STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345567	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY , CORNELIUS, North Carolina, 28031

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/21/25 through 07/25/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D1003-H1.	E0000		08/07/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/21/25 through 07/25/25. Event ID# 1D1003-H1. The following intakes were investigated: 748206, 748207, 748208, 748209, 748210, and 748211. 2 of the 10 complaint allegations resulted in deficiency.	F0000		08/07/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, staff and resident interview, the facility failed to reassess for the ability to self-administer medications for a resident who was self-administering a medication for 1 of 1 resident reviewed for self-administering medications (Resident #10). The findings included: Resident #10 was admitted to the facility on 03/30/23 with diagnoses that included gastroesophageal reflux disease (GERD). Review of Resident #10's physician orders dated 08/06/24 for calcium carbonate chewable tablets 500 milligrams, take two tablets every eight hours as needed for GERD.	F0554	Resident #10 Medication was removed from room and locked in the medication cart. Self-administration assessment completed on 8/4/25 by DON/ Designee to determine resident's ability to self-administer medications. Resident #10 remains in facility and has no negative outcome from having Medication at bedside. DON/Designee completed an audit on 8/5/25 to identify residents with medications in their room. No other medications were found in resident rooms and all resident were asked if they were interested in self administering medications. Those with the desire were assessed for self-administration of medication ability. Any identified resident that was found capable of self-administration of medications was provided education and a locked area to store medications. To prevent this from recurring, DON/Designee provided education on 8/6/25 to all nurses on the policies and procedures for self-administration of medications. New nurses will be educated upon hire. Beginning the week of 8/11/25 the DON/Designee will audit 5 resident rooms per week to ensure no medications are not left at bedside. Will interview 5 residents per week to ensure no other residents wish to self administer their medication. Audits to continue for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and	08/11/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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F0554 SS = D	Continued from page 1 Review of Resident #10's Self-Administration assessment dated10/02/24 indicated the Resident did not want to self-administer medications. Review of Resident #10's annual Minimum Data Set (MDS) assessment dated 03/15/25 indicated the Resident was cognitively intact. On 07/22/25 at 1:05 PM during an interview and observation of Resident #10 it was noted that there was a bottle of antiacid tablets approximately ¼ full of tablets of various colors sitting on her over bed table in her room. When Resident #10 was asked about the medication the Resident explained that a family member brought the medication to her because she had gastric reflux and heart burn mostly at night and she took the medication when she needed them. The Resident stated she did not have heartburn every night, but she wanted them close by when she needed them. Subsequent observations were made on 07/23/25 at 2:23 PM, 07/24/25 at 8:42 AM and 07/25/25 at 8:51 AM and the bottle of antiacid tablets remained at Resident #10's bedside. An interview was conducted with Nurse #4 on 07/25/25 from 11:25 AM. The Nurse explained that Resident #10 did not have an order to self-medicate and she did not think she would be able to administer her own medications. The Nurse was notified of the bottle of antiacids on the Resident's over bed table and the Nurse retrieved the medication and stated she would address it with the Director of Nursing. The Nurse stated she had not noticed the medication in the Resident's room. During an interview with the Director of Nursing (DON) on 07/25/25 at 11:54 AM, the DON explained that residents had to be assessed to be able to keep their medications at bedside and had to be assessed to be able to medicate themselves according to the physician orders. She indicated that Resident #10 could possibly self-administer her antiacid medication but first she would have to be assessed in order to do so.	F0554	Continued from page 1 recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	
F0569 SS = D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-	F0569	Resident #107 received a refund on 7/2/25. Resident #104 received a refund on 7/10/25. There was no negative outcome due to the resident not receiving a refund within 30 days of discharge. All residents have the potential to be affected. On 8/4/2025, accounts for all residents that have discharged, had an eviction, or death were reviewed. Other findings were corrected.	08/11/2025

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F0569 SS = D	Continued from page 2 (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Responsible Party and staff interviews, the facility failed to refund the balance of an expired resident's personal fund account within thirty days to the individual or probate jurisdiction administering the resident's estate (Resident #107) and failed to refund Social Security checks received after a resident transferred to another nursing facility (Resident #104) for 2 of 2 residents reviewed for personal funds. Findings included: 1. Resident #107 was admitted to the facility on 01/21/25. A discharge Minimum Data Set (MDS) assessment dated 02/09/25 revealed Resident #107 passed away at the facility. The Resident Statement for Resident #107 with a billing date of 02/13/25 revealed a payment in the amount of $10,304.00 received on 02/06/25 was applied to room charges for the period 02/01/25 to 02/08/25 totaling $2,944.00 resulting in an overpayment in the amount of $7,360.00. Review of the refund requests for Resident #107 provided by the Business Office Manager on 07/24/25 at 1:00 PM revealed an initial request for a refund was submitted to the corporate office on 03/26/25 and a second refund request was submitted to the corporate	F0569	Continued from page 2 On 8/4/25, the facility Administrator educated the Business Office Manager on the facility policy for issuing refunds within the required 30 day timeframe of discharge, eviction or death. New Business Office staff will be educated upon hire. The Business Office Manager or designee will audit 5 random discharged resident ledgers weekly for 12 weeks to ensure personal funds deposited within the facility were returned within 30 days of discharge. The Business Office Manager will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 8/11/2025.	

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F0569 SS = D	Continued from page 3 office on 04/28/25. During a phone interview on 07/21/25 at 2:00 PM, Resident #107's Responsible Party (RP) revealed prior to Resident #107's passing, a payment was made to pay Resident #107's account in full. The RP explained after Resident #107 passed away, he had been corresponding frequently with the Business Office Manager to get a refund issued so that he would be able to close Resident #107's estate. The RP stated he wasn't sure why it took the facility 5 months to issue the refund but it was finally received approximately two weeks ago (July 2025). During interviews on 07/23/25 at 2:30 PM and 07/24/25 at 1:00 PM, the Business Office Manager revealed Resident #107 passed away at the facility mid-month February 2025, however, resident accounts were not closed out until the following month to ensure there was no balance owed. If there was a refund due once the account was closed, she submitted a request to the corporate office to issue a refund that included the amount of the refund, name of the person to make the check payable to and the address to mail the refund. The Business Office Manger stated she was aware of the 30 day regulatory requirement for issuing refunds and explained it was hard to meet that requirement due to the facility's process of closing accounts the following month. The Business Office Manager stated one reason for the delay in issuing the refund was due to waiting on Resident #107's RP to send documentation that he was named as the executor of the estate which she received via email on 05/20/25. She stated a refund check was then issued to Resident #107's RP. The Business Office Manager explained after receiving a call from Resident #107's RP on 06/20/25 stating he had not received the refund, she submitted a inquiry to the corporate office for a status. She discovered when the check was initially mailed to Resident #107's RP by the corporate office, it was sent to the incorrect address. She stated the refund was reissued and mailed to Resident #107's RP at the correct address on 07/02/25. During interviews on 07/24/25 at 12:48 PM and 3:40 PM, the Administrator stated a refund should have been issued to Resident #107's RP within the 30 day regulatory timeframe following Resident #107's death. He explained with the facility's process on closing out resident accounts, it was difficult to get refunds processed timely. The Administrator stated a refund check was issued to Resident #107's RP and when it was discovered the refund was mailed to the wrong address, another refund check was reissued.	F0569		

