STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345229**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/11/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources- Shelby	**1101 North Morgan Street , Shelby, North Carolina, 28150**

(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 02/08/26 through 02/11/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 1E2FD6-H1.	E0000		02/26/2026
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 02/08/26 through 02/11/26. Event ID:1E2FD6-H1. The following intakes were investigated: 2716398, 2724334, 2712433, 2710030, 2666763, 2663331, 2638594, 2644369, 748942, 748939, 748937 and 748933. 3 of 36 complaint allegations resulted in deficiency. This survey was originally scheduled to start on 01/26/26 but due to Winter Storm Fern travel was unsafe. The survey had to be rescheduled again on 02/02/26 due to QSO 26-04-All Federal Government Shutdown and Winter Storm Gianna which again made travel unsafe.	F0000		02/26/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F0580	POC F580 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Resident Affected: The Physician Assistant (PA) was notified on 12/29/2025 that the resident had not received the medication as ordered on multiple occasions due to an incomplete medication order. The PA clarified the medication order on 12/29/2025 and the order was transmitted to the pharmacy and delivered on 12/29/2025. Resident #75 refused the next two doses and did not receive the	03/03/2026

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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F0580 SS = D	Continued from page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Physician Assistant interviews, the facility failed to notify the Physician/Physician Assistant when a resident did not receive a prescribed medication for 1 of 1 resident reviewed for notification (Resident #75). The findings included: Resident #75 was admitted to the facility on 3/14/25	F0580	Continued from page 1 medication until 01/19/2026. The residents did not suffer any adverse effects related to alleged deficient practice. Nurse #1 and Nurse #2 were educated by DON on 2/11/2026 regarding requirement to notify the Physician and/or PA regarding any incomplete medication orders and if/when a resident does not receive a medication as ordered. Other Residents with potential to be affected: An audit was completed by the Director of Nursing (DON)/designee on 2/27/26 for all residents that had not received medications as ordered for the past 14 days. The Physician and/or PA were notified by the DON on 2/27/2026 regarding the missed medication administrations. The PA did not give any additional orders regarding the missed administration for any residents. No residents suffered any adverse effect related to the alleged deficient practice. Systemic changes: All licensed nurses and medication aides, including agency nurses, were educated that the physician/PA must be notified of any/ all medications that are not administered as ordered. This education was completed by February 16th, 2026, by Staff Development Coordinator (SDC). Any licensed nursing staff or medication aide out on leave or PRN (as needed) status will be educated prior to returning to duty by the DON, Nurse in Charge, and/or their designee. Newly hired licensed nursing staff, medication aides and agency nursing staff are educated on this process during orientation by the Staff Development Coordinator (SDC). Monitoring: The Administrator, Director of Nursing, Nurse in Charge, and/or RN Supervisor will audit 25% of all missed medication administrations daily, Monday through Friday, x 2 weeks, then weekly x 2 weeks, then biweekly x 4 weeks, then monthly x 1 month to ensure that the Physician and/or the PA was notified of any medication not administered as ordered. The results of these audits will determine the need for further monitoring. QAPI: The results of the monitoring tool will be brought to the monthly Quality Assurance and Performance	

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F0580 SS = D	Continued from page 2 with a diagnosis of type 2 diabetes. Resident #75's physician orders and medication administration record (MAR) revealed the following: On 11/25/25 a physician order was written for semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays. The MAR indicated it was administered on 12/01/25 at 8:00 AM (Nurse #2), was not administered on 12/08/25 due to the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). On 12/22/25 semaglutide (0.25 mg or 0.50 mg) was discontinued. A review of Resident #75's medical record revealed there was no documentation indicating the Physician/Physician Assistant had been notified that semaglutide was not administered as ordered. An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available in the medication room on 12/01/25 or 12/08/25 or 12/15/25 and she did not administer the medication. Nurse #2 stated she documented on the MAR in error that she administered the semaglutide on 12/01/25 and that Resident #75 refused the medication on 12/08/25 and she should have documented the medication was not administered because it was unavailable. Nurse #2 indicated she notified the provider when a resident did not receive a prescribed medication, however she did not recall if she notified the Physician Assistant that Resident #75 had not received the semaglutide. An interview conducted with the Physician Assistant on 2/11/26 at 1:25 PM revealed she gave a new order on 11/25/25 for Resident #75 to start semaglutide 0.25 mg to help regulate her blood sugars and assist with weight loss. The Physician Assistant stated she entered the order in the electronic medical record (EMR) and notified Nurse #1 the order was ready to be sent to the pharmacy. The Physician Assistant stated she was not notified that the order sent to the pharmacy did not have the dose of the medication or that the medication was not delivered until 12/29/25. The Physician Assistant revealed there were no adverse outcomes from	F0580	Continued from page 2 Improvement Committee for three months by the DON for further review and recommendations. Completion date: 3/3/26	

