAR) from April 2025 to May	F 0689		

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F 0689	Continued From page 56 2025 revealed Resident #25's seat belt was checked every shift for placement and functioning, and the pressure alarm was checked twice daily for placement and functioning for safety. Review of the nursing assistant Kardex (summary of resident information) for Resident #25 effective 05/19/25 indicated to maintain a pressure alarm to the wheelchair to alert staff to unassisted rising. The physician ordered seat belt was not listed on the Kardex to inform nursing assistants of the safety order. Interview on 05/19/25 at 4:35 P.M. with the Director of Nursing (DON) verified Resident #25 had an alarming Velcro seat belt and pressure alarm ordered without any assessments to ensure it was necessary and appropriate. The care plan did not address these devices with any plan for monitoring or assessments. Observation on 05/20/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #364 of Resident #25 verified there was no physician ordered seatbelt or pressure alarm in place for safety or positioning. Interview at the time of the observation with CNA #364 could not state when or why the devices were not in place. An interview on 05/20/25 at 1:52 P.M. with Resident #25 denied remembering when the alarm or seat belt was last used. Interview on 05/20/25 at 1:54 P.M. with	F 0689		

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F 0689	Continued From page 57 Registered Nursing (RN) #431 confirmed both the seat belt and pressure alarm devices were not in place as ordered and were signed off on the TAR as being checked and in place as safety interventions. RN #431 indicated the devices were removed some time ago but could not identify when but remembered it was because Resident #25 was no longer trying to get up without assistance. A second review of the progress notes from September 2024 to May 2025 revealed no documentation to identify the removal of the alarming seat belt or pressure alarm for Resident #25. Observation on 05/21/25 at 12:13 P.M. of Resident #25 being transported to the dining room via wheelchair revealed no visible seat belt or alarming device in place. Review of the facility policy, "Managing Falls and Fall Risk," revised March 2018, revealed position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy, and staff will document each resident's response to interventions intended to reduce falls or the risks of falling. If interventions were successful in preventing falling, staff would continue the interventions or reconsider whether the measures were still needed.	F 0689		

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F 0689	Continued From page 58	F 0689		
F 0695 SS=D	483.25(i) 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 STANDARD is not met as evidenced by: Based on record review, interview, observation and review of the facility policy, the facility failed to clean Resident #10's Continuous Positive Airway Pressure (CPAP) (machine used to treat sleep apnea) equipment and mask as recommended. This affected one (Resident #10) out of one resident reviewed for use of CPAP. This had the potential to affect two (Residents #9 and #10) who had orders for CPAPs. The facility census was 66. Findings include: Review of the medical record for Resident #10 revealed an admission date of 11/03/21 with diagnoses including chronic obstructive pulmonary disease (COPD),	F 0695	Resident #10 was immediately assessed and found to have no adverse effects. All residents with orders for a CPAP have the ability to be effected. Resident #10 CPAP was immediately cleaned by respiratory nurse. All cpaps were immediately audited by respiratory nurse to ensure proper cleaning. Education provided to respiratory nursing by DON on 5/22/25 regarding CPAP cleaning policy. DON/ Designee to complete weekly audits to ensure all cpaps are cleaned per policy for 4 weeks to ensure compliance. Results to be reviewed in QAPI.	05/22/2025

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F 0695	Continued From page 59 obstructive sleep apnea, diabetes and hypertension. Review of the undated care plan revealed Resident #10 had diagnoses of COPD and obstructive sleep apnea. Resident #10 utilized a BiPap (Bilevel positive airway pressure) with oxygen every night. Interventions included oxygen therapy as ordered, head of bed elevated as tolerated, and monitor for difficulty breathing. There was nothing in the care plan regarding cleaning of respiratory equipment. Review of the quarterly Minimum Data Set (MDS) dated 03/28/25 revealed Resident #10 had intact cognition. She required oxygen therapy and was on a non-invasive mechanical ventilator. Review of the nursing notes dated 04/01/25 to 05/18/25 revealed no documentation regarding Resident #10's CPAP equipment and/or mask was cleaned. Review of the Treatment Administration Record (TAR) for April 2025 and May 2025 revealed there were no orders/documentation regarding the cleaning of Resident #10's CPAP equipment and/or mask. Review of the May 2025 Physician Orders revealed Resident #10 had an order to wear a CPAP when sleeping at night and as needed during the day. There were no	F 0695		

