STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175348	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE , BELOIT, Kansas, 67420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey. The 2567 was sent electronically on 01/28/26.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 66 residents. The sample included 18 residents, with one resident reviewed for dignity. Based on observation and interviews, the facility failed to ensure Resident (R) 3 was covered when sitting in her Broda chair (specialized wheelchair with the ability to tilt and recline), with just a brief and a shirt on visible to the door. Findings Included: - R3's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), repeated falls, and dysphagia (swallowing difficulty). The "Significant Change Minimum Data Set" (MDS) dated 10/15/25 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R3 was rarely or never understood. The MDS documented R3 had impairment of her upper and lower body. The MDS documented R3 needed staff assistance for all activities of daily living (ADL). R3's "Functional Abilities (Self-Care Mobility) Care Area Assessment" (CAA) dated 10/15/25 was triggered due to R3 requiring assistance with any of the self-care or mobility activities. The CAA documented R3 was at risk for further decline in functional abilities, falls, contractures, isolation, pressure ulcers, and incontinence. The CAA documented R3 would be referred to therapy. R3's "Care Plan," revised 05/28/25, documented the following: 03/16/21- R3 had impaired cognitive function related to Schizophrenia.	F0550		

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F0550 SS = D	Continued from page 2 03/16/21- R3 would be able to communicate basic needs daily. 03/16/21- Directed staff to approach R3 in a gentle, friendly, and unhurried manner. On 01/13/26 at 07:45 AM, R3 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) in her room. R3 had a brief and a shirt on, her legs and brief were visible to the residents walking past her room. R3 had a grey blanket with the call light attached to the blanket, which had fallen down and was on her feet. On 01/13/26 at 07:44 AM, Certified Nurse's Aide (CNA) O stated R3 should be dressed and groomed. She stated it was the expectation of the facility that residents were dressed, covered, and not exposed to other residents. On 01/13/26 at 07:35 AM, Licensed Nurse (LN) I stated the facility should not leave residents uncovered and the call light out of her reach. She stated residents should be dressed or covered and not exposed. On 01/13/26 at 08:41 AM, Administrative Nurse D stated it was the expectation of the facility that residents were dressed and groomed when they were out of bed. She stated residents should never have their briefs exposed unless it was a behavior, and the situation was care planned. The facility's “Promoting/Maintaining Residents' Dignity” policy, dated 01/01/20, documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity, as well as care for each resident in an environment that maintains or enhances residents' quality of life by recognizing each resident's individuality.	F0550		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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--	F0657		

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F0657 SS = D	Continued from page 3 (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 REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to revise the care plan with interventions to prevent falls and injury for Resident (R) 50. Findings included: - R50's Electronic Medical Record (EMR) included diagnoses of unspecified abnormalities of gait and mobility, abnormal posture, muscle weakness, repeated falls, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and a personal history of traumatic fracture (broken bone) unspecified. R50's "Annual Minimum Data Set" (MDS) dated 11/06/25 documented R50 had moderately impaired cognition, and experienced no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. The MDS further documented that R50 used a walker and wheelchair for mobility, had no functional range of motion impairments, required substantial to maximal assistance with toileting hygiene, upper and lower body	F0657		

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F0657 SS = D	Continued from page 4 dressing, and was dependent on putting on and taking off footwear and walking ten to 150 feet. R50 required partial/moderate assistance with chair/bed transfers. R50 was frequently incontinent of urine and always continent of bowel, received as-needed pain medication, had shortness of breath or trouble breathing when lying flat, and had two or more falls without injury. The “Care Area Assessment” (CAA) dated 11/08/25 documented R50 triggered for falls due to multiple falls during the review period. The CAA further documented that R50 was at risk for injury related to his fall risk. R50’s “Care Plan” dated 02/17/21 documented R50 had limited physical mobility related to Parkinson’s Disease and had an actual fall with no injury related to unsteady gait. The Care Plan documented that R50 was able to ambulate with his front-wheeled walker/cane independently in his room. He required stand by assistance of one staff member when out of his room. The “Progress Notes” dated 01/15/25 at 08:34 PM documented that R50 fell while trying to ambulate independently to the bathroom and had no injuries. The facility failed to conduct an investigation for causal factors of the fall. The “Progress Note” dated 01/31/25 at 05:42 AM documented that R50 was found on the floor around 11:10 PM by two Certified Nurse Aides (CNA). The nurse found no injuries. R50 reported he was trying to turn on the power strip to the television as it came unplugged, he slid down the dresser with his back and fell forward. The “Progress Note” dated 02/01/25 at 04:18 AM documented that the nurse was called to R50’s room at approximately 08:10 PM (the previous evening, 01/31/25), and R50 was lying on his back on the floor. R50 reported he was going to the bathroom and went too close to the door, fell against the door, and slid down the door, landing on his buttocks. The nurse found no signs or symptoms of injuries. The “Progress Note” dated 05/07/25 at 11:18 AM documented that the nurse was called to R50’s room at 10:30 AM. R50 was sitting on his buttocks with his hands on the floor beside him. R50 reported he was getting clothes out, lost his balance, and fell back on his buttocks. No injuries were found. The note further documented that R50 was encouraged to utilize the call light to request assistance with getting clothes out of the dresser drawers.	F0657		