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F0580 SS = D	Continued from page 3 Resident #75 not receiving the semaglutide starting in November however the facility should have notified her that Resident #75 was not receiving the medication. An interview conducted with the Administrator on 2/11/26 at 3:42 PM revealed the Physician/Physician Assistant should be notified when a resident was not receiving a prescribed medication whether the medication was unavailable or the resident refused to take the medication.	F0580		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641		02/27/2026

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F0641 SS = A	Continued from page 4 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Prognosis and Hospice for 1 of 20 residents reviewed for accuracy of assessments (Resident #111). Findings included: Resident #111 was admitted to the facility on 10/31/2025 with diagnoses which included history of a cerebral infarction (a type of stroke caused by a blockage in a blood vessel supplying the brain, resulting in tissue death from lack of oxygen), vascular dementia, severe protein calorie malnutrition and adult failure to thrive. A review of a Hospice Recertification Summary Report dated 11/11/2025 indicated Resident #111 was receiving Hospice services prior to admission to the facility with a start of care date of 12/13/2024. It further indicated that a recertification of Resident #111's prognosis of 6 months or less was received on 9/24/2025 from the physician. A discharge MDS assessment dated 1/11/2026 for Resident #111 was not coded that Hospice services were received or for a prognosis of 6 months or less. Resident #111 was discharged to the hospital on 1/11/2026. An interview on 2/9/2026 at 3:00 PM with MDS Coordinator #1 was conducted. The MDS Coordinator stated she completed the discharge MDS assessment dated 1/11/2025 and should have coded yes for Hospice services and yes for the prognosis of 6 months or less. The MDS Coordinator stated the incorrect coding was a mistake on the MDS assessments and the MDS should have been coded correctly. An interview on 2/9/2026 at 3:15 PM with the Interim Director of Nursing (DON) indicated the MDS assessment should be correct. An interview on 2/11/2026 at 3:45 PM with the Administrator indicated that the MDS assessments should always be accurate.	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as	F0658	POC F658 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted	03/04/2026

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NAME OF PROVIDER OR SUPPLIER: Peak Resources- Shelby	STREET ADDRESS, CITY, STATE, ZIP CODE: 1101 North Morgan Street , Shelby, North Carolina, 28150		

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F0658 SS = D	Continued from page 5 outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Pharmacist, Physician Assistant, Medical Director, resident and staff interviews, the facility failed to respond to the pharmacy's request for a corrected physician order with the dosage information of a medication to ensure a resident's medication was obtained and administered as ordered for 1 of 3 residents reviewed for professional standards (Resident #75). The findings included: Resident #75 was admitted to the facility on 3/14/25 with a diagnosis of type 2 diabetes. The Physician Assistant note dated 11/25/25 revealed Resident #75 was evaluated due to a weight gain of approximately 15 pounds in 3 months. Resident #75 had a diagnosis of type 2 diabetes and was receiving scheduled insulin but was not complying with a diabetic diet which likely contributed to the weight gain. Resident #75 was agreeable to starting semaglutide to help with regulating her blood sugars and to assist with weight loss. A new order was given to start semaglutide 0.25 mg once a week on Mondays. Resident #75's physician orders and Medication Administration Record (MAR) revealed the following: On 11/25/25 a physician order was written for semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays. The MAR indicated semaglutide (0.25 mg or 0.50 mg) was administered on 12/01/25 at 8:00 AM by (Nurse #2), was not administered on 12/08/25 with a note the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). On 12/22/25 semaglutide (0.25 mg or 0.50 mg) was discontinued per physician's order. On 12/29/25 semaglutide 0.25 mg was ordered to be administered subcutaneously once a week on Mondays. The MAR indicated semaglutide 0.25 mg was not administered on 1/05/26 or 1/12/26 due to resident refusal (Nurse #2), was administered on 1/19/26 at 8:00 AM (Staff Development Coordinator) and was administered	F0658	Continued from page 5 to meet requirements established by the state and federal law. Affected Resident On 12/29/25 the Nurse in Charge clarified the medication order with the resident's physician with the accurate amount to administer and the complete order was transmitted to the pharmacy. The medication was received on 12/29/25 and administered to the resident on 1/19/26 by the Nurse, due to refusals of two prior doses. The resident did not suffer any adverse effects related to alleged deficient practice. Nurse #1, Nurse #2 and Nurse #3 were educated by the Director of Nursing (DON) on 2/11/2026 regarding clarifying incomplete medication orders to ensure residents medication was obtained and administered as ordered. Other Residents who could potentially be affected An audit of all orders entered into the electronic health record (EHR) written by the Physician Assistant (PA) that requires nurse verification were reviewed to ensure that the order was complete and that the medication was delivered to the facility and administered as ordered. This was completed by DON/Designee on 2/27/26. No new concerns were identified. No residents suffered any adverse effect related to the alleged deficient practice. Systemic Changes to Prevent Recurrence All licensed nurses were educated on the following: nurses are required to seek clarification from the authorized prescriber if a medication order is illegible, incomplete, or inappropriate orders entered into the electronic health record by the PA must be verified for accuracy, which includes the dosage to be administered, by the end of their shift. This was completed by Staff Development Coordinator (SDC) February 26, 2026. All licensed nurses and medication aides were educated on general practices for medication administration which include ensuring that all medication orders are complete and any discrepancies in the medication order	

