STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gates Health and Rehabilitation Center	**38 Carters Road , Gatesville, North Carolina, 27938**

(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
E0001	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	E0001	1. Corrective Action Taken for Residents Found to Have Been Affected All residents had the potential to be affected. On August 26, 2025 an Emergency preparedness exercise with Gatesville Fire Department and no adverse outcomes occurred. As of August 27th, 2025, the Emergency Preparedness Plan (EPP) has been revised to include: • Names and contact information for other LTC facilities and residents' physicians. • Primary and alternate means for communication with staff, Federal, State, regional, and local emergency management agencies. • Processes for cooperation and collaboration with local, and county. • Methods for sharing information and medical documentation for residents with other health providers to maintain continuity of care. 2. Identify Other Residents All current residents are considered potentially affected. A facility-wide review of emergency contacts, health records, and evacuation procedures has been completed as of August 27th, 2025. Updated lists of all residents' physician and alternate care facilities have been placed in the EP Binder. 3. Systemic Changes to Ensure Deficiency Does Not Recur Required Element Corrective Action Annual Exercises Two annual emergency plan exercises have been coordinated: Tabletop exercise completed 10/03/2025 with Gates County Emergency Management; Full-scale	08/27/2025

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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E0001	Continued from page 1 This CONDITION is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to include a process for cooperation and collaboration with local, regional, State, and Federal Emergency Preparedness (EP) officials and development of EP policies and procedures. The facility also failed to develop a communication plan, provide contact information for other Long-Term Care (LTC) Facilities and the resident physician(s), and provide alternative communication options during a disaster or emergency. In addition, they failed to conduct a second community-based exercise to test the emergency plan. This deficient practice had the potential to affect all residents and staff. The findings included: The facility's EP plan dated April 21, 2025, was reviewed and revealed: a. The EP plan did not include a process for cooperation and collaboration with local, regional, State, and Federal EP officials to maintain an integrated response during a disaster or emergency. b. The EP plan did not have evidence a communication plan was developed and maintained that complied with Federal, State, and local laws and was reviewed and updated at least annually. c. The EP plan did not include the names and contact information for other LTC facilities and the residents' physicians. d. The EP plan did not include primary and alternative means for communicating with LTC facilities staff and Federal, State, regional, and local emergency management agencies. e. The EP plan did not include a method for sharing information and medical documentation for residents that were under the LTC facility's care with other health providers to maintain continuity of care. f. The EP plan did not include a second community-based exercise to test the emergency plan at least annually. On 8/15/2025 at 4:36 PM Nurse #5 was interviewed and stated that the EP binder could be found at the nursing station. She indicated that she would be able to find the emergency phone numbers in the binder, and that patient information could be found in the binder too. On 8/15/2025 at 5:37 PM the Director of Nursing (DON) was interviewed. The interview revealed that if she	E0001	Continued from page 1 community-based drill scheduled 11/28/2025 with Gates County Fire Marshall and EMS. Documentation kept in EP Binder. Monitoring/QAPI Oversight The Quality Assurance & Performance Improvement (QAPI) Committee will review the Emergency Preparedness Program monthly for six months, then quarterly. The Administrator and Maintenance Director are responsible for ongoing monitoring and documentation. Staff Education All staff were re-educated on the revised Emergency Preparedness Plan by Maintenance Director on 8/27/2025; this education is added to new employee and agency orientation packets. Sign-in sheets are on file. Quarterly Audits Quarterly audits will review: (1) completeness of emergency contact lists; (2) evidence of collaboration with local, and county (3) documentation of training and drills; (4) generator logs; (5) food/water supply; (6) policies for continuity of care. Monthly Checks Maintenance Director/ Kitchen Manager will complete monthly checks of generator logs, food/water stock, and emergency contacts. Monthly results will be reported to QAPI. Monitoring will continue for at least 12 months or until QAPI determines sustained compliance. Completion Dates 8/27/2025 4. Monitoring to Ensure Sustained Compliance The Administrator and Maintenance Director will verify monthly that:	