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F0657 SS = D	Continued from page 5 The “Progress Note” dated 05/16/25 at 04:17 AM documented that a CNA alerted the nurse that R50 was lying on the floor. R50 reported he was trying to get something out of his drawers and did not want to bother the staff, then his knees gave out. No injuries were found. The “Progress Note” dated 05/19/25 at 06:06 PM documented that the nurse was called to R50’s room, as R50 was on the floor of the bathroom. R50 reported he was trying to get briefs from the shelf while in the bathroom due to being incontinent, but the shelf was too high, and he lost his balance. The note further documented that R50 was educated on call light use. No injuries were found. The “Progress Note” dated 06/15/25 at 09:30 AM, documented a CNA reported to the nurse that R50 was sitting on the floor in front of his recliner. R50 reported getting things for bed, had a four-centimeter abrasion to the left knee, and no other injuries were noted at that time. The “Progress Note” dated 06/16/25 at 01:23 PM documented that a CNA alerted the nurse that R50 was on the floor. R50 was on the floor in front of his recliner, the call light was in reach, with a sign posted in front of R50 reminding the resident to use the call light. R50 reported he was trying to get Chapstick from the dresser drawer and knew he was to use the call light for assistance with walking, but did not feel like he needed help. No injuries were found. The “Progress Note” dated 08/02/25 at 04:50 PM documented R50 stated he was checking to see if he had soup on his counter, he lost his balance and fell onto his bottom. No injuries were found at the time. The “Progress Note” dated 09/12/25 at 08:40 PM documented that a CNA notified the nurse that R50 was on the floor. R50 reported he stood up and turned around to check and see if the pad on his chair was wet and lost his balance. No injuries were found. The “Progress Note” dated 09/19/25 at 10:47 PM documented that the CNA notified the nurse that R50 was on the floor. R50 reported he stood up and turned around to check and see if his pad on the chair was wet and lost his balance. The walker was beside the chair, and the call light was clipped to his recliner in reach. The note further documented that staff offered dressing for bed and toileting at 06:30 PM, and R50 had refused. No injuries were found.	F0657		

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F0657 SS = D	Continued from page 6 The “Progress Note” dated 09/27/25 at 04:19 AM documented that the nurse was called to R50’s room. R50 reported a fall that happened on 09/26/25 at 05:00 PM. R50 refused vital signs assessments. The “Progress Note” dated 10/08/25 at 12:49 AM, documented a CNA called the nurse to R50’s room, and reported the resident was on the floor. R50 reported he was trying to get his handkerchief from the shelf in front of his recliner. The call light was fastened to the recliner within R50’s reach. The “Progress Note” dated 10/15/25 at 11:34 PM documented that the CNA called the nurse to R50’s room. R50 was on the floor in front of his recliner. R50 was last seen about ten minutes before falling, when both the nurse and CNA. R50 reported was going to get his donuts from the top of his dresser. No injury was observed at that time. The “Progress Note” dated 11/11/25 at 09:20 AM documented while CNA was walking by R50’s room, R50 put the power recliner into the standing position, and R50 was wearing slick pajamas and slid down the chair instead of standing. The CNA reported that R50 went to his knees after sliding down. R50 stated he was just trying to stand up to readjust while in the recliner, and instead of standing, slid down when the CNA came into the room. No injuries were documented. The “Progress Note” dated 12/01/25 at 10:10 AM documented that a CNA was assisting R50 in going through clothes and helping R50 move to a new room. The CNA took some belongings to the new room and when the CNA returned R50 was on the floor. R50 reported he tried to get into his recliner and fell. R50 reported that he hit his head on the wheelchair. A small laceration to the lateral side of his left eyebrow. The “Progress Note” dated 12/03/25 at 07:30 PM documented that Administrative Nurse D had contacted R50’s DPOA regarding frequent falls. R50’s room change had been completed on 12/01/25, and he had a fall when a staff member had left the room. The DPOA was very frustrated with the situation and R50’s “stubbornness.” Administrative Nurse D had a face-to-face conversation with R50 related to his safety and the continued lack of use of the call light and waiting for staff assistance. A discussion with R50 about plans for improving his safety and decreasing falls. R50 had a call light and bell at chairside within reach. The “Progress Note” dated 12/04/25 at 04:00 PM documented that R50 had been assisted from the shower	F0657		