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F 0695	Continued From page 60 orders regarding cleaning of CPAP equipment and/or mask. Interview on 05/18/25 at 10:58 A.M. with Resident #10 revealed she wore a CPAP at night and was concerned as the staff never cleaned her CPAP equipment and/or mask. She revealed she was concerned about getting an infection due to the equipment being dirty. Observation on 05/18/25 at 10:58 A.M. revealed Resident #10's CPAP machine was sitting on her dresser with her mask hanging on a clip on the wall. Observations on 05/19/25 at 9:30 A.M., 05/19/25 at 11:59 A.M., and 05/20/25 at 7:56 A.M. revealed no indication Resident #10's CPAP machine, equipment and mask were cleaned. Interview on 05/20/25 at 2:00 P.M. with Licensed Practical Nurse (LPN) #304 revealed she was the nurse assigned to care for Resident #10 and was frequently on her unit. She revealed she was unsure who cleaned the CPAP equipment and/or mask as nothing was on the TAR to indicate the floor nurse was to clean it. She verified she had not cleaned the equipment when she was assigned to Resident #10. Interview on 05/20/25 at 2:04 P.M. with LPN #312 revealed when she was first asked if she handled cleaning of CPAP equipment and/or masks she stated, "well	F 0695		

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F 0695	Continued From page 61 that is the question" as she stated she was going to transfer the cleaning to Respiratory/Registered Nurse (RN) #360 as she had too much to manage with the wounds and medical records. When this surveyor attempted to clarify the cleaning of the CPAP equipment, LPN #312 revealed there was no official cleaning schedule and/or procedure that she followed. She verified she had no documentation in regard to when Resident #10's CPAP equipment and/or mask was cleaned in the last two months. Interview on 05/20/25 at 2:05 P.M. with MDS Coordinator/LPN #333 verified there was nothing in the care plan regarding cleaning the CPAP equipment and/or mask. She revealed the care plan should have indicated she utilized a CPAP not a BiPap. Interview on 05/20/25 at 2:15 P.M. with the Director of Nursing (DON) verified the facility did not have a system in place regarding when the CPAP equipment and/or masks were getting cleaned. She verified there was no documentation regarding the cleaning of Resident #10's CPAP equipment and/or mask. She revealed there should have been an order placed on the TAR indicating how the equipment was to be cleaned, how often it should have been cleaned and the nurse documenting when it was cleaned. Review of the facility policy, "Care of the BiPap/ CPAP Equipment," dated	F 0695		

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F 0695	Continued From page 62 01/17/09, revealed the objective of the policy was to decrease the risk of infections and maintain a clean environment. The procedure revealed to rinse the tubing and the mask in warm, soapy water, using mild detergent, soak the mask and large boar tubing for 20 minutes in a one-to-three-part solution of white vinegar and water, and hang both the mask and tubing on a clean towel to air dry. The headgear, tubing and mask should be washed once a week and as needed. This deficiency represents non-compliance investigated under Complaint Number OH00165776.	F 0695		
F 0699 SS=D	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This STANDARD is not met as evidenced by: Based on record reviews, interviews and facility policy review, the facility failed to adequately train staff on trauma related care and provide trauma-informed care to Residents #25 and #140. This affected two (Residents #25 and #140) out of two	F 0699	Resident #25 and #140 were immediately assessed and found to have no adverse effects. All residents have the ability to be effected. Resident #25 and #140 chart immediately reviewed, trauma informed assessment was added by Social Services. All residents were reviewed to ensure they had trauma informed care plans in place. Education provided to all staff by DON on 5/22/25 regarding trauma informed care importance and policy. DON/ Designee to complete weekly audits of new hire paperwork to ensure review of trauma informed care for 4 weeks to ensure compliance. Results to be reviewed in QAPI. plans	05/22/2025

