STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345507	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Myrtle Grove	**5725 Carolina Beach Road , Wilmington, North Carolina, 28412**

(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 survey and complaint investigation was conducted on 08/18/25 through 08/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D3C93-H1.	E0000		
F0000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 08/18/25 through 08/21/25. Event ID# 1D2C93-H1. The following intakes were investigated 2581008, 2587923, and 2565365. 1 of the 6 complaint allegations resulted in deficiency.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F0656	F656 Develop/Implement Comprehensive Care Plan Corrective Action Based on observations, record review, and staff/resident interviews, the facility failed to: Develop a person-centered care plan as indicated by the MDS Care Area Assessment to include a plan of care for Resident #9 admitted with a feeding tube. Implement the use of bilateral fall mats as care planned for Resident #9 to prevent injury in the event of a fall from bed. Resident #9's care plan was reviewed and updated on 8/21/25 by the current facility MDS nurse to include individualized interventions related to the feeding tube. Bilateral fall mats were placed at Resident #5's bedside on 8/20/25 per resident care plan.	09/09/2025

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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F0656 SS = D	Continued from page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to 1.) develop a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include a plan of care for a resident (Resident #9) admitted with a feeding tube. 2.) implement the use of bilateral fall mats as care planned to prevent injury in the event of a fall from bed (Resident #5) for 2 of 21 residents reviewed for care plan development and implementation. Findings Included: 1.) Resident #9 was admitted to the facility on 9/12/24 with diagnoses including gastrostomy (feeding) tube. The Minimum Data Set (MDS) admission assessment and care areas assessment dated 9/18/24 revealed Resident #9 was cognitively impaired and received tube feedings. The care area assessment indicated to initiate a care plan for Resident #9's feeding tube. Review of Resident #9's medical record from 9/18/24	F0656	Continued from page 1 Others having the potential to be affected All residents with feeding tube in place and all residents with fall mats care planned have the potential to be affected. All residents with feeding tubes were audited on 9/3/25 to ensure a person-centered care plan was developed and implemented. All residents with fall mats included in their care plans were audited on 9/3/25 to confirm interventions were in place. Corrections were made immediately where discrepancies were identified. What measures will be put in place or what systemic changes All Licensed MDS staff (RN/LPN) and licensed members of the Interdisciplinary Team (IDT) (RN/LPN) to include FT, PT, and PRN staff will be educated on: Facility policy Comprehensive Care Planning Policy by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or designee. Education began on 8/21/2025 and will be completed by 9/08/25. Monitoring of corrective action The DON/ADON and/or designee will conduct weekly audits x12 weeks of: All new admissions with feeding tubes to verify appropriate person-centered care plans are in place. 5 random residents with fall mats to verify mats are in place as per resident care plan. Results of these audits will be brought before the Quality Assurance and Process Improvement Committee (QAPI) monthly x3 months with the QAPI committee responsible for ongoing compliance.	

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F0656 SS = D	Continued from page 2 through 8/21/25 revealed no care plan was developed to care for Resident #9's feeding tube. During an observation on 8/18/25 at 1:00 PM Resident #9 was observed with a feeding tube in place. During an interview on 8/21/25 at 1:00 PM the MDS Nurse stated she was not aware Resident #9 did not have a care plan in place for care of the feeding tube. She stated she began working as the MDS Nurse a few months ago and the previous MDS Nurse would have been the person responsible for initiating a care plan for the feeding tube after the MDS admission assessment was completed. During an interview on 8/21/25 at 2:00 PM the Director of Nursing (DON) stated the previous MDS nurse was no longer employed with the facility. She indicated care plans should be developed and implemented according to the required guidelines. 2. Resident #5 was admitted to the facility 07/01/25. Review of Resident #5's physician order dated 07/30/25 listed: Bilateral fall mats - left and right side of bed, while resident is in bed. Review of Resident #5's admission Minimum Data Set assessment dated 07/11/25 revealed Resident #5 was severely cognitively impaired, required total assistance for bed mobility and transfers, extensive assistance for locomotion, personal hygiene, and dressing. A nursing note dated 07/23/25 at 3:53 PM for Resident #5 revealed resident experienced a witnessed fall in their room at 1:30 PM with no complaints of pain or discomfort reported at the time of the fall. The resident slid out of bed to a sitting/upright position and no visible injuries, bleeding, swelling, or deformities noted. The resident returned to bed via mechanical lift with two nursing staff assisted. Fall prevention measures were reinforced, and resident's Responsible Party (RP) and provider were notified of the incident. An Interdisciplinary Team (IDT) Meeting note dated 07/30/25 at 1:29 PM for Resident #5 revealed the resident was admitted on 07/01/25 after stroke. Fall on 07/23/25. Resident lowered himself from bed to floor.	F0656	Continued from page 2 The Director of Nursing is responsible for this plan. Allegation of Compliance: 9/09/25	