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F0657 SS = D	Continued from page 7 by the CNA. R50 was in a wheelchair while the CNA cleared his recliner. R50 stood up suddenly and fell. No signs of injury. R50 was re-educated by Administrative Nurse D about asking for help with transfers and safety. The “Progress Note” dated 12/14/25 at 04:12 AM documented while a CNA was assisting with a bathroom need and changing his clothes at 03:30 AM, R50 had an abrasion to the right outer knee and a bruise to the right outer eye. R50 initially denied falling but admitted that he had fallen on 12/13/25 at approximately 05:00 PM. Education provided on always using the call light. R50 reported that he used the call light, the CNA answered it, but did not ask him what he needed to he got up on his own. R50’s “Care Plan” intervention dated 01/15/25 directed staff to frequently offer bathroom privileges. R50’s “Care Plan” intervention dated 05/07/25 documented a non-injury fall, all interventions in place, and directed staff to encourage the resident to ask for assistance prior to getting up. R50’s “Care Plan” intervention dated 09/20/25, documented R50 had a non-injury fall and directed staff to continue to educate R50 on the importance of asking for assistance. R50's “Care Plan” intervention dated 09/30/25, documented a non-injury fall on 09/26/25, and directed staff to continue education and monitoring. R50's "Care Plan" dated 10/07/25 documented a non-injury fall. The DPOA was contacted regarding concerns, and the facility would discuss with R50's physician the need for a negotiated risk agreement (An agreement in which a resident waives the facility's liability) for R50. R50’s “Care Plan” intervention, dated 10/15/25, documented that R50 had a non-injury fall, a negotiated risk agreement, and to move R50 closer to the nurses’ station. R50’s “Care Plan” dated 11/20/25 directed staff to allow R50 to make decisions about the treatment regimen to provide a sense of control and to educate family and caregivers about possible outcomes of not complying. Encourage participation as much as possible during care. Give a clear expectation of all care activities before any as they occur with each contact. If R50 resists with activities of daily living, reassure him, assure he is safe, leave and return in five to ten minutes, and retry. If possible, negotiate a time for activities of daily living so that R50 could participate in decision-making and return at the agreed time R50’s “Care Plan” lacked a new intervention to prevent further falls and injuries for the falls that occurred on the following dates: 01/31/25 (one in the AM and one	F0657		

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F0657 SS = D	Continued from page 8 in the PM), 02/01/25, 05/16/25, 05/19/26, 06/15/25, 06/16/25, 08/02/25, 12/04/25, and 12/13/25. On 01/12/26 at 09:28 AM, R50 sat in his recliner with his feet elevated, the call light clipped to the recliner arm. He reported that staff assisted him to the bathroom, and he used the call light to call staff. On 01/12/26 at 09:34 AM, CNA M reported that the staff check R50 often, and every time they go by his room, the staff leave his door open and assist him to the bathroom. She reported the resident does not have a scheduled routine, and it was up to the resident to decide when he needed to go to the bathroom or perform other activities of daily living. CNA M stated that R50 used his call light and was not forgetful. On 01/13/26 at 08:13 AM, Administrative Nurse D reported R50 had numerous falls. She verified the frequent use of educating the resident to call for assistance had been ineffective, and the resident continued to fall. She reported that the staff were to get his clothes ready in the morning and evening to prevent falls, and to make sure he had everything he needed or wanted within his reach. Administrative D reported talking with R50's DPOA, and the DPOA reported that R50 was choosing not to use the call light and was very independent. Administrative Nurse D verified there have been falls that lacked a fall investigation with a root cause analysis or a new intervention added to the Care Plan. The facility's "Care Plan Revisions" policy, dated 02/01/20, documented that the comprehensive care plan would be reviewed and revised as necessary when a resident experiences a status change. The care plan would be updated with the new or modified intervention.	F0657		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in	F0688		

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F0688 SS = D	Continued from page 9 range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 66 residents. The sample included 18 residents, with three residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 41's washcloth or carrot (soft roll, designed to position severely contracted fingers away from the palm of the hand) was applied to his right hand to help prevent the risk of wounds related to his contractures. Findings included: - R41's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dystonia (impairment in muscle tone), dysphagia (swallowing difficulty), traumatic brain injury (a brain injury caused by an outside force), and contracture (abnormal permanent fixation of a joint or muscle). The "Quarterly Minimum Data Set" (MDS) dated 12/11/25 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R41 had impairments of both the lower and upper body. The MDS documented R41 was dependent on staff for all activities of daily living (ADL). R41's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 07/10/25 triggered due to the R41 needing assistance with all of his self-care or mobility activities. The CAA documented R41 was at risk for further decline in functional abilities, falls, contractures, isolation, pressure ulcers, and incontinence. The CAA documented R41 would be referred to therapy for annual screening. R41's "Care Plan" documented the following: 07/24/24- Directed staff to observe and report changes in routine, decrease functional abilities, and decrease range of motion (ROM). 08/31/24- Documented R41 was at risk for skin	F0688		

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F0688 SS = D	Continued from page 10 breakdown. 08/31/24 - Directed staff to place a rolled washcloth or carrot in R41's right hand as tolerated. On 01/12/26 at 08:45 AM, R41 laid on his side with his head elevated. R41's hand laid across his lap. R41 had a dressing on his right-hand thumb. R41's hands were clenched; he did not have a washcloth or a carrot in his right hand. On 01/13/26 at 07:50 AM, R41 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room. R41 was yelling for a nurse. R41's hands were laid in his lap. R41 had a dressing on his right-hand thumb. R41's hand was clenched shut; he did not have a rolled washcloth or carrot in his hand. On 01/13/26 at 07:44 AM, Certified Nurses Aide (CNA) O stated restorative personnel would normally place a washcloth or a carrot in R41's hand. CNA O stated if the CNAs noticed the washcloth or carrot was not in his hand, we would talk to the nurse and have her place the washcloth. On 01/13/26 at 07:35 AM, Licensed Nurse (LN) I stated it was the nurse assigned to R41's responsibility to place a washcloth or carrot in R41's right hand. LN I stated the washcloth should have been placed in R41's right hand. On 01/13/26 at 07:51 AM, Administrative Nurse D stated a washcloth should have been placed in R41's hand. She stated there was a bandage on his thumb for preventative wound care, due to contractures. Administrative Nurse D stated she expected nursing to place the washcloth in R41's hand. The facility's "Restorative Nursing Program" policy, which was undated, documented it was the policy of the facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Physical functioning of all residents would be assessed in accordance with the facility assessment protocol.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689		