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F 0699	Continued From page 63 residents reviewed for trauma-informed care. The facility reported two (Residents #25 and #140) who had trauma-related diagnoses. The facility census was 66. Findings include: 1. Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of dementia, major depressive disorder recurrent, generalized anxiety disorder and post-traumatic stress disorder (PTSD). Review of the quarterly Minimum Data Set (MDS) assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment. Review of the care plan updated on 04/18/25 indicated Resident #25 had impaired cognition including poor memory and poor choices. The resident had depression, anxiety, and a history of alcohol abuse, who demonstrated behaviors related to maintaining personal space. There was no reference in the care plan relevant to Resident #25's trauma including triggers and trauma-informed care. Review of the physician orders effective May 2025 revealed no orders related to trauma-informed care other than to consult psychotherapies. Review of the assessments for Resident #25 revealed no trauma screening or	F 0699		

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F 0699	Continued From page 64 assessments completed since admission. Review of the nursing progress notes from May 2024 to May 2025 revealed no documentation relevant to Resident #25's trauma or trauma-informed care. Review of the physician progress notes from psychiatric services on 11/18/24, 12/09/24, 01/14/25, 02/10/25, 03/10/25 and 05/05/25 revealed no documentation relevant to Resident #25's trauma or trauma-informed care. Review of the nursing assistant Kardex for Resident #25 effective 05/19/25 indicated no information relevant to trauma-informed care. Interview on 05/19/25 at 4:26 P.M. with the Director of Nursing (DON) verified there were no assessments used for trauma-informed care and no information on Resident #25's trauma, triggers or needed interventions to care for the resident's PTSD which included in the care plan, Kardex and progress notes. Interview on 05/20/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #364 stated believing of hearing that Resident #25 had PTSD but was unaware of any information relevant to it such as cause, triggers or interventions needed to reduce anxiety or approach care. Interview on 05/20/25 at 1:52 P.M. with Resident #25 denied talking to any staff	F 0699		

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F 0699	Continued From page 65 related to the PTSD or trauma. Interview on 05/20/25 at 1:54 P.M. with Registered Nursing (RN) #431 revealed no knowledge of Resident #25's trauma and care needs related to PTSD. Interview on 05/20/25 2:24 P.M. with Social Services Director (SSD) #318 verified there was no trauma assessment completed for Resident #25 to contribute to trauma-informed care. SSD #318 indicated a trauma assessment should have been completed within 48 hours after admission so it would reflect on the baseline care plan and then into the comprehensive care plan thereafter. Resident #25 had no trauma assessment completed upon admission and none afterwards so therefore it was not included in the care plan. Interview on 05/20/25 at 3:43 P.M. with the DON confirmed an inability to provide evidence the facility staff had received training related to trauma-informed care, trauma assessments, screening tools or strategies to address residents' triggers, but it was scheduled to be implemented on 05/22/25. Review of the facility policy, "Trauma Informed Care," revised March 2019, revealed all staff were provided training about trauma, its impact on health, and PTSD in the context of the healthcare setting. Nursing staff were trained in screening tools, trauma assessment and	F 0699		

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F 0699	Continued From page 66 how to identify triggers associated with re-traumatization. The facility supports a culture of emotional well-being and physical safety for staff, residents and visitors. Trauma-informed care was culturally sensitive and person-centered. Caregivers were taught strategies to help eliminate, mitigate or sensitively address a resident's triggers, and the facility implemented universal screening of residents for trauma. 2. Review of the medical record revealed Resident #140 was admitted to the facility on 05/13/25 with diagnoses including PTSD, anxiety disorder, congestive heart failure, chronic obstructive pulmonary disease, and alcohol dependence with unspecified alcohol use disorder. Review of the baseline care plan dated 05/13/25 revealed Resident #140 was new to the nursing facility, had adjustment issues related to admission, had the potential for bleeding, was ordered physical therapy (PT) and occupational therapy (OT), had the potential for skin impaired skin integrity, had skin impairments noted on admission, was admitted on a regular diet, was admitted with anti-anxiety medications, was dependent on the facility's activities staff for activities and social interaction, was at risk for falls, and was at risk for nutritional problems related to class three morbid obesity. There was no information found in the	F 0699		