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E0001	Continued from page 2 hears of potential disasters or emergencies, then she checks supplies (i.e. food and water) and coordinates with pharmacy for medication refills. She reported that the EP book could usually be found at the nursing station. She stated that during an emergency her role was to help ensure resident and staff safety. Furthermore, she reported her last in-person EP training was January 15, 2025. On 8/15/2025 at 1:58 PM The Administrator and Maintenance Director were interviewed. The Maintenance Director stated he provided in-person education with staff annually regarding information in the EP plan. The Administrator stated the plan was updated and reviewed on April 25, 2025, and that she and the Maintenance Director were responsible for updating the plan. The Maintenance Director reported that he had attempted to coordinate a second community-based exercise with the Gates County Fire Marshall a little over a month ago but had not heard back regarding a test date since then. The Administrator and Maintenance Director were unable to provide documentation specific to the facility regarding processes for cooperation and collaboration with local, regional, State, and Federal EP officials to maintain an integrated response during a disaster or emergency, names and contact information for other LTC facilities and the residents' physicians, primary and alternative means for communicating with LTC facilities staff and Federal, State, regional, and local emergency management agencies, and a method for sharing information and medical documentation for residents that were under the LTC facility's care with other health providers to maintain continuity of care. In addition, the EP plan did not have evidence a communication plan was developed and maintained that complied with Federal, State, and local laws and was reviewed and updated at least annually. The Administrator and Maintenance Director indicated they were not aware that the information in the EP plan needed to be specific to their facility.	E0001	Continued from page 2 • Generator test logs are complete. • Emergency food and water supply meets minimum standards. • Emergency contact lists are updated. The QAPI Committee will review quarterly audits and drill reports and take corrective action if issues are identified. Findings and corrective actions will be documented in QAPI minutes and maintained in the Emergency Preparedness Binder. Monitoring will continue for at least one year or longer if compliance issues are identified. 5. Policy Changes / Education Emergency Preparedness Policy updated 8/25/2025 to include: • Collaboration process with local/state/federal agencies. • Communication plan with primary/alternate methods. • Resident information-sharing protocols. Staff in-service training completed 8/27/2025 by Maintenance Director with Administrator oversight. Sign-in sheets filed. All new hires receive EP training on hire and annually thereafter. 6. Completion Date of Corrective Action August 27, 2025	
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/12/2025 through 08/15/2025. Event ID# 1D34AE-H1. The following intake was investigated #2578462. 1 of 5 complaint allegations resulted in deficiency.	F0000		09/27/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F0686	Corrective Action for Affected Residents: Resident #56 is receiving wound care per physician	08/27/2025

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F0686 SS = D	Continued from page 3 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with staff and the Wound Care Physician, the facility failed to (1) follow Physician's instructions to apply betadine (an antiseptic) and leave it open to air on a resident's right heel pressure wound, (2) ensure a resident's left buttock pressure ulcer was cleaned before applying a clean dressing, and (3) clean wounds starting from the center of the wound and moving to the outer edges of the wound in a continuous circular motion. This deficient practice affected 1 of 3 residents observed for pressure ulcers (Resident #56). Findings included: Resident #56 was readmitted on 08/06/25. Resident #56 had diagnoses of an unstageable pressure ulcer on the right heel and a stage 2 pressure ulcer on the left buttock. The Significant Change Minimum Data Set (MDS) dated 08/12/25 revealed Resident #56 was severely cognitively impaired with no behaviors. The MDS documented a stage 2 pressure ulcer and deep tissue injury. The MDS also showed Resident #56 was dependent on all activities of daily living. The care plan for Resident #56 dated 08/13/25 showed a focus for a stage 2 pressure ulcer to the left buttock and deep tissue injury (DTI) pressure ulcer to the right heel and potential for pressure ulcer development related to history of ulcers, and immobility. The goals for Resident #56 included the pressure ulcers would show signs of healing and remain free from infection. Interventions included administer treatments as ordered	F0686	Continued from page 3 order. On 8/15/2025 the Director of Nursing provided Nurse #2 education on strict adherence to physician orders including application of betadine; ensuring wounds are clean prior to applying a clean dressing; leaving wounds open to air, if ordered; cleaning a wound starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. On 8/15/2025 the Director of Nursing observed Nurse #2 perform wound care following strict adherence to physician orders including application of betadine; ensuring wounds were clean prior to applying a clean dressing; leaving the wounds open to air, if ordered; cleaning a wound starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. Identification of Other Residents: On 8/15/2025 the Director of Nursing, Assistant Director of Nursing, and Wound Care Nurse conducted a house-wide skin observation audit to identify all residents with skin integrity impairment. The residents identified with skin integrity impairment have the potential to be affected. Systemic Changes / Measures to Prevent Recurrence: On 08/21/25 the Wound Care Nurse Practitioner provided train-the-trainer education to the Director of Nursing, Assistant Director of Nursing, and Wound Care Nurse on performing wound care following strict adherence to physician orders including application of betadine; ensuring wounds were clean prior to applying a clean dressing; leaving the wounds open to air, if ordered; cleaning a wound starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. On or before 8/27/2025 the Director of Nursing, Assistant Director of Nursing, and / or Wound Care Nurse provided education and observation to each Licensed Nurse, including agency Licensed Nurses, on performing wound care following strict adherence to physician orders including application of betadine; ensuring wounds were clean prior to applying a clean dressing; leaving the wounds open to air, if ordered; cleaning a wound starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. After 08/27/2025 no Licensed Nurse or Agency will be permitted to work without receiving the aforementioned education by the Director of Nursing, Assistant	