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F0569 SS = D	Continued from page 4 2. Resident #104 was admitted to the facility on 06/24/21. A discharge Minimum Data Set (MDS) assessment dated 10/08/24 revealed Resident #104 discharged to the community. The Resident Statement detail report for Resident #104 revealed checks were received from the Social Security Administration (SSA) on 11/01/24 in the amount of $2,094.00 and on 12/03/24 in the amount of $2,518.00. During a phone interview on 07/21/24 at 7:14 PM, Resident #104's Responsible Party (RP) revealed at her request, Resident #104 discharged from the facility on 10/08/24 to move out of state to an assisted living facility closer to her. The RP stated following Resident #107's discharge on 10/08/24, the facility received Resident #107's social security checks for November 2024 and December 2024. The RP stated she contacted the SSA in both states and was told the money had not been returned. The RP explained Resident #104 owed a balance for November 2024 and December 2024 to the assisted living facility where she now resided and was fearful Resident #104 would be discharged due to non-payment since the facility had not refunded the money to SSA nor sent the refund to the assisted living facility. During an interview on 07/23/25 at 2:30 PM, the Business Office Manager revealed when Resident #104 first admitted to the facility (2021) she received a pension check in addition to her social security check. She explained Resident #104's social security check was sent directly to the facility but the pension check was not which resulted in her accumulating a balance owed at the facility. The Business Office Manager stated at one point she noticed that Resident #104's social security payments were short and when she called the SSA to inquire, she found out Resident #104's checks were being garnished due to back taxes. She stated she filled out a form to have the garnishment refunded which was applied to the balance Resident #104 owed at the facility. The Business Office Manager explained when Resident #104 discharged from the facility (10/08/24) the remaining amount of her October 2024 social security check was also applied to her balance owed. She explained on 03/17/25 a refund check was issued to Resident #104 in the amount of $2,254.62 for the remainder of the November 2024 social security check the facility received but still showed as outstanding (not cashed). The Business Office Manager explained she wasn't aware the facility had also received Resident #104's December 2024 social security	F0569		

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F0569 SS = D	Continued from page 5 check in the amount of $2,448.00 because a credit did not generate on her account due to the system automatically applying the payment to her balance owed. The Business Office Manager stated she submitted a request for an expedited refund in the amount of $2,448.00 that was being sent to Resident #104 at the assisted living facility she now resided and she would be contacting the corporate office to inquire about having the refund in the amount of $2,254.62 reissued and sent to Resident #104. During an interview on 07/24/25 at 1:00 PM, the Administrator stated they had overlooked the refund owed to Resident #104 and a refund should have been issued within the regulatory timeframe.	F0569		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Law Enforcement Detective and staff interviews, the facility failed to assure residents' property was safeguarded and staff did not misappropriate the residents' property for personal gain. Nurse Aide #1 used Resident #118's credit card to make unauthorized purchases totaling $757.73 without Resident #118's permission or knowledge and Housekeeper #1 used Resident #119's credit card to make an unauthorized purchase totaling $152.13 without Resident #119's permission or knowledge for 2 of 3 residents reviewed for misappropriation of resident property (Resident #118 and Resident #119). Findings included: The facility's Resident Abuse policy, last revised on 08/30/23, revealed in part, the facility would ensure all residents were free from misappropriation of property. 1. Resident #118 was admitted to the facility on 12/06/24.	F0602	Resident #118 and #119 are no longer residents at the facility. Resident #118 was reimbursed from her bank for the charges on 1/1/25. Resident #119 was reimbursed on 8/6/25 by the facility for fraudulent charges. The Administrator or designee completed an audit on 8/5/25 to ensure all alert and oriented residents were offered and knew their rights to lockable storage space to safeguarded their personal property. Those identified were provided a lockable space and education on how to access space. Those that declined a lockable space were encouraged to not store valuable possessions at the facility. On 8/5/25 the family members of all non-alert and oriented residents were offered and knew their rights to lockable storage space to safeguarded their personal property. Those identified were provided a lockable space and education on how to access space. Those that declined a lockable space were encouraged to not store valuable possessions at the facility. New residents will be offered a lockable box or space upon admission by the facility Administrator or designee. To prevent this from recurring, on 12/6/24 all staff were educated on the abuse policy which included ensuring staff were not misappropriating resident money and/or belongings. Additionally, the Administrator/Designee provided education on 8/6/25 to all staff on informing residents of their right to request/utilize a lockable space. All staff will be educated upon hire. On 8/5/25 the Director of Human Resources was educated to request performance data on all new hires starting 8/11/25. Beginning the week of 8-11-25 the Administrator/Designee will audit all new admissions and 5 other random residents weekly for 12 weeks to ensure they have been offered a lockable space for their possessions. The Administrator will report the	08/11/2025