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F0656 SS = D	Continued from page 3 Fall mat was added to left side of his bed, as previously a fall mat was added to the right side of the bed, with bed kept in low position to reduce injury. Resident #5's revised care plan dated 07/30/25 revealed he had self-care and mobility deficits and was at risk for falls related to recent falls, weakness, right-side hemiplegia, and poor safety awareness. An updated care plan intervention included: Bilateral fall mats (right and left side of bed) while resident was in bed. A nursing note dated 08/02/25 at 6:05 AM for Resident #5 revealed the resident slid out of bed onto his buttocks on the fall mat on the left side of his bed. No injuries noted. Resident at his baseline for responsiveness and was sitting up smiling and giving us a thumbs up that he was okay. Resident representative (RP) and Nurse Practitioner (NP) notified. A nursing note dated 08/14/25 at 4:37 PM for Resident #5 revealed the resident was relocated to a room on the 700-hall, per family and Resident #5 request, with housekeeping staff placing all personal belongings in his 700-hall room. An observation was conducted on 08/20/25 at 11:10 AM for Resident #5 revealed resident resting in bed, fully dressed, with one fall mat located on the floor next to the left side of his bed, and no fall mat on the right side of his bed. The resident motioned with his hands that he did not know where his second fall mat was, and that he only had one mat in his current room but had bilateral fall mats in his previous room. An interview and observation were conducted on 08/20/25 at 11:15 AM with the Director of Nursing (DON). She observed Resident #5's room on the 700-hall and stated the resident should have had bilateral fall mats, one placed on each side of his bed as stated in resident's care plan and it did not. She stated the resident was recently transferred to a new room from the 400-hall within last few days and that facility staff must have left resident's second fall mat in his old room on. The DON stated per resident's care plan she would immediately ask housekeeping to make sure Resident #5 had another fall mat placed on the right side of his bed to help prevent him from a possible injury from another fall due to his history of falls.	F0656		

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F0656 SS = D	Continued from page 4 An interview was conducted on 08/20/25 at 11:20 AM with the Administrator. She stated the resident should have had bilateral fall mats, one placed on each side of his bed as stated in resident's care plan and it did not.	F0656		
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 - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to maintain an environment that was free from accident hazards when a mechanical lift that was not in use was left in the hallway (600 hall) by a staff member (Nurse Aide #3) which resulted in a cognitively impaired resident with poor safety awareness and a history of falls with injury to trip over the lift while ambulating in the hallway causing a fall with minor injury of blood on her left nostril. This occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #11). Findings included: Resident #11 was admitted to the facility on 9/26/23 with diagnoses including Alzheimer's with dementia and agitation, and a history of falls. A care plan revised 3/14/25 revealed Resident #11 was at risk for falls due to a history of falls with injury, other risk factors included weakness, use of psychotropic medications, impaired memory, confusion and incontinence. The goal of care was to minimize the risk of falls and minimize injuries. Interventions included in part; provide staff education regarding fall hazards and implement preventative fall interventions.	F0689	F689 Free of Accident Hazards/Supervision/Devices Corrective Action Based on record review and staff interviews, the facility failed to: Maintain an environment free from accident hazards when a mechanical lift not in use was left in the hallway (600 hall) by staff member (NA #3). This resulted in a cognitively impaired resident with poor safety awareness and a history of falls with injury tripping over the lift while ambulating in the hallway, sustaining a fall with minor injury (blood noted on left nostril) on 6/25/25. The resident was immediately assessed following the fall; minor injury (blood on left nostril) was treated. The physician and responsible party were notified on 6/25/25. Neurological checks were initiated and completed per facility protocol. The mechanical lift was promptly removed from the hallway and returned to the designated storage area. Nurse aide #3 was immediately re-educated on safe equipment storage practices and prevention of accident hazards Others having the potential to be affected All residents have the potential to be affected. A facility-wide audit was conducted on 8/29/25 to ensure all mechanical lifts stored properly in designated areas when not in use. What measures will be put in place or what systemic changes	09/09/2025