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F0689 SS = D	Continued from page 11 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. The sample included 18 residents, with three residents reviewed for falls. Based on observation, interview, and record review, the facility failed to identify and implement interventions to prevent falls and injury for Resident (R) 50, who sustained 18 falls. Findings included: - R50's Electronic Medical Record (EMR) included diagnoses of unspecified abnormalities of gait and mobility, abnormal posture, muscle weakness, repeated falls, Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and a personal history of traumatic fracture (broken bone) unspecified. R50's "Annual Minimum Data Set" (MDS) dated 11/06/25 documented R50 had moderately impaired cognition, and experienced no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. The MDS further documented that R50 used a walker and wheelchair for mobility, had no functional range of motion impairments, required substantial to maximal assistance with toileting hygiene, upper and lower body dressing, and was dependent on putting on and taking off footwear and walking ten to 150 feet. R50 required partial to moderate assistance with chair/bed transfers. R50 was frequently incontinent of urine and always continent of bowel, received as-needed pain medication, had shortness of breath or trouble breathing when lying flat, and had two or more falls without injury. The "Care Area Assessment" (CAA) dated 11/08/25 documented R50 triggered for falls due to multiple falls during the review period. The CAA further documented that R50 was at risk for fall-related injuries.	F0689		

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F0689 SS = D	Continued from page 12 R50's "Care Plan" dated 02/17/21 documented R50 had limited physical mobility related to Parkinson's disease and had an actual fall with no injury related to unsteady gait. The Care Plan documented that R50 ambulated with his front-wheeled walker/cane independently in his room. He required stand by assistance of one staff member when out of his room. The "Progress Notes" dated 01/15/25 at 08:34 PM documented that R50 fell while trying to ambulate independently to the bathroom and had no injuries. The facility failed to conduct an investigation for causative factors of the fall. The "Progress Note" dated 01/31/25 at 05:42 AM documented that R50 was found on the floor around 11:10 PM by two Certified Nurse Aides (CNA). The nurse found no injuries, and R50 reported he was trying to turn on the power strip to the television as it came unplugged, he slid down the dresser with his back, and fell forward. The "Fall Investigation" dated 01/31/25 at 08:10 PM documented that R50 had been encouraged and educated frequently on the importance of asking for assistance before getting up and moving around. The intervention was to continue to encourage the resident to be compliant, and concluded that R50 was very independent and wanted to do as much as he could on his own. The "Progress Note" dated 02/01/25 at 04:18 AM documented that the nurse was called to R50's room at approximately 08:10 PM (the previous evening 01/31/25), and R50 was lying on his back on the floor. R50 reported he was going to the bathroom and went too close to the door, fell against the door, and slid down the door, landing on his buttocks. The nurse found no signs or symptoms of injuries. The "Therapy Screen Progress Note" dated 02/03/25 at 09:24 AM documented R50 had fallen twice on 01/31/25, once in the early morning and again approximately at 08:00 PM. R50 had frequent falls due to his desire for independence and often refused to use a proper ambulation device and wait for staff to assist him. The facility failed to conduct an investigation for causative factors of the fall, and the care plan lacked intervention to prevent further falls. The "Progress Note" dated 05/07/25 at 11:18 AM documented that the nurse was called to R50's room at 10:30 AM. R50 was sitting on his buttocks with his hands on the floor beside him. R50 reported he was	F0689		

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F0689 SS = D	Continued from page 13 getting clothes out, lost his balance, and fell back on his buttocks. No injuries were found. The note further documented that R50 was encouraged to utilize the call light to request assistance with getting clothes out of the dresser drawers. The facility failed to conduct an investigation for causative factors of the fall. The “Progress Note” dated 05/16/25 at 04:17 AM documented that a CNA alerted the nurse that R50 was lying on the floor. R50 reported he was trying to get something out of his drawers and did not want to bother the staff, then his knees gave out. No injuries found. The “Fall Investigation” dated 05/15/25 at 10:40 PM documented that R50 continued to be non-compliant with requesting staff assistance with getting things out of drawers or closets, and all interventions were in place to keep the resident free from injury; however, R50 continued with non-compliant behaviors. The Durable Power of Attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) was aware and understood R50’s continued “stubbornness” with requesting assistance. The “Progress Note” dated 05/19/25 at 06:06 PM documented that the nurse was called to R50’s room, as R50 was on the floor of the bathroom. R50 reported he was trying to get briefs from the shelf while in the bathroom due to being incontinent, but the shelf was too high, and he lost his balance. The note further documented that R50 was educated on call light use. No injuries found. The “Fall Investigation” dated 05/19/25 at 06:00 PM, documented that R50 had a chronic history of non-compliance with fall interventions. R50 was educated to alert staff when needing assistance and would be assessed for the need of portable drawers to be placed in the bathroom for ease of access to incontinent supplies. The “Progress Note” dated 05/21/25 at 10:37 AM documented that the facility faxed the physician for physical and occupational therapy orders due to increased falls and balance concerns. The “Progress Note” dated 06/15/25 at 09:30 AM documented a CNA reported to the nurse that R50 was sitting on the floor in front of his recliner. R50 reported getting things for bed, had a four-centimeter abrasion to the left knee, and no other injuries were noted at that time.	F0689		