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F0686 SS = D	Continued from page 4 and monitor for effectiveness and follow facility policies/protocols for the prevention/treatment of skin breakdown. A physician order dated 08/13/25 for the right heel wound care revealed: Cleanse the right heel with wound cleanser. Pat dry. Apply betadine and leave open to air every - day shift for DTI. A physician order dated 08/13/25 for the left buttock wound revealed: Cleanse with wound cleanser. Pat dry. Apply collagen particles (a protein that regulates wound healing and forms a protective barrier against bacteria) and medihoney (used for antibacterial and anti-inflammatory effects and removes dead wound tissue). Cover with dry dressing every - day shift for wound care. Review of wound care documentation written by the Wound Nurse Practitioner (NP) dated 08/07/25 revealed a right heel deep tissue injury (DTI). The DTI measured 4 x 3 x 0 centimeters (cm). The wound was described as improving with 100% epithelial tissue (a type of body tissue that covers internal and external surfaces) without drainage. Review of wound care documentation written by the Wound NP dated 08/13/25 revealed an unstageable right heel pressure ulcer and a stage 2 left buttock pressure ulcer. The right heel pressure ulcer measured 4 x 3 x 0 cm. The wound was described as deteriorating with 100% eschar (black, crusty, dead tissue over or around a wound) without drainage. The left buttock pressure ulcer measured 2 x 2 x 0.1 cm with a small amount of serosanguinous drainage (light pink to red colored fluid) affecting the dermis (middle layer of skin). Observation and interview for Resident #56's wound care occurred on 08/14/25 at 10:05 AM with Nurse #2, Wound Care Nurse, and Nurse Aide (NA) #3. Nurse #2 removed the old dressing from Resident #56's right heel that showed a circular eschar (black, crusty, dead tissue over or around a wound) area with a yellow-pink center. Nurse #2 wiped and patted the heel wound with wound cleanser and then obtained a gauze 4x4 that Nurse #2 had previously placed betadine on. Nurse #2 used the betadine 4x4 gauze to pat Resident #56's right heel. She then used a clean 4x4 gauze and wiped over the betadine area of the right heel and replaced Resident #56's sock. Nurse #2 explained she was wiping off any excess betadine from Resident #56's heel. The Wound Care Nurse at this time spoke with Nurse #2 and told her that the heel was to have a generous amount of betadine and left to dry to air. Nurse #2 voiced	F0686	Continued from page 4 Director of Nursing, or Wound Care Nurse. Ongoing the education incorporated into orientation and annual skills check. Monitoring & Sustaining Compliance: The Director of Nursing or Assistant Director of Nursing will conduct one random observation wound care weekly for four weeks, then monthly for two months, then as directed by the facility's Quality Assurance Performance Improvement Committee. Any variance from the physician order or proper technique will result in immediate re-training and follow-up observations. Results of the observation audits will be presented by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. Completion Date: 08/27/2025	