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F0689 SS = D	Continued from page 5 The Minimum Data Set (MDS) quarterly assessment dated 5/31/25 revealed Resident #11 was severely cognitively impaired and independent with ambulation. She had two or more falls with injury. A post fall report dated 6/25/25 at 2:30 PM revealed Resident #11 had a fall in the hallway while ambulating. The current interventions that were not in place was the mechanical lift was in the hallway. The root cause was that a staff member left the lift in the hallway. Resident #11 tripped on the lift due to poor vision, inattention, and poor safety awareness. The immediate intervention was one-to-one education with the staff member (Nurse Aide #3). Education included the importance of always taking the mechanical lift back to the clean utility room when not in use. Attempts were made to contact Nurse Aide #3 on 8/21/25 at 1:30 PM with no response. A progress note dated 6/25/25 at 2:30 PM written by Nurse #1 revealed Resident #11 was found sitting on the floor on her buttocks having tripped on the mechanical lift while ambulating. A small trickle of blood was coming from her left nostril but subsided after being cleaned. There were no other injuries noted. Her vital signs were stable, and neurological checks were within normal limits. Resident #11 was able to move all extremities without difficulty or discomfort. She was wearing shoes at the time and was able to stand from the floor with two-person assistance as she was unsafe using the mechanical lift as evidenced by being unable to follow simple directions and grabs at the moving components of the lift. Resident #11 had been quickly ambulating throughout the facility with a slight lean to the left. She was taken to her room to rest throughout the day, but she gets out of the bed and continues to ambulate within minutes. During an interview on 8/21/25 at 10:15 AM Nurse #1 stated she routinely provided care to Resident #11 who had severe dementia with agitation and ambulated independently in the hallway and needed constant redirection. Nurse #1 stated Resident #11 had a fall in June 2025 when she tripped on the mechanical lift that was in the hallway outside of her room. She stated Resident #11 had some blood coming from her nose from the fall but had no other injuries, and her vital signs and neurological checks remained stable. Nurse #1 indicated Resident #11 continued to ambulate unassisted	F0689	Continued from page 5 All clinical (nursing) staff (RN/LPN/CNA/CMA) to include FT, PT, PRN and agency staff will be educated on Ease of Egress as related to Fall Prevention to include proper storage of mechanical lifts when not in use by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or designee. Education began on 8/21/2025 and will be completed by 9/08/25. No clinical (nursing) staff shall be permitted to work until education has been received. Monitoring of corrective action DON, ADON, and/or designee will conduct random environmental rounds to ensure mechanical lifts are stored appropriately when not in use 5 times per week for 12 weeks. Results of these audits will be brought before the Quality Assurance and Process Improvement Committee (QAPI) monthly x3 months with the QAPI committee responsible for ongoing compliance. The Director of Nursing is responsible for this plan. Allegation of Compliance: 9/09/25	