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F 0699	Continued From page 67 baseline care plan related to Resident #140's diagnosis of PTSD. The interview with the DON on 05/19/25 at 4:26 P.M. verified there were no care plans related to Resident #140's trauma informed care, no evidence the facility obtained information on resident's triggers, and verified there was no information related to trauma-informed care on the Kardex. Interview with SSD #318 on 05/20/25 at 2:24 P.M. will be doing a brief trauma assessment for residents with PTSD/trauma going forward, did not complete one until yesterday, 05/19/25, for Resident #140 and had a meeting with the resident and the resident's family, but typically the assessments should be completed within 48 hours of admission so it is reflected on the baseline care plan, but in this case, that did not get done prior to the baseline care plan being completed, so trauma care was not on it, but it should have been. Review of Residents #140's Brief Trauma Questionnaire confirmed it was completed on 05/19/25 at 3:59 P.M. Interview on 05/20/25 at 3:43 P.M. with the Don verified there was no evidence of staff training on trauma-informed care, but the trauma assessment and staff training were being implemented to take place this Thursday, 05/22/25.	F 0699		

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F 0699	Continued From page 68 Interview with the MDS Coordinator #333 on 05/20/25 at 4:03 P.M. confirmed that Resident #140 did not have a baseline care plan in place within the first 48 hours for PTSD. The pare plan was initiated on 05/16/25. Review of the facility policy titled, "Trauma Informed Care," revised in March 2019, revealed all staff are to be provided with in-service training about trauma, its impact on health, and PTSD in the context of the healthcare setting, nursing staff are to be trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. The facility supports a culture of emotional well-being and physical safety for staff, residents and visitors. Trauma-informed care is culturally sensitive, and person-centered caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers and implement universal screening of residents for trauma.	F 0699		

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F 0761	Continued From page 69	F 0761		
F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This STANDARD is not met as evidenced by: Based on record review, review of insulin manufacture guidelines, observation, interview and review of facility policy, the	F 0761	Resident #8, 11, 63 and 131 were immediately assessed and found to have no adverse effects. All residents with insulin orders have the ability to be effected. Resident #8, 11, 63 and 131 insulin pens were immediately dated by nursing. All insulin pens were audited immediately to ensure proper storage and labeling. Education provided to all nursing staff by DON on 5/22/25 regarding proper medication storage. Don/ Designee to audit 3 insulin pens per week for 4 weeks to ensure they are appropriately dated. Results to be reviewed in QAPI.	05/22/2025

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F 0761	Continued From page 70 facility failed to ensure insulin was dated after opening and failed to ensure insulin was disposed of per manufacture guidelines. This affected four (Residents #8, #11, #63, and #131) out of nine (Residents #5, #8, #11, #12, #41, #47, #63, #129, and #131) that had their insulin on the East and/or North medication cart. This had the potential to affect 12 (Residents #5, #8, #10, #11, #12, #41, #46, #47, #63, #129, #131, and #179) that had orders for insulin. The facility census was 66. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 12/09/14 with diagnoses including dementia, diabetes and hypertension. Review of the May 2025 physician's orders revealed Resident #11 had an order dated 11/22/24 for Lantus solution (insulin) 100 units per milliliter (ml) inject eight units subcutaneously (SQ) once a day due to diabetes. Review of the care plan revealed Resident #11 had the potential for hypoglycemia and/or hyperglycemia related to diabetes. Interventions included Accu checks (blood sugar checks) as ordered, diabetic medications as ordered and monitoring for side effects and effectiveness. 2. Review of the medical record for	F 0761		