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F0658 SS = D	Continued from page 6 on 1/26/25 at 8:00 AM (Nurse #3). The quarterly minimum data set (MDS) assessment dated 1/25/26 revealed Resident #75 was cognitively intact, had an active diagnosis of diabetes mellitus, and received insulin injections 7 out of 7 days during the assessment period. The care plan dated 1/30/26 revealed Resident #75 was at risk for hypoglycemic (low blood sugar) and hyperglycemic (high blood sugar) episodes due to a diagnosis of diabetes. The interventions included providing a diabetic snack at bedtime, monitoring for signs of hyperglycemia and hypoglycemia and notifying the physician if blood sugar readings were below 60 or above 450. An interview was conducted with Resident #75 on 2/09/26 at 3:09 PM. Resident #75 revealed on 11/25/25 the Physician Assistant ordered semaglutide to help regulate her blood sugars and assist with weight loss. Resident #75 indicated the medication was not administered until January 2026, but she did not question anyone about the delay because it usually took a while for the facility to get new medications from the pharmacy. Resident #75 stated she did refuse the first two doses of the semaglutide in January because she had a few questions for the Physician Assistant concerning possible reactions. Resident #75 stated the semaglutide was administered as ordered on 1/19/26 and 1/26/26. An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available on 12/01/25 or 12/08/25 or 12/15/25 and was not administered. Nurse #2 stated when a resident's medication was not administered because it was unavailable she notified Nurse #1 and the provider, but she did not recall if she notified them concerning Resident #75 not receiving the semaglutide. Nurse #2 revealed the semaglutide was available on 1/05/25 and 1/12/25 but Resident #75 refused it because she had a few questions for the Physician Assistant concerning possible reactions. Nurse #2 stated she documented on the MAR in error that she administered semaglutide to Resident #75 on 12/01/25 and that it was refused on 12/08/25 and she should have documented on the MAR that the medication was unavailable. An interview conducted with Nurse #1 on 2/11/26 at 8:56 AM revealed she was the first shift (7:00 AM to 3:00 PM) unit manager. Nurse #1 stated when a resident had a	F0658	Continued from page 6 are clarified with the provider immediately. This was completed by February 26th, 2026, by SDC. Any licensed nursing staff or medication aide out of leave or PRN (as needed) status will be educated prior to returning to duty by the SDC, Director of Nursing (DON), Nurse in Charge and/or their designee. Newly hired licensed nursing staff or medication aides and agency nurses are educated on this process during orientation by the SDC/designee. Monitoring and Quality Assurance The DON, Nurse in Charge and/or designee will audit 50% of all medication orders entered into the electronic health record by the PA to ensure that the order has been verified for completeness timely and that the medication has been delivered and administered as ordered. These audits will be done daily, Monday through Friday, x 2 weeks, then weekly x 2 weeks, then biweekly x 4 weeks, then monthly x 1 month. QAPI The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting x 3 months for further review Completed by: The facility will be in full compliance with F658 by 3/4/26 .	