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F0689 SS = D	Continued from page 6 and due to severe dementia and poor safety awareness she would not be able to call for staff assistance before ambulating in and out of her room. Nurse #1 stated the mechanical lifts were to be kept in the utility room when not in use. An interdisciplinary note dated 7/2/25 at 12:15 PM revealed Resident #11 had a fall on 6/25/25. Resident #11 tripped over the mechanical lift that was in the hallway. Intervention was one to one staff education in regard to maintaining egress (a continuous unobstructed pathway) of the hallway. Resident #11 remained at baseline and continued to wander ad lib through the facility. Resident #11 has occasional periods of agitation and continues with poor safety awareness and impulsivity. During an interview on 08/19/25 at 2:47 PM Unit Manager #1 stated the mechanical lifts were to be kept in the utility room when not in use and not left in the hallway. She stated Resident #11 had a fall in June 2025 due to tripping on the mechanical lift that was left unattended in the hallway by a staff member (Nurse Aide #3). She provided one-to-one education to Nurse Aide #3 regarding properly storing the lifts and not leaving the lift in the hallway when not in use due to it being a fall hazard. During an interview on 8/21/25 at 2:00 PM the Director of Nursing (DON) indicated Resident #11 had severe dementia, a history of falls, and ambulated independently on the 600-hall. The DON stated the mechanical lifts were to be stored when not being used and not left in the hallway to prevent accidents. She indicated staff had received training on fall hazards including where to properly store the mechanical lifts.	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	F761 – Label/Store Drugs and Biologicals Corrective Action Based on observations, record review, and staff interviews, the facility failed to: Discard 4 expired insulin pens according to manufacturer's guidelines located on 700 hall medication cart.	09/09/2025

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F0761 SS = D	Continued from page 7 §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 discard four expired insulin pens according to the manufacturer's guidelines and record an opened date on an insulin pen on 1 of 4 medication carts (700 hall medication cart) that were reviewed for medication storage. Findings Included. Review of the manufacturer's guidelines for Insulin Lispro (Humalog) pens and Insulin Glargine (Lantus) pens instructed to discard 28 days after opening. An observation of the 700-hall medication cart on 8/20/25 at 11:00 AM revealed the following: Insulin Lispro (Humalog) pen with an opened date of 6/12/25 and expiration date of 7/10/25. Insulin Lispro (Humalog) pen with an opened date of 7/7/25 and expiration date of 8/5/25. Insulin Lispro (Humalog) pen with an opened date of 6/18/25 and expiration date of 7/16/25. Insulin Glargine (Lantus) pen with an opened date of 7/1/25 and expiration date of 7/29/25. Insulin Glargine (Lantus) pen with no opened date and	F0761	Continued from page 7 Record the opened date on an insulin pen located on the 700 hall medication cart. All 5 insulin pens were immediately removed from 700 hall medication cart and properly discarded on 8/18/25. Others having the potential to be affected All residents who receive insulin have the potential to be affected. A facility-wide audit of all medication carts, medication storage rooms, and treatment carts was conducted on 9/4/25 to ensure all insulin pens and other biologicals were labeled and disposed of according to manufacturer's guidelines. Corrections were made immediately for any identified deficiencies. What measures will be put in place or what systemic changes All licensed staff (RN/LPN) and Medication Aide(s) to include, FT, PT, PRN and agency staff will be educated on policy 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles by Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or designee. Education began on 8/21/2025 and will be completed by 9/08/25. Monitoring of corrective action DON, ADON, and/or designee will conduct 5 random medication cart(s), treatment cart(s) and/or medication storage room(s) 3 times per week for 12 weeks. Results of these audits will be brought before the Quality Assurance and Process Improvement Committee (QAPI) monthly x3 months with the QAPI committee responsible for ongoing compliance. The Director of Nursing is responsible for this plan.	