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F0602 SS = D	Continued from page 6 The admission Minimum Data Set (MDS) assessment dated 12/12/24 assessed Resident #118 with intact cognition. Review of the facility's investigation revealed on 12/12/24 at 3:30 PM the facility became aware of an allegation of misappropriation of property when Resident #118 reported her credit card was missing and an investigation was initiated. Resident #118 was notified by a family member that there were charges made using her credit card and when Resident #118 looked, she was unable to locate the credit card. Resident #118's credit card was frozen by the bank, the charges were disputed and law enforcement was notified. Continued review of the facility's investigation included an undated statement signed by the Administrator that revealed in part, the Law Enforcement Detective contacted the Administrator on 12/23/24 at 1:00 PM stating they had identified Nurse Aide (NA) #1 through video surveillance as the person who made the unauthorized purchases using Resident #118's credit card. NA #1 was working at the facility on 12/23/24 and was on break until 2:00 PM. Immediately upon returning from break, NA #1 was escorted to the Director of Nursing's (DON) office by the Administrator and interviewed. At first, NA #1 denied the accusation but when NA #1 was informed that law enforcement had video evidence of her making the purchases using Resident #118's credit card, NA #1 admitted to the Administrator and DON that she had taken Resident #118's credit card without authorization. NA #1 was terminated from employment and escorted out of the facility. A review of Resident #118's bank account records from 12/07/24 to 12/12/24 revealed four separate purchases were made to restaurants on 12/07/24 totaling $92.92; five separate purchases were made to restaurants and department stores on 12/10/24 totaling $489.38; and three separate purchases were made to restaurants and a grocery store on 12/12/24 totaling $175.43. Resident #118 discharged from the facility on 12/20/24 and was unable to be interviewed during this investigation. During a phone interview on 07/23/25 at 2:55 PM, NA #1 stated she did not take Resident #118's credit card and did not make the unauthorized credit card purchases. NA #1 expressed she never provided care to Resident #118 and was not working the day the credit card was allegedly lost. When asked if she was informed that law enforcement was able to positively identify her through	F0602	Continued from page 6 results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	

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F0602 SS = D	Continued from page 7 video surveillance as the person making the unauthorized purchases, she replied no. NA #1 restated she did not do what she was being accused of and voiced she felt the facility administration singled her out for one reason or another. Review of the time clock report and corresponding staff schedule for 12/06/24 revealed NA #1 worked 7:00 PM to 7:00 AM and was assigned to Resident #118's hall. During a phone interview on 07/25/25 at 9:40 AM, the Law Enforcement Detective revealed he went to the grocery store and one of the department stores where purchases were made, told store employees what he was looking for and they were able to provide him with video security footage. He explained he was able to get still shots (photographs) from the video security footage, ran the images through facial recognition software and NA #1 was positively identified when a match was made to her driver's license photo. In addition, the loss prevention employee at the department store was able to confirm NA #1 used her membership number when making the purchase. The Law Enforcement Detective stated he never interviewed NA #1 as he had all the information needed and charges were filed. During an interview on 07/24/25 at 1:55 PM, the DON confirmed she was present on 12/23/24 when the Administrator interviewed NA #1 about Resident #118's credit card. The DON stated once the Administrator informed NA #1 that law enforcement had video evidence, NA #1 admitted that she took Resident #118's credit card without her knowledge and made the purchases. The DON stated NA #1 never provided any explanation as to why she took Resident #118's credit card. During interviews on 07/23/25 at 10:21 AM and 07/25/25 at 7:50 AM, the Administrator revealed at the time of Resident #118's admission to the facility (12/06/24), her family was managing her finances, noticed the charges made on her credit card and when they called Resident #118 about the charges, she denied spending any money. He stated he was informed by Resident #118's family they had notified her bank to freeze her account and they provided him with copies of the detailed transactions from her account. The Administrator stated when he spoke with Resident #118 she displayed no emotional distress, just appeared annoyed over the situation, and had no idea who would have taken her credit card. The Administrator stated at the time the allegation was made, he initially suspected another staff member who was involved in a similar situation a few weeks prior; however, she had resigned her position	F0602		

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F0602 SS = D	Continued from page 8 on 12/02/24 which was prior to this incident. He explained at the conclusion of the facility's investigation they were unable to determine what had happened to Resident #118's credit card or if it had been taken by an employee at the facility. The Administrator stated NA #1 was never a suspect until he was notified by law enforcement on 12/23/24 that they had video evidence of NA #1 making the unauthorized purchases and were able to make a positive identification by comparing pictures from the video to NA #1's driver's license photo. The Administrator stated after speaking to law enforcement, he brought NA #1 to the DON's office for an interview. He stated at first, NA #1 denied taking Resident #118's credit card and making unauthorized purchases but when she was told law enforcement stated they had video footage of her using the credit card, she told him "well you got me, there is no way around it" and finally admitted to taking and using Resident #118's credit card without her knowledge. The Administrator stated NA #1 never provided an explanation as to why she took Resident #118's credit card and basically stopped talking. The Administrator stated NA #1's employment was terminated and she was escorted out of the building. The Administrator stated he was informed by Resident #118 that her bank had refunded the money from the unauthorized purchases. 2. Resident #119 was admitted to the facility on 08/23/24. The quarterly Minimum Data Set (MDS) assessment dated 11/29/24 assessed Resident #119 with intact cognition. Review of the facility's investigation revealed on 12/06/24 at 2:15 PM the facility became aware of an allegation of misappropriation of property for Resident #119 and an investigation was initiated. Resident #119 reported an unauthorized purchase was made to a department store in the amount of $152.13 and her credit card was missing from her wallet. Resident #119 also alleged she thought Housekeeper #1 was the person who had taken her credit card. Resident #119 contacted her bank to freeze the card, reissue a new card and disputed the charges. The accused employee resigned employment around the same time the purchase was made using Resident #119's credit card. Resident #119 reported the bank refunded the money from the unauthorized purchase and issued her a new credit card. Law enforcement, Health Care Personnel Registry and Adult Protective Services were all notified of the incident. Resident #119 discharged from the facility on 12/23/24	F0602		

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AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY , CORNELIUS, North Carolina, 28031

(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
F0602 SS = D	Continued from page 9 and was unable to be interviewed during this investigation. Unsuccessful telephone attempts for an interview with Housekeeper #1 were made on 07/23/25 at 9:09 AM and 07/24/25 at 12:06 PM with no return phone call. During interviews on 07/23/25 at 10:21 AM and 07/25/25 at 7:50 AM, the Administrator revealed when Resident #119 reported her credit card was missing on 12/06/24, she alleged it was a housekeeper who took the credit card without her permission and he knew by the process of elimination that Housekeeper #1 was assigned to Resident #119's hall. The Administrator stated when he spoke with Resident #119 she displayed no emotional distress, just appeared annoyed over the situation. He explained an investigation was initiated, including reporting the incident to law enforcement, Adult Protective Services and the State Agency, and Housekeeper #1 had already resigned her position on 12/02/24 prior to the incident being reported. He stated he tried calling Housekeeper #1 but she never returned any of his phone calls. The Administrator stated Resident #119 reported that her bank had refunded the money from the unauthorized purchase.	F0602		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure Nurse #7 suctioned a resident's tracheostomy (a surgical opening in the neck to allow breathing) using sterile technique (a way of providing care that attempts to eliminate germs to prevent infection) for 1 of 1 resident reviewed for tracheostomy care (Resident #1). Findings included: Resident #1 was admitted to the facility 07/07/25 with diagnoses including pneumonia and respiratory failure	F0695	Nurse #1 received 1:1 education on 7/25/25 on the utilization of Sterile gloves when suctioning a tracheostomy. Resident #1 remains in facility and has no negative outcome from having her tracheostomy suctioned without utilizing sterile gloves. DON/Designee completed an audit on 8/5/25 of all residents with tracheostomies to ensure no other resident was suctioned without utilizing Sterile gloves. No other residents were found to have been suctioned without sterile gloves. To prevent this from recurring, DON/Designee provided education on 8/6/25 to Nurses on utilizing sterile gloves during tracheostomy suctioning. New Nurses will be educated upon hire. Beginning the week of 8-11-25 the DON/Designee will audit 2 episodes of suctioning a tracheostomy to ensure sterile gloves are being utilized when suctioning. Audits to continue for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	08/11/2025