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F0689 SS = D	Continued from page 14 The “Fall Investigation” dated 06/15/25 at 09:01 PM documented that R50 was getting things for bed and fell. The note further documented that R50 had a history of falls due to not allowing staff to assist him. R50 and staff were educated on setting out clothing for the resident every morning and evening to prevent falls. R50 was very aware of his” independence” and laughed at most of the education provided by staff, stating, “I know I fall, but I’m not hurt, I will be fine.” The “Progress Note” dated 06/16/25 at 01:23 PM documented that a CNA alerted the nurse that R50 was on the floor. R50 was on the floor in front of his recliner, the call light was in reach, with a sign posted in front of R50 reminding the resident to use the call light. R50 reported he was trying to get Chapstick from the dresser drawer and knew he was to use the call light for assistance with walking, but did not feel like he needed help. No injuries were found. The “Fall Investigation” dated 06/16/25 at 01:10 PM documented that R50 had a history of not requesting assistance from staff while ambulating or letting staff know that he was ambulating, as he had previously agreed. R50 did not utilize the call light for assistance. The resident had frequent falls due to the mentioned behaviors. Staff to check on the resident frequently to help ensure the resident is safe with ambulation. The “Progress Note” dated 08/02/25 at 04:50 PM documented R50 stated he was checking to see if he had soup on his counter, he lost his balance and fell onto his bottom. No injuries found at the time. The “Fall Investigation” dated 08/02/25 at 04:30 PM documented that R50 had been provided a three-drawer cart to store snacks in. R50 kept drawers packed full and not always facing him for convenience. The intervention for staff members is to sort through drawers to ensure safety and to encourage the resident to keep all snacks in the drawer. The conclusion of R50 had been educated multiple times on calling for assistance when needing things, and he continued to do things on his own. The “Progress Note” dated 09/12/25 at 08:40 PM documented that a CNA notified the nurse that R50 was on the floor. R50 reported he stood up and turned around to check and see if the pad on his chair was wet and lost his balance. No injuries were found.	F0689		

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F0689 SS = D	Continued from page 15 The “Fall Investigation” dated 09/12/25 at 08:40 PM documented that the root cause analysis was that R50 was getting into his dresser to obtain clothing for the night when he lost his balance, causing him to fall. The investigation documented that the staff were to set out his clothing to assist in the prevention of incidents. The conclusion was that staff were educated on the importance of setting clothes out every evening, as in the care plan. No evidence of abuse, neglect, and/or exploitation. The “Fall Investigation” dated 09/19/25 at 08:45 PM documented that the root cause analysis was R50 unsteady gait, the call light was pinned to his chair, and he continued to refuse to follow interventions in place. The intervention was to continue education on the importance of asking for assistance with things. The resident continued to refuse to use his call light and asked for assistance. R50 feels he is still capable of doing things for himself. The “Progress Note” dated 09/19/25 at 10:47 PM documented that the CNA notified the nurse that R50 was on the floor. R50 reported he stood up and turned around to check and see if his pad on the chair was wet, and lost his balance. The walker was beside the chair, and the call light was clipped to his recliner in reach. The note further documented that staff offered dressing for bed and toileting at 06:30 PM, and R50 had refused. No injuries found. The “Fall Investigation” dated 09/26/25 at 05:00 PM documented that on 09/27/25 at 04:19 AM, while staff were providing care for R50, staff noticed an abrasion to the resident's back on either side of the spine. R50 reported he fell at 05:00 PM the day before and stated, “I got myself up.” The investigation documented that R50 knows better than to get up on his own. R50 had continually been educated on asking for assistance, and he smiles and laughs when staff come to assess him. R50 had been educated to keep the door somewhat open and refused at times. The intervention was to continue to educate and monitor R50. The conclusion documented at times R50 reports of falling, and this might be more behaviorally related. The “Progress Note” dated 09/27/25 at 04:19 AM documented that the nurse was called to R50’s room. R50 reported a fall that happened on 09/26/25 at 05:00 PM. R50 refused vital signs assessments. The “Progress Note” dated 09/27/25 at 03:37 PM documented that R50 had a scratch on his back from the previous fall.	F0689		