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F0761 SS = D	Continued from page 8 60 of 300 units had been administered. During an interview on 08/18/25 at 11:01 AM Medication Aide #1 stated she was assigned to the 700-hall medication cart today. She stated she was not allowed to administer insulin and only nurses administered insulin therefore she did not check the cart for expired insulin. During an interview on 08/18/25 at 11:30 AM Unit Manager #1 stated the nurses were required to check the carts for expired medications. Unit Manager #1 indicated the nurses were required to check insulin pens for expiration dates before administering and record the date on the pen when opened. She stated she thought all of the medication carts had been checked today but unfortunately the insulin on the 700-hall cart was missed. During an interview on 08/19/25 at 4:00 PM the Director of Nursing (DON) stated all nurses were responsible for checking medication carts at least weekly for expired medications and insulin pens should be checked daily and prior to use. She stated the expired insulin on the 700-hall cart should have been discarded and an open date labeled on the Lantus pen.	F0761	Continued from page 8 Allegation of Compliance: 9/09/25	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F0880	F880 Infection Control Corrective Action Based on observations, record review, and staff interviews, the facility failed to follow the infection control policy and procedures when: On 8/20/25, Medication Aide #1 entered a resident's room (resident #73) who was on Contact Precautions due to a wound infection without donning personal protective equipment (PPE) to include gloves and a gown. On 8/18/25, Nurse Aide #1 did not don PPE for Enhanced Barrier Precautions (EBP) to include gown a gown when providing high-contact resident care activities for resident #26 who had a surgical wound dressing and a lower leg dressing.	09/09/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 9 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The 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.	F0880	Continued from page 9 On 8/20/25, Medication Aide #1 was immediately re-educated on the facility's Infection Control Policy and the proper use of PPE, including donning gown and gloves for residents on Contact Precautions by the Director of Nursing (DON). On 8/18/25 Nurse Aide #1 were immediately re-educated on the facility's Infection Control Policy and the proper use of PPE, including donning a gown for residents on Enhanced Barrier Precautions (EBP) when providing high-contact resident care activities by the Assistant Director of Nursing (ADON). Nurse aide #1 is no longer employed by facility. Others having the potential to be affected All residents on Contact Precautions and Enhanced Barrier Precautions have the potential to be affected. On 8/20/25, the DON and ADON/Infection Preventionist (IP) reviewed all residents on Contact Precautions and EBP to ensure proper PPE requirements were followed. No other concerns were identified What measures will be put in place or what systemic changes Education for all licensed nurses, medication aides, and nurse aides to include FT, PT, PRN and agency staff on facility Infection Control Policy, Transmission Based Precautions and Enhanced Barrier Precautions to include proper PPE usage specific to Contact Precautions and Enhanced Barrier Precautions by the DON, ADON/IP, and/or designee. Education began on 8/21/2025 and will be completed by 9/08/25. No licensed nurses, medication aides, and/or nurse aides shall be permitted to work until education has been received. Monitoring of corrective action The DON, ADON/IP, and/or designee will conduct 5 random	

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F0880 SS = D	Continued from page 10 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 follow the infection control policy and procedures when 1.) Medication Aide #1 entered a resident's room (Resident #73) who was on Contact Precautions due to a wound infection without donning personal protective equipment (PPE) to include gloves and a gown. 2.) Nurse Aide #1 did not don PPE for Enhanced Barrier Precautions (EPB) to include a gown when providing high-contact resident care activities for Resident #26 who had a surgical wound dressing and a lower leg dressing. This occurred for 2 of 4 staff members reviewed for infection control practices. Findings Included. 1.The facility's Infection Control Policy revised 5/19/25 revealed Contact Precautions were intended to prevent the transmission of infectious agents which were spread by direct or indirect contact with the resident or resident's environment. Contact Precautions were indicated in the presence of excessive wound drainage, urine or fecal incontinence or other discharges that could not be contained and suggest an increased potential for environmental contamination and risk of transmission. Personal Protective equipment included to wear gloves and a gown. During observations on 8/20/25 at 10:30 AM Medication Aide #1 was observed entering Resident #73's room who was on contact precautions without wearing gloves or a gown. A sign was posted on the outside of the resident's doorway that read to don gloves and a gown prior to entering the room and remove before exiting. A PPE supply cart was outside of the room by the doorway and stocked with gloves and gowns. Medication Aide #1 was observed at Resident #73's bedside using a stethoscope and blood pressure cuff to obtain Resident#73's blood pressure. Medication Aide #1 left the room after obtaining the blood pressure. During an interview on 8/20/25 at 10:35 AM Medication Aide #1 stated she was not aware that Resident #73 was on contact precautions due to not being assigned to her care since contact precautions were implemented. She stated she went in the room to check Resident #73's	F0880	Continued from page 10 audits of PPE use for residents on Contact Precautions and EBP weekly x12 weeks. Results of these audits will be brought before the Quality Assurance and Process Improvement Committee (QAPI) monthly x3 months with the QAPI committee responsible for ongoing compliance. The Director of Nursing is responsible for this plan. Allegation of Compliance: 09/09/25	