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F0695 SS = D	Continued from page 10 (when the lungs can't properly exchange oxygen and carbon dioxide). The admission Minimum Data Set (MDS) assessment dated 07/13/25 revealed Resident #1 was cognitively intact and received tracheostomy care and suctioning. Review of a respiratory care plan initiated 07/07/25 revealed Resident #1 had a tracheostomy and interventions included providing oxygen as ordered and suctioning her tracheostomy as needed. A continuous observation of Nurse #7 on 07/25/25 from 10:50 AM to 11:20 AM revealed she was providing tracheostomy care for Resident #1. During tracheostomy care, Resident #1 indicated she needed to be suctioned. Nurse #7 immediately discontinued tracheostomy care, removed her gloves, washed her hands, applied clean gloves, opened the package containing the sterile suction catheter (tube), connected the suction catheter to the suction machine, turned on the suction machine, and inserted the suction catheter into Resident #1's tracheostomy, applied suction for approximately 15 seconds, removed the suction catheter from the tracheostomy, waited approximately 30 seconds, reinserted the suction catheter, applied suction for approximately 15 seconds, removed the suction catheter from Resident #1's tracheostomy, removed the suction catheter from the suction machine, discarded the suction catheter in the trash, removed her clean gloves, discarded the gloves in the trash, and washed her hands. Nurse #7 did not don sterile gloves or use sterile technique while suctioning Resident #1. In an interview with Nurse #7 on 07/25/25 at 11:24 AM she confirmed she did not use sterile gloves or sterile technique to suction Resident #1's tracheostomy. She stated she was aware there were tracheostomy suction kits which contained sterile gloves and sterile water that she was supposed to use, but she was nervous and forgot. An interview with the Director of Nursing (DON) on 07/25/25 at 11:48 AM revealed she expected sterile technique to be used when suctioning a tracheostomy tube. An interview with the Administrator on 07/25/25 at 12:55 PM revealed he expected nursing staff to follow facility policy for suctioning a tracheostomy.	F0695		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F0755	"Past Noncompliance - no plan of correction required"	08/11/2025

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F0755 SS = D	Continued from page 11 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure accurate accounting for the receipt of nine (9) tablets of controlled medications. This was for 1 of 1 facility emergency-controlled medication storage areas. The findings included: Review of a pharmacy order sheet for scheduled I and II controlled medications revealed one (1) oxycodone immediate release (IR) 5 milligrams (mg) was ordered on 08/07/24. Review of a pharmacy order sheet for scheduled IV controlled medications revealed four (4) lorazepam 0.5	F0755		

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F0755 SS = D	Continued from page 12 mg tablets and four (4) tramadol 50 mg tablets were ordered on 08/07/24. Review of a pharmacy delivery sheet for controlled medications revealed the following controlled medications were delivered to the facility on 08/08/24: (1) oxycodone IR 5 mg tablet, (4) tramadol 50 mg tablets and (4) lorazepam 0.5 mg tablets. The delivery sheet was signed by the delivery driver and Nurse #5. On 07/22/2025 at 3:03 PM an interview was conducted with the Director of Nursing (DON) who explained that on 08/09/24 she reviewed the pharmacy delivery sheet for the controlled medications and found that the controlled medications were signed for by Nurse #5. The DON went to the medication cart that Nurse #5 worked on 08/08/24 to obtain the controlled medications but the medications were not on the medication cart. Nurse #6 who was assigned to the medication cart on 08/09/24, reported that she did not count controlled medications from the pharmacy with Nurse #5 during shift change that morning on 08/09/24. The DON continued to explain that she and Nurse #6 completed a review of all medication carts and could not find the controlled medications. The DON called Nurse #5 to inquire about the controlled medications and Nurse #5 reported that she received controlled medications for a resident but not for the facility's emergency controlled medication storage. Nurse #5 explained to the DON that she signed the delivery sheet but admittedly she did not count the controlled medications in the package with the delivery driver before she signed the delivery sheet. The DON explained that she notified the Administrator who called the pharmacy to report the missing controlled medications and inquire about the delivery driver. An interview was conducted with Nurse #5 on 07/22/25 at 7:46 PM who confirmed that she worked on the night of 08/08/24. The Nurse explained that she received the pharmacy delivery of controlled medications for a resident but did not receive the controlled medications for the emergency controlled storage. Nurse #5 reported she did not count the controlled medications with the delivery driver but did sign the delivery sheet. The Nurse was insistent that there were no other medications in the package except for the resident's controlled medications. The Nurse continued to explain that she was asked to come to the facility on 08/09/24 to provide a statement and adhere to a drug test for reasonable suspicion which she complied, and the result was negative on 08/09/24. Nurse #5 reported that she was suspended on 08/09/24 pending investigation of the missing controlled medications which lasted ten (10) days. The Nurse stated she was reported to the Board of	F0755		