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F0689 SS = D	Continued from page 16 The “Progress Note” dated 10/08/25 at 12:49 AM documented a CNA called the nurse to R50’s room, and reported the resident was on the floor. R50 reported he was trying to get his handkerchief from the shelf in front of his recliner. The call light was fastened to the recliner within R50’s reach. The facility failed to investigate the causative factors of the fall. The “Progress Note” dated 10/15/25 at 11:34 PM documented that the CNA called the nurse to R50’s room. R50 was on the floor in front of his recliner. R50 was last seen about ten minutes before falling, when both the nurse and CNA. R50 reported was going to get his donuts from the top of his dresser. No injury was observed at that time. The “Fall Investigation” dated 10/15/25 at 11:00 PM documented that R50 had not used his call light and got up on his own, and lost his balance, and this is a historical issue. The intervention was for a negotiated risk agreement and to move R50 closer to the nurses' station. The conclusion of no abuse or neglect, and R50 continued to do his own thing after several attempts from staff to educate him. The “Progress Note” dated 11/11/25 at 09:20 AM documented while CNA was walking by R50’s room, R50 put the power recliner into the standing position, and R50 was wearing slick pajamas and slid down the chair instead of standing. The CNA reported that R50 went to his knees after sliding down. R50 stated he was just trying to stand up to readjust while in the recliner, and instead of standing, slid down when the CNA came into the room. No injuries documented. The “Fall Investigation” dated 11/11/25 at 09:20 AM documented that R50 continued not to use the call light for assistance. The intervention was to have a care plan meeting to discuss with the DPOA about moving closer to the nurses' station. The conclusion was that R50 continued not use the call light, and staff continue to encourage him to ask for assistance. The “Progress Note” dated 12/01/25 at 10:10 AM documented that a CNA was assisting R50 in going through clothes and helping R50 move to a new room. The CNA took some belongings to the new room, and when the CNA returned R50 was on the floor. R50 reported he tried to get into his recliner and fell. R50 reported that he hit his head on the wheelchair. A small laceration to the lateral side of his left eyebrow.	F0689		

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F0689 SS = D	Continued from page 17 The “Fall investigation” dated 12/01/25 at 10:10 AM documented that R50 continued to feel he could transfer himself from the wheelchair to the recliner. The intervention was to discuss the harm that could happen when falling. The conclusion documented that the resident continued to refuse to ask for assistance and use of assistive devices. Staff would continue to educate on the importance of asking for assistance before transferring. The “Progress Note” dated 12/03/25 at 07:30 PM documented that Administrative Nurse D had contacted R50’s DPOA regarding frequent falls. R50’s room change had been completed on 12/01/25, and he had a fall when a staff member had left the room. The DPOA was very frustrated with the situation and R50’s “stubbornness.” Administrative Nurse D had a face-to-face conversation with R50 related to his safety and the continued lack of use of the call light and waiting for staff assistance. A discussion with R50 about plans for improving his safety and decreasing falls. R50 had a call light and bell at the chairside within reach. The “Progress Note” dated 12/04/25 at 04:00 PM documented that R50 had been assisted from the shower by the CNA. R50 was in a wheelchair while the CNA cleared his recliner. R50 stood up suddenly and fell. No signs of injury. R50 was re-educated by Administrative Nurse D about asking for help with transfers and safety. The “Fall Investigation” dated 12/04/26 at 04:00 PM documented that the root cause analysis was R50 falls due to refusing to practice safety precautions. R50 was aware of this and continues to refuse to comply with most interventions. The intervention was to have a conversation with R50’s DPOA about the potential for a negotiated risk agreement due to the resident’s continued non-compliance. No abuse and/or neglect associated with the incident. The “Progress Note” dated 12/14/26 at 04:12 AM documented a CNA was assisting with a bathroom need and changing his clothes at 03:30 AM. The CNA observed R50 had an abrasion to the right outer knee and a bruise to the right outer eye. R50 initially denied falling but admitted that he had fallen on 12/13/25 at approximately 05:00 PM. Education provided on always using the call light. R50 reported that he used the call light, the CNA answered it, but did not ask him what he needed so he got up on his own. The “Fall Investigation” dated 12/14/25 at 03:50 AM	F0689		