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F0880 SS = D	Continued from page 11 blood pressure before administering her medications and she did not notice the sign by the doorway. Medication Aide #1 stated she had received infection control training including providing care to residents on contact precautions and knew if contact precautions were in place that she was supposed to wear a gown and gloves. She indicated that not wearing the required PPE prior to entering the room was done in error. During an interview on 8/20/25 at 11:30 AM the Infection Preventionist Nurse stated Resident #73 was on contact precautions due to a wound infection and remained on antibiotics. A gown and gloves were required prior to entering Resident #73's room. She indicated staff had received infection control training to include contact precautions. During an interview on 8/20/25 at 4:30 PM the Director of Nursing (DON) stated Resident #73 remained on contact precautions due to a wound infection with wound drainage. Medication Aide #1 should have followed their policy for contact precautions and put on a gown and gloves before going into Resident #73's room. She stated staff had been trained on the infection control policy. 2. Review of facility's Enhance Barrier Precautions (EBP) Policy dated 05/19/25 revealed in part: "EBP are intended to prevent transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents during high contact. High-risk residents: those with chronic wounds and indwelling devices (such as central lines, urinary catheters, and tracheotomy) and for all those colonized or infected with MDRO currently targeted by Centers for Disease Control (CDC). High contact care activities: activities that may result in transfer of MDRO to hands and clothing of healthcare personnel, even when blood and body fluid exposure is not anticipated. These include dressing, bathing/showering, transferring, providing hygiene, changing linen, changing briefs, assisting with toileting, device care or use, and wound care. Residents placed on EBP should remain on EBP for the duration of their stay or until resolution of the wound." Review of Resident #26's August/2025 Medication Administration Record (MAR) revealed to cleanse right chest surgical incision with normal saline, apply petroleum ointment to wound bed and cover with dry dressing daily, and apply foam dressing to left shin	F0880		

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F0880 SS = D	Continued from page 12 wound every 3 days, with order dates for both orders of 07/24/25. During an observation on 08/18/25 at 2:00 PM an EBP sign was posted on Resident #26's room door that read in part: Enhanced Barrier precautions, and providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a central line, urinary catheters, feeding tubes, and wound care: any skin opening requiring a dressing. A follow-up observation was conducted on 08/18/25 at 2:01 PM, after knocking and opening Resident #26's door, revealed Nurse Aide (NA) #1 in Resident #26's room removing bed linen, helping the resident with activities of daily living, emptying resident's urinal, and was assisting resident from bed to wheelchair without a gown on. Resident #26 was lying in bed dressed, with sheets and blanket pulled off resident. NA #1 had on gloves when providing care activities for Resident #26 but was not wearing a gown. A bin with PPE (personal protective equipment) supplies was by the door, including one time use disposable gowns. An interview was conducted on 08/18/25 at 2:06 PM with NA #1. She stated she did not put on a gown when providing care for Resident #26. She stated she was trained on EPB and knew Resident #26 was on EPB (due to having wound dressings) and did not need to wear a gown because she was not doing wound care, just ADL care and transferring the resident. After reading the EPB sign on resident's door, NA #1 said she should have donned a gown during Resident #26's ADL care and transfer but had not read the whole EBP sign. An interview was conducted on 08/20/25 at 2:45 PM with the Director of Nursing (DON). She revealed on 08/18/25 at 2:01 PM the NA #1 should have donned a disposable gown during Resident #26's ADL care, linen change, and transfer, while being on Enhanced Barrier Precautions. An interview was conducted on 08/21/25 at 3:00 PM with the Administrator. She stated staff should wear the appropriate personal protective equipment PPE when providing direct care to residents on enhanced barrier precautions. She also stated that all the staff knew to	F0880		

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F0880 SS = D	Continued from page 13 abide by the different types of precautions posted on the residents' door and to follow the assigned personal protective equipment (PPE).	F0880		