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F 0761	Continued From page 71 Resident #63 revealed an admission date of 01/21/25 with diagnoses including diabetes, hypertension and congestive heart failure. Review of the May 2025 physician's orders revealed Resident #63 had an order for Lispro injection solution (insulin) 100 units per ml inject SQ per sliding scale for diabetes. Review of the care plan dated 02/13/25 revealed Resident #63 had diabetes. Interventions included diabetes medications as ordered by the physician, and monitoring side effects and effectiveness. 3. Review of medical record for Resident #131 revealed an admission date of 05/15/25 with diagnoses including malignant neoplasm of bronchus or lung, and diabetes. Review of the May 2025 physician's orders revealed Resident #131 had an order for Lantus solution pen- injector (insulin) 100 units per ml inject 20 units SQ one time a day due to diabetes. Review of the undated care plan revealed Resident #131 had diabetes. Interventions included diabetes medications as ordered by the physician, and monitoring, documenting, and reporting signs of hypoglycemia and hypoglycemia to the physician.	F 0761		

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F 0761	Continued From page 72 4. Review of the medical record for Resident #8 revealed an admission date of 10/02/23 with diagnoses including diabetes and congestive heart failure. Review of the May 2025 physician's orders revealed Resident #8 had an order for Degludec insulin solution pen-injector 100 units per ml inject 50 units SQ one time a day due to diabetes. Review of the undated care plan revealed Resident #8 had diabetes and was insulin dependent. Interventions included diabetes medications as ordered and monitoring, documenting, and reporting signs of hypoglycemia and hypoglycemia to the physician. Observation on 05/19/25 at 7:55 A.M. of the East medication cart with Licensed Practical Nurse (LPN) #351 revealed Resident #11's Lantus insulin pen was opened but not dated as to when it was opened, and Resident #63's Lispro insulin pen was opened and dated as opened 04/15/25. Interview on 05/19/25 at 7:55 A.M. with LPN #351 verified the above findings and revealed all insulin should be dated when it is opened. She revealed she thought insulin was only good for 30 days after it was opened but was not sure. Observation on 05/19/25 at 12:13 P.M. of the North medication cart with Registered Nurse (RN) #431 revealed Resident	F 0761		

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F 0761	Continued From page 73 #131's Lantus insulin pen was opened but not dated as to when it was opened. The cart also had Resident #8's Degludec insulin pen that was also opened but not dated. Interview on 05/19/25 at 12:13 P.M. with RN #431 verified the above findings and revealed all insulin should be dated when it is opened. She revealed she was unable to determine when the insulin was opened to track when it should be discarded. Review of the "Lantus" insulin drug manufacture guidelines, dated 08/2022, revealed after the Lantus was opened, keep at room temperature and after 28 days throw the opened Lantus away even if it has insulin in it. Review of the "Degludec" insulin drug manufacture guidelines, dated 11/24, revealed storage after use recommended to keep at room temperature or refrigerated for up to eight weeks. The guideline recommended to dispose after eight weeks even if there was insulin left in the pen. Review of the "Lispro" insulin drug manufacture guidelines, dated 2023, revealed store opened insulin pen at room temperature and throw away the pen after 28 days even if there was still insulin left in it. Review of the facility policy labeled,	F 0761		

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F 0761	Continued From page 74 "Administering Medications," dated April 2019, revealed when opening a multi-dose container, the date opened was to be recorded on the container. The expiration date and/or beyond use date on the medication label was checked prior to administration. Review of the facility policy labeled, "Storage of Medications," dated November 2020, revealed the facility was to store all drugs and biologicals in a safe, secure, and orderly manner. There was nothing in the policy regarding ensuring insulin was dated when opened and how long insulin was good for after opening.	F 0761		
F 0842 SS=D	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 0842	Resident #43 and #25 were immediately assessed and found to have no adverse effects. All residents have the ability to be effected. Resident #43 MAR was immediately updated. Resident #25 seat belt and chair alarm was immediately DCed by DON. Education provided to all staff by DON on 5/22/25 regarding appropriate and timely documentation. MAR and TAR reviewed on randomly selected residents 5/28/25 by IDT during Risk to ensure timely and accurate documentation. DON/ Designee to audit 2 MAR and 2 TAR weekly for 4 weeks to ensure accurate documentation. Results to be reviewed in QAPI.	05/22/2025