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F0755 SS = D	Continued from page 13 Nursing (BON) and the BON informed the Nurse that there would be no formal disciplinary action. The Nurse explained that she was called to the facility on 08/19/24 and was given a written warning on not following the proper procedure of obtaining controlled medications and was educated on the proper procedure of obtaining controlled medications. The Nurse reported that now the new procedure was for two (2) nurses to verify the controlled medication count when delivered from the pharmacy. During an interview with Nurse #6 on 07/22/25 at 8:00 PM the Nurse explained that she was approached by the DON on 08/09/24 and asked if she counted the emergency controlled medications during shift change with Nurse #5 and the Nurse reported that she had not counted any emergency storage medications with Nurse #5. Nurse #6 continued to explain that she helped the DON search for missing controlled medications and could not find them and she helped count all the controlled medications on all the medication carts in the facility and the counts were all reconciled. On 07/22/25 at 4:50 PM an interview was conducted with the Administrator who reported that he was notified on 08/09/24 of the missing emergency controlled medications ordered by the DON on 08/07/24. The Administrator explained that all the medication carts and medication rooms were searched but the missing controlled medications were not found. The Administrator stated that they brought Nurse #5 in on 08/09/24 for a written statement and a drug test which was negative and suspended her pending the completion of the investigation. He continued to explain that he reported the missing controlled medications to the local law enforcement who investigated the situation and there were no charges related to the investigation. He stated he reported the missing controlled medications to Adult Protective Services (APS) and there was no report taken by APS citing there was no resident involved in the missing controlled medications therefore, there was no abuse, neglect or exploitation. The Administrator explained that he called the pharmacy manager to inform them of the situation and asked that the delivery driver provide a written statement and adhere to a drug test, but the driver refused, and the pharmacy manager stated it was not a part of their policy to provide it. The facility provided the following correction action plan: Address how corrective actions will be accomplished for those residents to have been affected by the deficient	F0755		

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F0755 SS = D	Continued from page 14 practices. On 08/08/24 Nurse #5 signed a narcotics delivery sheet which states that 4 house stock Ativan 0.5 mg tablets, 1 house stock oxycodone 5 mg tablet, 4 house stock tramadol 50 mg tablets and 2 bottles of lorazepam 60 milliliters for a resident were delivered. Nurse #5 states that she did not verify and count the narcotics with the delivery driver but did sign the delivery sheet. Nurse #5 stated she acknowledges receiving 2 bottles of liquid lorazepam for the resident which she secured in the refrigerator. Nurse #5 does not recall seeing the house stock narcotics in the delivery. On 08/09/24 the Director of Nursing became aware that the house stock narcotics were missing. Nurse #5 was suspended on 08/09/24. The Director of Nursing or designee searched Nurse #5's medication cart and medication room and was unable to locate the missing house stock narcotics on 08/09/24. The Administrator submitted a 24-hour report to the Division of Health Services Regulation to report the missing narcotics on 08/09/24. The Administrator reported the missing medications to Adult Protective Services and the police department on 08/14/24. Nurse #5 was drug tested on 08/09/24. Results of the drug test were negative. Human resources completed a review of Nurse #5's employee file on 08/16/24 and verified she had a valid nurse license, had no disciplinary action against her license, had no exclusions from government programs, and had nothing on her background check that would preclude her from employment in a nursing home. Nurse #5 was drug tested on hire 01/06/21, and the results were negative. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 08/09/24 the Director of Nursing or designee completed a search of all other medication carts and medication rooms in the building. An audit was completed of the narcotics in the Omnicell, and an audit was completed of all resident narcotics on the medication carts. All other narcotics were accounted for. Human resources reviewed the employee files of five other employees on 08/14/24 and verified they had a valid license, and had no disciplinary action against their license, had no exclusions from government programs, and had nothing in their background checks that would preclude them from employment in a nursing home. All five employees were drug tested on hire and were negative. The 4-house stock Ativan, 1 house stock oxycodone, and 4 house stock tramadol were unable to be located. No other residents were affected by the missing house stock narcotics. The facility never ran out of any of the house stock narcotics. Narcotics were continually available to all residents.	F0755		

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F0755 SS = D	Continued from page 15 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 08/09/24 the Director of Nursing or Designee educated all licensed nurses and medication aides on the facility policy for narcotics handling to include reviewing the delivery manifest with the driver and completing a count of each narcotic listed on the manifest with the driver ensuring the accuracy of what medication was delivered and the quantity of each medication was delivered prior to two nurses signing the delivery form. Immediately after receiving the medication the nurse will secure the narcotics into the medication cart or the narcotics refrigerator. If the medication delivered is not correct the nurse is to decline the delivery and immediately inform the Director of Nursing. The Director of nursing or designee will ensure that all licensed nurses receive this education prior to working their next shift. The Director of Nursing will ensure all newly hired licensed nurses will receive this education during their orientation. No nurse will work prior to receiving this education. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained On 08/09/24 the Administrator and Director of Nursing discussed the plan of correction and determined to have an ADHOC Quality Assurance Process Improvement (QAPI) meeting. A verbal ADHOC QAPI was held on 08/09/24 with the Interdisciplinary team and educated the team on the interventions that were put into place to prevent narcotic medication discrepancies. The Medical Director was notified by the Director of Nursing via phone on 08/09/25 regarding narcotics discrepancy and what interventions that were put in place. The Director of Nursing implemented the plan of correction 08/09/24. During the QAPI meeting on 08/09/24 the decision was made to audit the plan of correction, and the Administrator informed the Director of Nursing or designee beginning the week of 08/19/24 she will audit the delivery slips with for house stock narcotics to ensure the delivery was reviewed by two nurses. Audits will continue for 8 weeks. The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and or Designee during the QAPI meeting for the next 3 months to ensure sustained compliance. Changes to the plan of correction will be made as needed. The Administrator and Director of Nursing will ensure the corrective action plan is implemented. Date of Compliance: 08/19/24	F0755		

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F0755 SS = D	Continued from page 16 The Plan of Correction was validated on 07/25/25 which included reviewing the facility's weekly audits of the pharmacy emergency controlled delivery sheets that ensured two (2) nurses signed the delivery sheets. The education provided to the nurses was evident by the signatures on the education sign in sheets and through verbal affirmation by the nurses that they received the education. The audits were presented to QA for three (3) consecutive months. The facility's compliance date of 08/19/24 was validated.	F0755		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12% for 3 of 5 residents observed during the medication administration (Resident #79, Resident #84 and Resident #26). The findings included: The manufacturer's instructions for a prefilled insulin pen indicated that priming the insulin pen each time was an important step to ensure there were no air bubbles in the insulin and the full dose of insulin was given. Priming the insulin pen: 1. Dial up 2 units: turn the dose selector dial to 2 units, 2. Prime the pen: Press the injection button to let out any air bubbles and ensure the insulin is flowing correctly, 3. Check for a drop of insulin: you should see a drop of insulin on the tip of the needle, 4. Repeat if necessary. 1. Resident #79 was admitted to the facility on 02/21/25 with diagnoses that included diabetes mellitus. Review of Resident #79's physician orders dated	F0759	Resident #26 Physician was notified on 7/23/25 that Resident received 1,500mg Vitamin B12 instead of 2,500mg as ordered. No new orders noted at this time. Nurse #3 was educated on Medication administration to include correct dose. Resident #26 remains in facility and has no negative outcomes from receiving the incorrect dose of vitamin B12. Resident #79 Physician was notified on 7/24/25 that Resident received units of insulin without priming the pen. Physician offered no new orders. Nurse #26 was educated on Medication administration to include priming of insulin pen. Resident #79 remains in the facility and has no negative outcomes from not priming their insulin pen. Resident #84 Physician was notified on 7/23/25 that resident received 2 units of insulin without priming the pen. Physician offered no new orders. Nurse #2 was educated on Medication administration to include priming of insulin pen. Resident #3 remains in the facility and has no negative outcomes from not priming insulin pen. A medication pass audit completed on all residents that receive insulin to ensure Insulin pens are being primed prior to administration to ensure correct dosage. Residents on B12 were reviewed to ensure correct dosages were available. No other issues were noted Audit was completed by DON/Designee on 7/29/25. On 8/6/25 the DON/Designee provided education to all licensed Nurses and medication aides on the 6 rights of medication administration to include correct dosage of Vitamin B12. All licensed nurses were educated on administering insulin using an insulin pen to include priming the pen before administering insulin. All licensed nurses and certified medication aides will receive training prior to working their next shift. All newly hired nurses and medication aides will receive this education during the new hire orientation. Beginning the week of 8/11/25 DON/Designee will complete a medication administration audit on 3 Nurses	08/11/2025