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F0689 SS = D	Continued from page 18 documented immediate intervention of education was done, directing the resident not to get up by himself, to use the call light, and to call again if he did not get what he needed. The root cause analysis was that R50 did not alert staff to his needs, so they could assist, not to get things himself, then fell, causing a minor injury. The intervention was to secure a negotiated risk agreement due to frequent falls. Conclusion of no abuse and exploitation associated with the incident. R50's "Care Plan" intervention dated 01/15/25 directed staff to frequently offer bathroom privileges. R50's "Care Plan" intervention dated 05/07/25 documented a non-injury fall, all interventions in place, and directed staff to encourage the resident to ask for assistance prior to getting up. R50's "Care Plan" intervention dated 09/20/25, documented R50 had a non-injury fall and directed staff to continue to educate R50 on the importance of asking for assistance. R50's "Care Plan" intervention dated 09/30/25, documented a non-injury fall on 09/26/25, and directed staff to continue education and monitoring. R50's "Care Plan" dated 10/07/25 documented a non-injury fall. The DPOA was contacted regarding concerns, and the facility would discuss with R50's physician the need for a negotiated risk agreement (an agreement in which a resident waives the facility's liability) for R50. R50's "Care Plan" intervention, dated 10/15/25, documented that R50 had a non-injury fall, a negotiated risk agreement, and to move R50 closer to the nurses' station. R50's "Care Plan" dated 11/20/25 directed staff to allow R50 to make decisions about the treatment regimen to provide a sense of control and to educate family and caregivers about possible outcomes of not complying. Encourage participation as much as possible during care. Give a clear expectation of all care activities before any as they occur with each contact. If R50 resists with activities of daily living, reassure him, assure he is safe, leave and return in five to ten minutes, and retry. If possible, negotiate a time for activities of daily living so that R50 could participate in decision-making and return at the agreed time R50's "Care Plan" lacked a new intervention to prevent further falls and injuries for the falls that occurred on the following dates: 01/31/25 (one in the AM and one in the PM), 02/01/25, 05/16/25, 05/19/26, 06/15/25, 06/16/25, 08/02/25, 12/04/25, and 12/13/25. On 01/12/26 at 09:28 AM, R50 sat in his recliner with his feet elevated, the call light clipped to the recliner arm. He reported that staff assisted him to	F0689		

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F0689 SS = D	Continued from page 19 the bathroom, and he used the call light to call staff. On 01/12/26 at 09:34 AM, CNA M reported that the staff check R50 often, and every time they go by his room, the staff leave his door open and assist him to the bathroom. She reported the resident does not have a scheduled routine, and it was up to the resident to decide when he needed to go to the bathroom or perform other activities of daily living. CNA M stated that R50 used his call light and was not forgetful. On 01/13/26 at 08:13 AM, Administrative Nurse D reported R50 had numerous falls. She verified the frequent use of educating the resident to call for assistance had been ineffective, and the resident continued to fall. She reported that the staff were to get his clothes ready in the morning and evening to prevent falls, and to make sure he had everything he needed or wanted within his reach. Administrative D reported talking with R50's DPOA, and the DPOA reported that R50 was choosing not to use the call light and was very independent. Administrative Nurse D verified there have been falls that lacked a fall investigation with a root cause analysis or a new intervention added to the Care Plan. The facility's "Accident and Supervision" policy, dated 10/16/23, documented that the resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents, by identification of hazards and risks, evaluation and analysis, implementation of interventions, monitoring and modification, and supervision.	F0689		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F0761		

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F0761 SS = D	Continued from page 20 §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 REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 47 insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use. Findings included: - On 01/11/26 at 09:00 AM, observation of the North Hall Nurse Treatment cart revealed R47's Lantus (long-acting insulin) flex pen was not labeled with an opened date. On 01/11/26 at 09:05 AM, License Nurse (LN) G verified the nurses should label and date the insulin flex pens with the date opened. On 01/13/26 at 10:00 AM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date opened, and the date expired. Administrative Nurse D stated the nurses have a sticker to label the insulin pens with that information. Medlineplus.gov directs open, unrefrigerated Lantus can be used within 28 days; after that time, they must be discarded. The facility's "Medication Storage" policy, dated 01/01/20, documented medications would be stored in the medication carts or medication room according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.	F0761		
F0800 SS = F	Provided Diet Meets Needs of Each Resident	F0800		

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F0800 SS = F	Continued from page 21 CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to provide the nutritional dietary needs for the residents who received meals from the kitchen. Findings included: - On 01/11/26 at 11:00 AM, Dietary Staff (DS) CC obtained one three-ounce scoop of the cornbread stuffing and placed it in a 12-ounce (oz.) household Bullet blender for the pureed diets. The facility prepared pureed diets for five servings. DS CC blended the cornbread stuffing briefly, then added milk and blended the mixture till smooth. The contents were divided into two stainless steel steam table containers and placed in the oven until time to transfer to the steam tables for serving. The pureed recipe for a portion size of a #8 scoop, which totals four ounces. On 01/11/26 at 11:30 AM, during the serving of the main dining room, DS BB served the regular diet portions of copped buttered carrots with a one-ounce portion controlled scooped spoon and the cornbread stuffing with a one-ounce portion rounded scoop. The regular diet buttered carrot recipe portion was four ounces. On 01/12/26 at 10:52 AM, Activity Staff Z and Administrative Staff A reported supervising the kitchen staff while the Certified Manager was absent from the facility. Both staff verified that DS BB and DS CC should have followed the meal recipes for the correct portion sizes of the buttered carrots and cornbread stuffing. The facility's "Dining Manager 2026 Dining RD" policy, dated 2026, recipe directed staff to serve four ounces of prepared pureed cornbread stuffing and regular diet	F0800		

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F0800 SS = F	Continued from page 22 chopped carrots of four ounces.	F0800		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary condition for 66 residents who reside in the facility and receive meals from the facility's kitchen, placing them at risk for foodborne illness. Findings included: - On 01/11/26 at 08:39 AM, during the initial tour of the kitchen with Dietary Staff (DS) BB revealed: A four-quart container of diced pineapples without a label with an open date. Deli-sliced ham and turkey were opened without an open date.	F0812		