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F 0842	Continued From page 75 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law;	F 0842		

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F 0842	Continued From page 76 or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This STANDARD is not met as evidenced by: Based on record review, interview and review of facility policy, the facility failed to ensure accurate documentation on the medication administration record (MAR) for Resident #43 and the treatment administration record (TAR) for Resident #25. This affected two (Residents #25, and #43) out of 21 medical records reviewed for accuracy. The facility census was 66. Findings included:	F 0842		

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F 0842	Continued From page 77 1. Review of the medical record for Resident #43 revealed an admission date of 12/20/21 with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, indwelling urethral catheter, and neuromuscular dysfunction of the bladder. Review of the May 2025 physician's orders revealed Resident #43 had an order dated 05/16/25 for meropenem (antibiotic) intravenous solution one gram intravenously (IV) every eight hours for urinary tract infection (UTI). Review of the May 2025 MAR revealed Resident #43's order for meropenem IV was scheduled to be administered at 6:00 A.M., 2:00 P.M., and 10:00 P.M.. The MAR was blank on 05/17/25 at 6:00 A.M. and 05/18/25 at 2:00 P.M. indicating the meropenem was not administered. Review of undated care plan revealed Resident #43 was in IV antibiotic due to UTI that was to be administered from 05/16/25 to 05/23/25. Interventions included administering the antibiotic as ordered, and monitoring for side effects and effectiveness. Interview on 05/20/25 at 1:39 P.M. with Licensed Practical Nurse (LPN) #304 verified the MAR was blank on 05/17/25 at 6:00 A.M. and 05/18/25 at 2:00 P.M. indicating the meropenem was not administered. She revealed she did not	F 0842		

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F 0842	Continued From page 78 know if Resident #43's IV antibiotic was administered. Interview on 05/20/25 at 2:15 P.M. with the Director of Nursing (DON) verified the MAR was blank on 05/17/25 at 6:00 A.M. and 05/18/25 at 2:00 P.M. indicating the meropenem was not administered. She revealed she spoke with the nurses assigned to administer the IV antibiotics and they had stated they administered the medication but did not document the MAR. Review of the facility policy labeled, "Charting and Documentation," dated July 2017, revealed documentation in the medical record would be complete and accurate. 2. Review of the medical record for Resident #25 revealed an admission date of 02/18/17 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus type two, dementia, major depressive disorder recurrent, generalized anxiety disorder and post-traumatic stress disorder. Review of the quarterly Minimum Data Set (MDS) assessment completed 01/11/25 revealed Resident #25 had moderate cognitive impairment. Review of a physician order dated 09/17/24 indicated Resident #25 had an alarming Velcro seat belt to the wheelchair for positioning and safety. Another physician order dated 03/17/25	F 0842		

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F 0842	Continued From page 79 specified an additional pressure alarm was applied to the wheelchair for safety. Review of the TAR from April 2025 to May 2025 revealed Resident #25's pressure alarm was checked twice daily at rising and bedtime, and the seat belt was checked every shift for placement and functioning. The pressure alarm was not signed as being checked on 04/07/25, 04/24/25, 04/28/25 and 05/14/25 at bedtime. The seat belt was not signed as being checked on 04/03/25 on night shift, and on 04/24/25 and 04/28/25 on evening shift. Observation on 05/20/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #364 of Resident #25 verified there was no physician ordered seatbelt or pressure alarm in place for safety or positioning. Interview at the time of the observation with CNA #364 could not state when or why the devices were not in place. An interview on 05/20/25 at 1:52 P.M. with Resident #25 denied remembering when the alarm or seat belt was last used or whether being able to release the seat belt when it was in place. Interview on 05/20/25 at 1:54 P.M. with Registered Nursing (RN) #431 confirmed both the seat belt and pressure alarm devices were not in place as ordered and were signed off on the TAR as being checked and in place as safety interventions. RN #431 indicated the	F 0842		