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F0658 SS = D	Continued from page 7 new medication order it was entered into the electronic medical record (EMR), verified and then sent electronically to the pharmacy. Nurse #1 revealed the Physician Assistant entered an order in the EMR on 11/25/25 for Resident #75 to start semaglutide. Nurse #1 indicated she verified the order in the EMR and sent it to the pharmacy on 11/28/25. Nurse #1 stated she was not aware the dose of semaglutide was not on order or that the pharmacy needed the order to be clarified. During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the dosage information. He stated the Former Director of Nursing (DON) was notified on 11/25/25, 12/03/25, 12/17/25 and 12/22/25 that the order needed to be resent with the dosage information so the pharmacy could dispense and deliver the medication. The Pharmacist revealed the facility sent a new order on 12/29/25 for semaglutide 0.25 mg to be administered subcutaneously once a week and the medication was delivered to the facility on 12/29/25. Several attempts made to contact the Former DON were unsuccessful. An interview conducted with the Physician Assistant on 2/11/26 at 1:25 PM revealed she evaluated Resident #75 on 11/25/25 due to a weight gain of approximately 15 pounds in three months. The Physician Assistant revealed she consulted with the Medical Director, and he agreed with starting semaglutide, so she entered the order in the EMR on 11/25/25. The Physician Assistant stated she was not notified the pharmacy needed the order for semaglutide to be clarified, or that Resident #75 was not administered the medication until 1/19/26. The Physician Assistant stated there were no adverse outcomes from Resident #75 not starting semaglutide however resident medications should be administered as ordered. During a phone interview with the Medical Director on 2/11/26 at 1:14 PM he revealed the Physician Assistant did consult him regarding Resident #75's weight gain and varying blood sugars and he agreed with starting semaglutide. The Medical Director stated Resident #75 not receiving the semaglutide would not have caused an adverse outcome however resident medications should be administered as ordered. An interview conducted with the Administrator on 2/11/26 at 3:42 PM when the pharmacy notified the Former DON the order sent for Resident #75 to start semaglutide did not include the dosage information, she	F0658		

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F0658 SS = D	Continued from page 8 should have clarified the order with the Physician Assistant and sent the updated order to the pharmacy. The Administrator indicated medications should be obtained from the pharmacy and administered to the residents as ordered by the physician.	F0658		
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 3 residents reviewed for foot care (Resident #63). Finding included: Resident #63 was admitted on 08/18/25 with diagnoses that included coronary artery disease (CAD), hypertension, diabetes mellitus and cerebrovascular accident (CVA). Resident #63's care plan revised on 12/07/25 revealed Resident #63 was care planned for activities of daily living (ADL) care. The goals included extensive and total staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff assistance with grooming and personal hygiene. Resident #63 was noted to walk independently with a cane. The quarterly Minimum Data Set (MDS) dated 12/18/25 revealed Resident #63's cognition was assessed as moderately impaired and he was independent with upper	F0687	POC F687 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected resident Resident #63 toenails were assessed immediately by a licensed nurse on 02/10/2026. A podiatry referral was placed the same day by facility staff. Resident #63 attended an appointment at the Podiatrist office on 02/18/2026 and his toenails were trimmed by the Podiatrist at that time. Resident #63 did not suffer any sustained adverse effects related to the alleged deficient practice. Other Residents who may be affected 100% of residents' toenails were observed by facility nursing staff on 2/17/26. All residents requiring toenail care had their toenails trimmed by facility nursing staff or were referred to the podiatrist for toenail care. No residents suffered any sustained adverse effects related to the alleged deficient practice. Systemic changes to prevent recurrence All licensed nursing staff, medication aides and Certified Nursing Assistants (CNA's) were educated by Staff Development Coordinator (SDC) on foot care. The education included the following: Nursing staff will observe residents' toenails daily and provide nail care for overgrown toenails Residents with Diabetes and/or circulatory disorders will be referred to the Podiatrist for routine foot/toenail care. Nurses are permitted to clip all other residents'	02/19/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources- Shelby	**1101 North Morgan Street , Shelby, North Carolina, 28150**