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F0812 SS = F	Continued from page 23 A sack of four hard-boiled eggs without an open date. A gallon of liquid cheese, without an open date. A quarter of lime juice with an expiration date of 12/01/25, stored in the refrigerator. A gallon-sized tub of mayonnaise and mustard without an open date. Two bags of chopped lettuce without an open date. The walk-in freezer had a box of chicken breast filets sitting directly on the freezer floor and a sack of opened French fries without an open date. The freezer floor also had a small hand-sized bag of an unlabeled item resting on the floor, which DS BB could not identify. On 01/11/26 at 08:43 PM, DS BB verified that the food items should have been labeled with the date when they were opened, and the freezer floor should not have anything touching it. On 01/12/26 at 09:28 AM, Activity Staff Z reported supervising the dietary department with Administrative Staff A, while the Certified Dietary Manager (CDM) was absent from the facility. Activity Staff Z verified that all open foods should have when-opened dates clearly marked on the containers of storage, and expired foods should be discarded. Administrative Staff A also verified that foods should have the open dates and that foods were not to be stored on the freezer floor. The facility's "Food Storage" policy, dated 05/2020, documented dairy products of processed/open cheese may be refrigerated for three to four weeks, hard-cooked eggs three to four days, shredded leaf lettuce three to five days, open packages of lunch meats of three to five days, and mustard one year. The facility's "Food Safety and Sanitation" policy, dated 2017, documented that when a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when food should be discarded.	F0812		
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.	F0851		

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F0851 SS = C	Continued from page 24 Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing	F0851		

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F0851 SS = C	Continued from page 25 information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 66 residents. Based on observation, record review, and interview, the facility failed to submit complete and accurate staffing information through Payroll-Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for Fiscal Year (FY) 2025 Quarter (Q) 1, FY 2025 Q2, and FY 2025 Q3 indicated excessively low weekend staffing and a one-star staffing rating. A review of the facility's staffing and nursing hours of the Quarters listed above revealed adequate staffing coverage. On 01/12/26 at 02:30 PM, Administrative Nurse D stated that there had been the appropriate number of staff that worked; however, it was the salaried nurse staff that did not clock in, so their hours did not calculate that they worked when they filled in for staff. Administrative Nurse D verified the facility always had nurse and aide coverage. The facility's "Payroll Based Journal" policy, dated 12/19/19, documented that it was the policy of the facility to electronically submit to Centers for Medicare and Medicaid services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format to specifications established by CMS.	F0851		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880		

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F0880 SS = D	Continued from page 26 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880		

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F0880 SS = D	Continued from page 27 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 66 residents. The sample included 18 residents. Based on record review, observations, and interviews, the facility failed to ensure oxygen saturation equipment was sanitized after each resident's use and further failed to ensure Resident (R) 45's, and R32's oxygen nasal cannulas, and R48 and R29's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks, and R2's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) masks were stored in a sanitary manner. Findings included: - On 01/11/26 at 08:44 AM, during the initial walk-through of the facility, R45's nasal oxygen tubing laid in his chair. The nasal cannula was not stored in a sanitary manner. On 01/11/26 at 09:56 AM R48's nebulizer mask hung over the bedside table; the mask was not stored in a sanitary manner. On 01/11/26 at 12:10 PM, observation revealed an uncovered oxygen cannula and tubing lying on the oxygen tank cylinder valve in the North Hall dining room while R32 ate lunch. Observation revealed R32 had a nasal cannula and tubing attached to an oxygen concentrator in use.	F0880		

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F0880 SS = D	Continued from page 28 On 01/11/26 at 10:25 AM, R2's CPAP mask laid on his dresser; R2's CPAP mask was not stored in a sanitary manner. On 01/12/26 at 08:16 AM R29's nebulizer laid on her bedside table; R29's nebulizer was not stored in a sanitary manner. On 01/12/26 at 11:50 AM, observation revealed R32's uncovered oxygen cannula and tubing rolled up and placed under the oxygen concentrator handle in the North Hall dining room. On 01/13/26 at 07:44 AM, Certified Nurse Aide (CNA) O stated that all respiratory equipment not in use should be placed in a drawer or in a bag to keep the equipment sanitary. On 01/13/26 at 07:35 AM, Licensed Nurse (LN) I stated all respiratory equipment should be rinsed and laid to dry, and the equipment should be covered while drying. LN I stated the equipment should be placed in a marked bag to ensure the equipment stays clean. On 01/13/26 at 07:51 AM, Administrative Nurse D stated all respiratory equipment that was not in use should be placed in a bag labeled with the resident's name and date. She stated she expected staff to place respiratory equipment in a bag when the equipment was not in use. On 01/13/26 at 09:30 AM, Administrative Nurse D stated the resident's oxygen concentrators and tanks have bags available for staff to store the nasal cannulas and tubing in when not in use, and they should not be left uncovered if not in use. The facility's "Oxygen Storage" policy, undated, documented oxygen would be administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. The policy documented staff would change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. The policy documented staff would keep delivery devices covered in a plastic bag when not in use.	F0880		