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F0686 SS = D	Continued from page 5 understanding however Nurse #2 nor the Wound Care Nurse corrected the wound care that was provided. Continued observation of wound care at 10:20 AM revealed after performing hand hygiene, Nurse #2 moved to Resident #56's left buttock wound. NA #3 was observed holding Resident #56 on his right side. Resident #56 was wearing a brief. The brief was observed not to have any visible contamination. Nurse #2 unfastened the brief and removed the old dressing. There was no drainage observed on the old dressing. Nurse #2 obtained a 4x4 gauze that contained wound cleanser and proceeded to wipe Resident #56's wound from the bottom of the wound to the top then left outer edge to the right outer edge. When Nurse #2 turned to perform hand hygiene and obtain the clean dressing, NA #3 was observed to lay Resident #56 back onto his brief allowing the clean wound to touch his brief. Nurse #2 returned with the clean dressing and applied the dressing to Resident #56's left buttock wound without re-cleaning the area. The Wound Care Nurse was interviewed on 08/14/25 at 10:45 AM. All wound care provided for Resident #56 was reviewed. The Wound Care Nurse stated the left buttock wound touching the resident's brief, after it was cleaned, was acceptable due to the brief usually being changed prior to the wound care by the Nurse Aides. She stated a clean barrier did not need to be placed under the resident's buttocks due to the brief being clean. The Wound Care Nurse stated wounds did not have to be cleaned by starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. She stated wounds could be cleaned by swiping from the center of a wound and outward repeatedly and was acceptable if the process began at the center of the wound. The Wound Care Nurse stated she did not realize Nurse #2 had not cleaned the wound starting from the center. The Wound Care Nurse stated that it was difficult to see betadine on a person of color due to skin tone; therefore, betadine could not be visualized during each treatment. She verified she was knowledgeable with the Wound NP's orders and preferences regarding wound care. She stated that Nurse #2 was nervous during the observation. The Wound Care Nurse confirmed Nurse #2 did not provide wound care often. She stated that she did not supervise wound care treatment for each resident because the other nurses knew how to provide the treatment but that she was available if needed. During an interview with Nurse #2 on 08/15/25 at 9:10 AM via telephone, Nurse #2 denied she had received wound care education from the Wound NP. She discussed	F0686		

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F0686 SS = D	Continued from page 6 not providing wound care to the residents very often and received education from the Wound Care Nurse. Interview with the Wound NP by phone on 08/14/25 at 11:25 AM confirmed she was familiar with Resident #56. Her wound care orders were reviewed. The Wound NP explained Resident #56's heel wound should be cleansed with gauze saturated with wound cleanser. She stated the wound should be cleaned using the technique of wiping the wound starting at the center of the wound and moving to the outer edges of the wound in a continuous circular motion. A clean gauze should be used to pat the wound dry. Lastly, the Wound Nurse NP stated the wound should be wiped from the center of the wound and moving to the outer wound edges of the wound in a continuous circular motion, with gauze saturated in betadine. The betadine should be left to air dry. She explained she expected the Wound Care Nurse to be generous with the betadine. The Wound NP stated socks/heel protectors should be placed after the betadine had completely air-dried. The Wound NP stated the right heel wound care should have been repeated using the process previously described. She stated she tried to provide education to the nurses to use copious amounts of betadine for wound care requiring betadine. Next, Resident #56's left buttock wound care was discussed. The Wound NP stated gauze saturated with wound cleanser should be used to clean the wound as previously described and patted dry. Then, the medihoney and collagen should be applied and covered with an adhesive dry dressing. The Wound NP was informed of the observation of the left buttock wound care performed today (08/14/25) that included the wound being cleaned by wiping in an upward motion and side-to-side; and the resident being laid down on the brief after the wound was cleaned and the clean dressing being applied without re-cleaning the wound. The Wound NP stated the wound should have been recleaned after the wound contacted the resident's brief. She stated wound care was done using clean technique and not by sterile technique. A clean barrier should have been placed under the resident's buttocks prior to the wound care being performed. During weekly facility visits, the Wound NP stated she provided education on correct wound care technique to the staff nurses. An interview with the Wound Care Nurse was conducted on 08/15/25 at 7:58 AM. The Wound Care Nurse stated she was aware the Wound NP expected betadine to be used liberally on Resident #56's heel. She stated she was aware when Nurse #2 did not provide this treatment and stated betadine was applied.	F0686		