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F 0842	Continued From page 80 devices were removed some time ago but could not identify when but remembered it was because Resident #25 was no longer trying to get up without assistance. Review of the progress notes from September 2024 to May 2025 revealed no documentation to identify the removal of the alarming seat belt or pressure alarm for Resident #25. Observation on 05/21/25 at 12:13 P.M. of Resident #25 being transported to the dining room via wheelchair revealed no visible seat belt or alarming device in place. Interview on 05/20/25 at 4:31 P.M. with the Director of Nursing (DON) verified the seat belt and pressure alarm were not documented accurately as being in place and/or functioning.	F 0842		
F 0868 SS=F	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be	F 0868	All residents were immediately assessed and found to have no adverse effects. All QAPI reviewed and ensured that physician was in attendance Quarterly. Education immediately provided by admin to all staff required to be in attendance at QAPI regarding attendance requirements. Admin/ Designee to review next 3 QAPI meetings to ensure all necessary attendees are present. Results to be reviewed in QAPI.	05/22/2025

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F 0868	Continued From page 81 the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This STANDARD is not met as evidenced by: Based on record review, interview and review of facility policy, the facility failed to	F 0868		

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F 0868	Continued From page 82 ensure the medical director attended the Quality Assurance and Performance Improvement (QAPI) meetings. This had the potential to affect all 66 residents residing at the facility. Findings included: Review of QAPI meeting attendance sign in sheets dated 12/27/23, 01/16/24, 02/20/24, 03/19/24, 04/16/24, 05/22/24, 06/26/24, 07/24/24, 08/02/24, 09/25/24, 10/24/24, 11/26/24, 12/27/24, 01/23/25, 02/25/25, 03/26/25, and 04/22/25 revealed the Medical Director/Primary Care Physician (PCP) #600 did not attend the above meetings. Interview on 05/18/25 at 3:58 P.M. with Administrator verified the Medical Director/PCP #600 did not sign any of the QAPI meeting attendance sheets and she had no evidence from 12/27/23 to 04/22/25 that he attended a QAPI meeting at least quarterly. Review of the facility policy labeled, "Quality Assurance and Performance Improvement (QAPI) Program- Design and Scope," dated February 2020, revealed the facility QAPI program was ongoing, comprehensive and addresses all care and services provided by the facility. The policy did not identify the required members including the medical director that needed to attend the QAPI meeting and/ or identify the frequency of how often the required members were to	F 0868		

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F 0868	Continued From page 83 attend.	F 0868		
F 0921 SS=F	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the building floors in safe and clean condition. This had the potential to affect all 66 residents residing in the facility. Findings include: Review of a floor repair quote dated 03/22/25 revealed the quote included installation of vinyl floor tiles to the facility's front areas, halls and nurses' stations, but it did not seem to include repair to resident rooms. Observation on 05/19/25 at 1:37 P.M. of the environment revealed the following: The front foyer and entry way had various dark soiled areas with one large area near the right front entrance door. Multiple areas of the floor appear worn and scratched. There were various scuffs,	F 0921	All residents were immediately review and found to have no adverse effects. All residents have the ability to be effected. Flooring was immediately reviewed by Admin, Housekeeping supervisor and maintenance department to ensure floors were safe and clean. Housekeeping supervisor immediately buffed all tile flooring . Maintenance department replaced all cracked and chipped tiles by 5/30/25. Housekeeping supervisor deep cleaned all carpeting 5/22/25. Maintenance/ designee to monitor flooring weekly for 4 weeks to ensure compliance. Results to be reviewed in QAPI.	05/30/2025