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F0759 SS = D	Continued from page 17 04/29/25 for Lantus insulin give 10 units subcutaneously every day. On 07/23/25 at 8:55 AM an observation was made of Nurse #3 preparing to administer insulin to Resident #79 via an insulin pen. The Nurse removed the Lantus insulin pen from the medication cart and set the counter to 10 units. Nurse #3 administered the 10 units of insulin without priming the insulin pen as advised by the manufacturer's instructions. An interview was conducted with Nurse #3 on 07/23/25 at 2:51 PM. The Nurse was asked to review the steps of giving insulin via an insulin pen. Nurse #3 repeated the steps she had taken when administering insulin to Resident #79 but did not include priming the insulin pen. The Nurse was asked if she knew about priming the insulin and she indicated she knew but thought it was only for the first time the insulin pen was used. During an interview with the Pharmacist on 07/24/25 at 2:30 PM the Pharmacist explained it was important to prime the insulin every time it was used in order to remove any air bubbles that may be present in order to inject the full amount of insulin prescribed for the Resident. During an interview with the Director of Nursing (DON) on 07/24/25/25 at 2:30 PM the DON indicated that she expected Nurse #3 to follow the manufacture's recommendations when given insulin using an insulin pen. 2. Resident #84 was admitted to the facility on 01/18/25 with diagnoses that included diabetes mellitus. Review of Resident #84's physician orders revealed an order dated 01/18/25 for Lispro insulin 2 units subcutaneously before meals. On 07/22/25 at 4:10 PM an observation was made of Nurse #2 preparing to administer insulin to Resident #84 via an insulin pen. The Nurse removed the Lispro insulin pen from the medication cart and set the counter to 2 units. Nurse #2 administered the 2 units of insulin without priming the insulin pen as advised by the manufacturer's instructions. An interview was conducted with Nurse #2 on 07/23/25 at 2:35 PM. The Nurse was asked to review the steps when giving insulin using an insulin pen and Nurse #2 repeated how he administered the insulin the day before. When the Nurse was asked about priming the	F0759	Continued from page 17 per week to ensure the correct dosage of medication was administered and insulin was primed before administration. Audits to continue for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	

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F0759 SS = D	Continued from page 18 insulin pen the Nurse reported that he was not aware that the insulin pen needed to be primed before giving the insulin and stated he would remember to do that going forward. During an interview with the Pharmacist on 07/24/25 at 2:30 PM the Pharmacist explained it was important to prime the insulin every time it was used in order to remove any air bubbles that may be present in order to inject the full amount of insulin prescribed for the Resident. During an interview with the Director of Nursing (DON) on 07/24/25/25 at 2:30 PM the DON indicated that she expected Nurse #2 to follow the manufacture's recommendations when given insulin using an insulin pen. 3. Resident #26 was admitted to the facility on 03/05/25 with diagnoses that included neuralgia (nerve pain caused by damage or irritation). Review of Resident #26's physician orders dated 03/22/25 revealed Vitamin B-12, 2,500 micrograms (mcg) by mouth once a day for neuralgia. An observation was made of Nurse #3 on 07/23/25 at 9:00 AM during a medication administration of Resident #26. The Nurse prepared Resident #26's medications which included Vitamin B-12. The Vitamin B-12 was supplied in a bottle of 1,000 mcg per tablet. The Nurse picked up the bottle of B-12 and stated she would have to cut one of the tablets in half in order to give the correct dose then proceeded to cut one tablet in half and put the half tablet in the medicine cup along with a whole tablet and administered 1,500 mcgs to Resident #26 instead of 2.5 tablets which would equal 2,500 micrograms. An interview was conducted with Nurse #3 at 2:51 PM on 07/23/25. The Nurse was asked to review the calculation of Resident #26's Vitamin B-12 tablets. The Nurse stated the total dose to be given was 2,500 and she cut one tablet in half and thought she gave the Resident 2.5 tablets. The Nurse was informed that she only gave 1.5 pills which was not enough to equal the 2,500 dose of Vitamin B-12 and the Nurse stated she should have gotten the 500-microgram stock bottle from the medication room and used it instead of cutting one of the pills in half. Nurse #3 stated she was nervous during the medication pass. On 07/24/25 at 2:30 PM an interview was conducted with the Pharmacist who explained that the correct dose of	F0759		

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F0759 SS = D	Continued from page 19 Vitamin B-12 should have been administered to Resident #26. An interview was conducted with the Director of Nursing (DON) on 07/24/25 at 2:30 PM. The DON stated Nurse #3 should have retrieved the bottle of Vitamin B-12 from the medication room to help prevent making the medication error.	F0759		
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 §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: Based on observations, record review, and staff interviews, the facility failed to secure 3 bottles of medicated powder observed in a resident's room for 1 of 1 resident reviewed for medication storage (Resident #19). Findings included: Resident #19 was admitted to the facility 08/13/24 with diagnoses including obstructive uropathy (a condition that occurs when urine cannot drain out of the body)	F0761	On 7/25/25 Resident #19 medicated powder was removed from resident's room and locked in treatment cart. Resident #19 remains in facility and has no negative outcome from having medicated powder at bedside. DON/Designee completed an audit on 7/31/25 of all resident rooms to ensure no other resident has medicated powder left at bedside. No other concerns were noted. To prevent this from recurring, DON/Designee provided education on 8/6/25 to the Nurses and medication aides on proper medication storage and not leaving medicated powder at bedside. New Nurses will be educated upon hire. Beginning the week of 8/11/25 the DON/Designee will audit 5 resident rooms per week to ensure no medicated powders are left at bedside. Audits to continue for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	08/11/2025