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F0686 SS = D	Continued from page 7 The Director of Nursing (DON) was interviewed on 08/15/25 at 4:07 PM. The DON stated wounds did not have to be cleaned by starting at the center of a wound and moving to the outer edges of the wound in a continuous circular motion. She explained Resident #56 was a resident of color and that betadine was difficult to see on a person of color. She also stated she was not aware the Wound NP expected betadine to be used liberally on a wound. The DON also discussed Resident #56's left buttock wound and stated she did not think the wound should have been re-cleaned after being placed on his brief. The DON stated the Wound Care Nurse was responsible for providing wound care education. Interview with the Administrator on 08/15/25 at 4:27 PM revealed the Wound Care Nurse had made her aware of the wound care treatment on 08/14/25 for Resident #56. She confirmed Nurse #2 was nervous and did not routinely provide wound care. The Administrator explained Nurse #2 was knowledgeable in how to provide wound care but was nervous having the Wound Care Nurse, and surveyors present. She stated the Wound Care Nurse was available to assist/educate any staff providing wound care.	F0686		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives	F0690	Corrective Action for Affected Residents: Resident #56 catheter cover bag has been repositioned off the floor to reduce the risk of infection 08/15/2025 Identification of Other Residents: On 8/15/25 at 8:15 P.M. the Director of Nursing performed a facility-wide audit of all residents with urinary catheters was performed to ensure catheter bags were properly positioned off the floor to reduce the risk of infection. All catheter bags were correctly positioned during the observational audit. Systemic Changes / Measures to Prevent Recurrence: On 8/21/2025 the Director of Nursing and Assistant Director of Nursing provided education to the Licensed Nurses and Certified Nursing Staff and Agency on placement of catheter bags to assure the bags are not on the floor due to potential risk of infection. After 08/27/2025 no Licensed Nurse or Certified Nursing Assistant will be permitted to work without receiving the aforementioned education by the Director of Nursing or Assistant Director of Nursing. Ongoing the aforementioned education incorporated into orientation.	08/27/2025

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F0690 SS = D	Continued from page 8 appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to keep a urinary catheter drainage bag from touching the floor to reduce the risk of infection for 1 of 1 resident reviewed for urinary catheter (Resident #56). Findings included: Resident #56 was readmitted on 08/06/25. Related diagnoses included urinary tract infection, chronic kidney disease, bacteremia (bloodstream infection), pyonephrosis (kidney infection). Physician order dated 08/06/25 for an indwelling urinary catheter to straight drainage related to acute kidney injury and secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction every shift for acute kidney injury. The significant change Minimum Data Set (MDS) dated 08/12/25 revealed Resident #56 was severely cognitively impaired without behaviors. The MDS documented an indwelling urinary catheter. The MDS showed Resident #56 was dependent on rolling left to right and lying to sitting on the side of the bed was not attempted. Care plan for Resident #56 dated 08/13/25 showed a focus for an indwelling catheter. The goals were for the resident to be/remain free from catheter-related trauma; and the resident will show no signs and symptoms of urinary infection. Interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door and check tubing for kinks. On 08/15/25 at 8:08 AM an observation of Resident #56 showed the resident lying in bed. The indwelling urinary catheter bag was observed positioned below the level of the bladder on the floor and partially under the bed, covered with a privacy bag.	F0690	Continued from page 8 Monitoring & Sustaining Compliance: Director of Nursing or Assistant Director of Nursing will conduct random catheter care audits at random times twice a week for one month, then weekly for two months. If a catheter bag is noted on the floor, it will be repositioned appropriately off of the floor and re-education will be provided by the Director of Nursing and Assistant Director of Nursing to the Licensed Nurse and Certified Nursing Assistant. Results of the observation audits will be presented by the Director of Nursing to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. Completion Date: 08/27/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0690 SS = D	Continued from page 9 Another observation on 08/15/25 at 8:53 AM showed the indwelling urinary catheter bag was positioned below the level of the bladder on the floor and partially under the bed, covered with a privacy bag. Follow-up observation on 08/15/25 at 10:10 AM revealed the catheter bag remained positioned below the level of the bladder on the floor covered with the privacy bag. A subsequent observation on 08/15/25 at 11:39 AM revealed the catheter bag remained on the floor covered with the privacy bag. Interview with Nursing Aide (NA) #2 on 08/15/25 at 1:32 PM confirmed that she was assigned to Resident #56. The NA observed the resident's catheter on the floor with the surveyor. NA #2 stated the catheter should not be touching the floor. She stated she did not know how the catheter ended up on the floor because she had hung it up on the side of the bed after providing Resident #56 with morning care. NA #2 stated the resident could not reach the catheter bag to knock it on the floor. Interview with Nurse #3 on 08/15/25 at 2:51 PM confirmed she was assigned to Resident #56. Nurse #3 stated she was unaware of the catheter bag lying on the floor. She confirmed that she had been in the resident's room throughout the day (08/15/25) and had not assessed the catheter and/or catheter bag. She stated she assessed catheters once per shift. Interview with the Director of Nursing (DON) on 08/15/25 at 4:07 PM revealed NA #2 made her aware Resident #56's catheter bag was lying on the floor. She acknowledged the bag should not be lying on the floor. Stated there were areas on the bedframe that were thinner and could be used to clip the bag to those areas. The DON stated the bag clip may be broken and the bag may need to be replaced. Interview with the Administrator on 08/15/25 at 4:27 PM revealed she was made aware of the catheter on the floor by NA #2 and that it should not be on the floor. She stated that it was difficult to keep catheter bags off the floor when the bed was in the lowest position. The Administrator stated that the resident could be responsible for the catheter drainage bag being on the floor by knocking it off.	F0690		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812	Tag F0812 – Food Procurement, Storage, Preparation & Sanitary Practices Corrective Action for Affected Residents:	08/27/2025