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F 0921	Continued From page 84 and two small circular areas cracked and sunken. The carpeted area in the building front near the dining room which included the television area and around the nurses' station had multiple small and large dark stained areas. The floor which borders the front of the nurses' station outward approximately two feet slopes downward toward the nurses' station desk which posed a fall hazard to all residents who ambulated through there. Interview on 05/19/25 at 2:10 P.M. with Licensed Practical Nurse (LPN) #351 verified the floor sloped toward the nurses' station and had for quite a while, which was a fall hazard for residents. LPN #351 reported having tripped because of it but was uncertain if any residents had done the same. The floor in the Concord Hall area between the kitchen and laundry area appeared soiled, dark and worn. Throughout the rest of the hallway there were various scuff marks, scratches and worn areas of the floor with multiple dark stains and cracked floor tiles. Rooms 126 and 134 had dark soiled areas at the entrances. Room 133 had various stained discolorations and floor scratches. Room 131 had dark soiled areas inside the room near the bed. The floor in the Hummingbird Lane area had large dark soiled areas which	F 0921		

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F 0921	Continued From page 85 appeared stained at the hallway entrance. There were multiple cracks in the floor tiles with some tiles sunken closest to where the fire doors were located. Room 125 had small cracks in the floor tiles at the entrance. Room 123 had dark soiled stains at the room entrance and a small crack in the floor tile near the bottom of the bed by the room door. Throughout the hallway there were multiple various scuff marks, some small and large with discolored stained areas. The floor in the Northern Lights area had multiple various scuffs and small and large dark stained discolored areas, some worn, most notably at Room 117's entrance. Room 110 had an elongated crack in the floor going across the hall from the room's entrance with the floor sunken where cracked. Room 112 had a small floor area with an imprint of what appears to be tire tread from the nearby electric wheelchair. Room 116 had a quite large crack in the floor tile which transversed from the room entrance into the room toward the bathroom area. The floor had sunken in some areas with the cracked tile. At the hallway entrance just inside the fire doors adjacent to Rooms 107 and 108 were multiple cracked tiles with missing pieces which covered a floor area of approximately 11 tiles. Room 107 had floor tile crack just inside the room door and dark stained areas near the door entrance and bed. Room 106's entrance area had approximately five cracked floor tiles. The hallway floor between Rooms	F 0921		

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F 0921	Continued From page 86 105 and 106 had approximately four cracked tiles. Room 105's entrance had cracked floor tiles across with dark soiled stained areas and scuff marks throughout the room. The back of the hallway had multiple various cracked floor tiles with scuff marks on the floor and small dark soiled areas. Room 101 had multiple cracked floor tiles and dark soiled areas. The emergency exit at the back of the hallway had chipped and cracked floor tile with pieces of the floor tiles pulled away and scattered across the doorway. Some areas of the floor were sunken or raised up due to the floor damage. Observation and interview on 05/19/25 at 2:38 P.M. with Housekeeping Director (HD) #359 of the environment verified the above observations. HD #359 indicated the floors were scrubbed at least once monthly but could not confirm it received deep cleaning routinely each month. HD #359 reported the floors were mopped daily, but denied any staffing issues which would cause a lack in routine floor deep cleaning each month. HD #359 further reported the carpeted floors were cleaned once weekly but the stains were permanent. HD #359 also acknowledged being aware of the floor sloping toward the nurses' station by the dining room, and agreed it was a fall risk for the residents. Interview on 05/19/25 at 4:08 P.M. with the Administrator confirmed knowledge of the above observations. The	F 0921		

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F 0921	Continued From page 87 Administrator acknowledged discussing the floor status with the owners and a plan to obtain quotes for floor replacement but was unaware of any formal plan with dates. Review of a text message involving the facility's administration dated 05/09/25 revealed the Administrator being asked if she wanted the flooring done with an affirmative response.	F 0921		