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F0761 SS = D	Continued from page 20 and macular degeneration (an eye disease that causes vision loss). The annual Minimum Data Set (MDS) assessment dated 06/12/25 revealed Resident #19 was severely cognitively impaired and required partial/moderate assistance with bed to chair transfers. An observation of Resident #19's dresser on 07/21/25 at 3:10 PM revealed two 15 gram (gm) and one 60 gm bottles of Nystatin powder (antifungal medication) 100,000 units/gm sitting on top. Additional observations Of Resident #19's dresser on 07/22/25 at 1:55 PM, on 07/23/25 at 8:22 AM, on 07/24/25 at 8:42 AM, and on 07/25/25 at 10:32 AM revealed two 15 gm and one 60 gm bottles of Nystatin powder 100,000 units/gm sitting on top. An observation of Resident #19's dresser with Nurse #4 on 07/25/25 at 11:35 AM revealed two 15 gm and one 60 gm bottles of Nystatin powder 100,000 units/gm sitting on top. An interview with Nurse #7 on 07/25/25 at 11:35 AM revealed medicated powders should be stored in the treatment cart unless there was a physician's order to leave the medication in the resident's room. She stated she had not been all the way in Resident #19's room since beginning her shift at 7:00 AM on 07/25/25 and had not seen the bottles of medicated powder or she would have removed them. An interview with the Director of Nursing (DON) on 07/25/25 at 11:40 AM revealed Resident #19's medicated powder should have been stored in the treatment cart unless there was a physician's order to store the medication in the resident's room. The DON confirmed there was no physician order to leave Nystatin powder in Resident #19's room. An interview with the Administrator on 07/25/25 at 12:55 PM revealed he expected staff to follow the facility's policy for medication stored at the bedside.	F0761		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F0803	On 7/23/25 identified residents on the 700/800 hall were offered additional vegetables after the meal was served. On 7/23/25 identified residents on the 700/800 hall were offered puree bread after the meal was served. On 8/5/25 all resident neighborhoods were audited to ensure plated food complied with approved menus and that all food was served for all diet consistency's.	08/11/2025

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F0803 SS = E	Continued from page 21 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and dietary staff, Registered Dietitian (RD), and Regional Registered Dietitian interviews, the facility failed to provide food items as specified by the approved menu. This practice had the potential to affect 11 residents receiving a regular diet and 2 residents receiving a puree diet (consisting of foods with a pudding-like texture) on 1 of 4 units (700/800 hall). Findings included: A review of the approved menu for residents receiving a regular diet on 07/23/25 revealed the following foods were on the menu: chili and beans, garden salad with dressing, cornbread, and carrot cake. Alternate food items for the lunch meal included mixed vegetables and noodles. A review of the approved menu for residents receiving a puree diet revealed the following foods were on the menu: chili and beans, steamed squash, puree bread, and carrot cake. a. An observation of Dietary Aide #1 on the 700/800 hall on 07/23/25 from 12:10 PM through 12:19 PM revealed he checked the temperature of the garden	F0803	Continued from page 21 To prevent this from reoccurring, on 8/6/25 the Dietary Manager completed education for all kitchen staff to ensure facility provides food items specific according to the approved menu. New staff will be educated upon hire. The Dietary Manager or designee will audit 20 meals served, 5 days per week. The audit will last 12 weeks to ensure continued compliance. The Administrator or designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 8/11/2025.	

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F0803 SS = E	Continued from page 22 salad, and the temperature was 43 degrees Fahrenheit. Dietary Aide #1 placed the pan of salad on ice and re-checked the temperature, which was 46.8 degrees Fahrenheit. Dietary Aide #1 was instructed by the Regional Registered Dietitian to serve mixed vegetables instead of garden salad to residents receiving a regular diet since the garden salad did not reach the correct temperature. An observation of Dietary Aide #1 revealed he began plating food on 07/23/25 at 12:20 PM. Residents receiving a regular diet received chili and beans, mixed vegetables, cornbread, and carrot cake. On 07/23/25 at 12:50 PM Dietary Aide #1 ran out of mixed vegetables and began serving chili and beans, noodles, cornbread, and carrot cake to residents receiving a regular diet. Dietary Aide #1 did not ask the Registered Dietitian (RD) or the Regional Registered Dietitian before substituting noodles for mixed vegetables. An interview with Dietary Aide #1 on 07/23/25 at 1:05 PM revealed he frequently ran out of food on the tray line, and he would plate whatever food he had left on the serving line. He stated he did not notify his supervisor when he ran out of food and did not ask for guidance to provide a nutritionally equivalent substitute. An interview with the Regional Registered Dietitian on 07/24/25 at 1:21 PM revealed Dietary Aide #1 should have stopped the meal tray line for the lunch meal on 07/23/25 when he ran out of mixed vegetables, notified his supervisor, and waited until a nutritionally equivalent substitute was available before sending regular trays to residents. She stated noodles were not an appropriate substitution for mixed vegetables. An interview with the Administrator on 07/24/25 at 3:22 PM revealed Dietary Aide #1 should have waited until an appropriate substitute was available for the lunch meal on 07/23/25 instead of substituting noodles for mixed vegetables. b. An observation of the meal tray line on 07/23/25 at 12:20 PM revealed Dietary Aide #1 began plating the food. Residents on a puree diet did not receive puree bread or a substitute for bread. In an interview with the RD on 07/23/25 at 12:30 PM she confirmed no puree bread was available for the lunch meal on 07/23/25. She stated residents receiving a puree diet should receive the same food or an appropriate substitution as residents receiving any	F0803		