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F0812 SS = F	Continued from page 10 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to keep 1 of 1 walk-in refrigerator walls free of a dark black/green substance. The Findings Included: An initial tour of the kitchen was conducted on 8/12/2025 at 10:20 am. A dark black /green substance was observed on all four walls of the walk-in refrigerator. An area located under the refrigerator rack and adjacent to the walk-in freezer door was observed to have a large area of a dark black/green substance in the corner that extended to the floor. An interview and observation were conducted on 8/12/2025 at 10:25 am of the walk-in- refrigerator with the Dietary Manager. Upon observation of the walk-in refrigerator, the Dietary Manager stated she did not know what the substance was on the walk-in refrigerator walls. She further stated the dietary staff cleaned the walk-in- refrigerator every Wednesday. Although the walk-in refrigerator was cleaned, the substance continued to come back. The Dietary Manager indicated she had not notified the Maintenance Director or the Administrator that the substance continued to return.	F0812	Continued from page 10 The walk-in refrigerator with dark black-green substance on all four walls was immediately cleaned, sanitized, and re-inspected. Affected food items were discarded. Identification of Other Residents: Residents who receive nutrients from the dietary department are identified as having the potential to be affected. Systemic Changes / Measures to Prevent Recurrence: On 08/27/2025 Dietary staff were re-educated by the Nursing Home Administrator on food storage and sanitation policy with emphasis on: daily cleaning logs for refrigerators/freezers; weekly deep cleaning schedule posted and signed off by Dietary Manager; and any noted dark green or black colored substances must be reported immediately to Maintenance. Monitoring & Sustaining Compliance: Dietary Manager/Assistant Dietary Manager will complete five times a week walk-in refrigerator inspection for one month then weekly for two months. Dietary Manager / Assistant Dietary Manager will observe for any black-green substance or discoloration. Maintenance Director and Nursing Home Administrator will be notified with any concerns noted on observation. Findings will be documented and submitted to Nursing Home Administrator. Results of the observation audits will be presented by the Dietary Manager to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. Completion Date:08/27/2025	

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F0812 SS = F	Continued from page 11 Interview and observation with the Maintenance Director on 8/12/2025 at 10:36 am revealed the dark black/green substance in the walk-in refrigerator appeared to be mold. He further revealed that what appeared to be mold could have been due to condensation. If the walk-in refrigerator door was not closed properly, the door seal would not ensure the walk-in refrigerator stayed cooled. The Maintenance Director stated he had not been notified of the substance in the walk-in refrigerator or that when it was cleaned it would return. An interview with the Administrator on 8/15/2025 at 4:51 pm revealed she had observed the walk-in refrigerator on 8/12/2025. She revealed she did not know what the substance was, but it was dark in color. She thought the substance was from when the walk-in refrigerator doors were not being closed properly. An outside agency had cleaned the walk-in refrigerator months ago, but she was not informed that the black substance had come back. She was unaware the Maintenance Director had no knowledge of the dark black/green substance.	F0812		