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F0803 SS = E	Continued from page 23 other diet texture. An interview with Dietary Aide #1 on 07/23/25 at 1:05 PM revealed he did not have puree bread or a substitute to serve residents receiving a puree diet on 07/23/25 and he did not notify his supervisor that the puree bread was unavailable. An interview with Cook #1 on 07/24/25 at 1:21 PM revealed she did make puree bread for the lunch meal on 07/23/25, but it did not get sent to the 700/800 hall. An interview with the Administrator on 07/24/25 at 3:22 PM revealed puree bread did not get sent to the 700/800 hall for the lunch meal on 07/23/25. He stated residents receiving a puree diet on 07/23/25 did not receive bread and they should have received bread per the menu.	F0803		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to honor a resident's food preferences for 1 of 1 resident reviewed for food preferences (Resident #88). Findings included: Resident #88 was admitted to the facility 03/08/23. Review of Resident #88's physician orders revealed an order dated 05/31/24 for a low concentrated sugar diet (a diet that reduces or eliminates foods with high amounts of sugar). Review of the quarterly Minimum Data Set (MDS)	F0806	On 7/22/25 Resident #99 had their oatmeal removed from her tray and was given a banana. On 8/7/25 all resident neighborhoods were audited to ensure plated food complied with resident preferences. To prevent this from reoccurring, on 8/6/25 the Dietary Manager completed education for all kitchen staff to ensure facility provides food items specific the preferences of the resident. New staff will be educated upon hire. The Dietary Manager or designee will audit 20 meals served, 5 days per week. The audit will last 12 weeks to ensure continued compliance. The Administrator or designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance. Compliance date is 8/11/2025.	08/11/2025

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F0806 SS = D	Continued from page 24 assessment dated 05/07/25 revealed Resident #88 was cognitively intact, was able to make herself understood, and was able to understand others. Resident #88's nutrition care plan, last edited 06/23/25, revealed she had increased nutrition/hydration risks related in part to diabetes and interventions included monitoring her dietary intake and respecting/honoring resident dietary choices. The Dietary Manager (DM) was observed to interview Resident #88 on 07/21/25 at 1:04 PM. During the interview Resident #88 informed the DM that she was taught not to waste food and it was upsetting to her when she received food like oatmeal or grits that she knew she would not eat. The DM stated she understood that Resident #88 did not want to receive oatmeal or grits on her meal trays. An observation of Resident #88's meal tray ticket on 07/22/25 at 8:30 AM revealed she was documented to receive scrambled eggs, sausage patties, toast, cereal of choice, and a banana. Resident #88's meal tray ticket documented she was to receive double portions. There was no documentation on her meal tray ticket reflecting her dislikes. An observation of Resident #88's breakfast meal tray at the same date and time revealed she received a bowl of grits, a scoop of eggs, 2 pieces of sausage patties, 2 pieces of toast, and no banana. An interview with Resident #88 on 07/22/25 at 8:32 AM revealed she would like to have her banana as requested. She stated having fresh fruit for breakfast was important to her and receiving the grits on her tray was frustrating to her because she had informed the dietary department numerous times she did not like grits. An interview with the Dietary Manager (DM) on 07/24/25 at 10:41 AM revealed residents should receive all items listed on their tray ticket, and she expected resident preferences to be honored. She stated residents should not receive items they had asked not to receive. An interview with the Administrator on 07/24/25 at 3:30 PM revealed he expected residents to receive the food preferences they communicated to staff.	F0806		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	Resident #1 remains in facility and has no negative outcome from having incontinence care complete without changing of gloves between peri care and bed linen changes. Employee#4 was immediately educated on	08/11/2025

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F0880 SS = D	Continued from page 25 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the 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	F0880	Continued from page 25 changing gloves after peri care and before starting the next task. DON/Designee completed an audit on 8-5-25 to ensure all CNA's on were changing gloves after providing incontinent care. No other concerns were identified. To prevent this from recurring, DON/Designee provided education on 8/6/25 to Nursing staff on incontinence care, specifically on when to change gloves during care. New nursing staff members will be educated upon hire. Beginning the week of 8/11/25 the DON/Designee will complete 4 incontinence care observations a week to ensure gloves are being changed as required. Audits to continue for 12 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Compliance date is 8/11/2025.	

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F0880 SS = D	Continued from page 26 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure staff implemented their infection control policy for hand hygiene when a nurse aide failed to remove dirty gloves and perform hand hygiene during incontinence care for Resident #1. This deficient practice was identified for 1 of 7 staff members observed for infection control practices (Nurse Aide #4). Findings included: Review of the facility's policy titled "Hand Hygiene/Handwashing Policy" last revised 02/28/25 read in part as follows: "Hand hygiene is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by handwashing. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: before moving from work on a soiled body site to a clean body site on the same patient, after contact with bodily fluids, and immediately after glove removal." A continuous observation of Nurse Aide (NA) #3 on 07/23/25 from 8:41 AM through 9:05 AM revealed NA #3 provided incontinence care to Resident #1. With gloved hands NA #3 cleaned urine with resident care wipes, placed the wipe in the trash can, assisted Resident #1 with rolling onto her left side, cleaned urine with	F0880		

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F0880 SS = D	Continued from page 27 resident care wipes, placed the wipe in the trash can, applied skin barrier ointment to Resident #1's right buttock, rolled a clean brief and bed pad under Resident #1, assisted Resident #1 with rolling onto her right side, cleaned urine with resident care wipe, placed the wipe in the trash can, pulled the clean brief and bed pad under resident, applied skin barrier ointment to Resident #1's left buttock, assisted Resident #1 with rolling onto her back, pulled up the brief and fastened it, pulled Resident #1's gown down, removed the pillow under Resident #1's head and pulled her up in the bed using the bed pad, assisted Resident #1 with rolling on her left side, placed a pillow under her left side, assisted Resident #1 with rolling onto her right side, placed a pillow under her right side, placed a pillow under Resident #1's head, pulled up her bed sheet and cover, used the bed control to raise Resident #1's head, placed the call light on Resident #1's bed and within her reach, pulled her overbed table across her bed and lowered the table, removed his gloves and placed them in a trash bag, picked up the trash bag, and exited the room. NA #3 did not remove his gloves and perform hand hygiene after removing urine, after applying ointment to Resident #1's buttocks, and before touching other items in Resident #1's environment. NA #3 did not perform hand hygiene after removing his gloves at the completion of care and before exiting Resident #1's room. An interview with NA #3 on 07/23/25 at 9:08 AM revealed he usually changed his gloves during incontinence care only if they were visibly soiled and he performed hand hygiene when he was ready to exit the resident's room. He stated he was nervous and that was why he did not perform hand hygiene after removing his gloves when he finished providing care and before exiting Resident #1's room. An interview with the Director of Nursing (DON) on 07/23/25 at 10:40 AM revealed she expected staff to remove gloves and perform hand hygiene when moving from dirty to clean tasks. An interview with the Administrator on 07/24/25 at 4:20 PM revealed he expected staff to remove their gloves and perform hand hygiene after performing incontinence care and before performing the next task. An interview with the Infection Preventionist on 07/25/25 at 10:11 AM revealed when staff performed incontinence care they should remove their gloves after cleaning the resident, perform hand hygiene, and then continue care.	F0880		