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F0687 SS = D	Continued from page 9 and lower body dressing, putting on/taking off footwear and personal hygiene. Resident #63 was coded as independent for ambulation with use of a walker as a mobility device. He was not coded for rejection of care during the assessment period. Resident #63's most recent weekly skin assessment completed by Nurse #1 dated 02/05/26 revealed no notation that the resident's toenails were long, thick and needed trimming or a referral for podiatrist's care. Review of the facility's podiatry clinic schedule for February 2026 revealed Resident #63 was not scheduled to be seen by the podiatrist. Resident #63's medical record from admission through 02/11/26 revealed no consultation reports or notations in Resident #63's medical record that he had been seen by a podiatrist. An observation and interview were conducted with Resident #63 on 02/08/26 at 11:37 AM. During the interview he removed his socks and showed the surveyor his toenails on the left foot. The toenails were observed to be thick and long extending past his toenail bed. Resident #63 stated, "When I put my shoes on it hurts, I need them cut." When the surveyor asked Resident #63 if he had told a staff member he stated, "Oh, I don't want to bother them, but they've seen." On 02/10/26 at 2:45 PM an observation of Resident #63's left foot toenails was conducted with Nurse #1. Resident #63's toenails were observed to be thick and long. The left hallux (innermost digit of the foot) toenail was curved to the side. Resident #63 stated to Nurse #1 that he was having some discomfort when he walked and while putting his shoes on. An interview was conducted with Nurse #1 on 02/10/26 at 2:50 PM. During the interview she stated she had conducted the resident's weekly skin assessment on 2/05/26. She stated she noticed his toenails were long at that time but didn't document it because the resident didn't have any complaints about them. Nurse #1 stated she felt like Resident #63 needed a podiatry consult after observing his toenails with the surveyor.	F0687	Continued from page 9 toenails. All other facility staff can only use nail files or orange sticks to perform care to residents' toenails. This education was completed by 02/16/2026. Any licensed nursing staff, medication aide or CNA out on leave or PRN (as needed) status will be educated prior to returning to duty by the Staff Development Coordinator (SDC), Director of Nursing (DON), or Nurse in Charge. Newly hired licensed nursing staff, medication aides, CNA's and agency nursing staff are educated on this process during orientation by SDC. Monitoring and quality assurance The DON, Nurse in Charge or Designee, will audit the condition of residents' toenails on 5 residents weekly for 4 weeks, then biweekly for 4 weeks, then monthly for 1 month. The audits will verify that toenails trimmed and podiatry referrals are made timely, as needed. QAPI The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting x 3 months for further review and recommendations. Completion date The facility will be in full compliance by 2/19/26.	

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F0687 SS = D	Continued from page 10 An interview was conducted with Nurse Aide (NA) #1 on 02/10/26 at 2:52 PM. She stated she was responsible for Resident #63 during the 7:00 AM to 7:00 PM shift. NA #1 stated she had not seen the residents' toenails because he was always wearing his socks, which he applied independently. The interview revealed Resident #63 wanted to take his own baths in his room. Staff would provide set-up assistance only. She explained Resident #63 would also dress himself, so she had not seen his toenails, nor had he mentioned he was experiencing discomfort with the length of his toenails. An interview was conducted with NA #2 on 02/11/26 at 12:05 PM. During the interview she stated she had provided Resident #63 with set-up assistance for a bath on 2/08/26. She stated she did not observe Resident #63's toenails while caring for him because he dressed himself. An observation was conducted on 02/11/26 at 4:39 PM with the Wound Care Nurse. The Wound Care Nurse was observed measuring Resident #63's toenails on the left foot. The length of the toenail measurements were as follows: hallux 3 centimeters (cm), index (second) 1.9 cm, middle 1.6 cm, ring (fourth) 1.4 cm, and pinky (fifth) 1.1 cm. The Wound Nurse stated, "his toenails are long and need to be trimmed by the podiatrist." An interview was conducted with the Director of Nursing (DON) on 02/11/26 at 2:46 PM. The DON stated the NAs should have been alerting the nurses and the nurses should have assessed Resident #63's toenails during weekly skin assessments. She stated if the nursing staff thought Resident #63's toenails were too long, they could have placed him on the podiatry list and obtained consent from the Responsible Party. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 02/11/26 at 10:24 AM. The Administrator stated nobody had mentioned to her that Resident #63's toenails were long nor had he come to her and voiced concerns regarding his toenails hurting or difficulty ambulating. The Administrator stated normally the nurses were very good about following through if a resident needed to be seen by the podiatrist. The Administrator indicated she expected all residents to receive podiatry services when needed and Resident #63	F0687		

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F0687 SS = D	Continued from page 11 would be receiving services moving forward.	F0687		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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, staff and Pharmacist interviews, the facility failed to ensure a prescription that was sent to the pharmacy to be filled contained complete prescribing information for a diabetic medication so that the prescription could be filled and further failed to respond to attempts by the pharmacy to reach the facility to get a corrected physician order for 1 of 5 residents (Resident #75) reviewed for pharmacy services.	F0755	POC F755 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Residents: On 12/29/2025, the Physician Assistant (PA) for Resident #75 was notified of the incomplete medication order for Resident #75's Ozempic injection. A complete and accurate medication order was obtained by facility nursing staff and transmitted to the pharmacy on 12/29/2025. The medication was delivered to the facility the same day. Resident #75 refused the administration of the medication on 12/29/2025 and 01/05/2026. Nursing administration was not aware of the incomplete order or missed administrations until 02/09/2026. The resident was assessed by nursing staff on 2/10/26 for any adverse effects, and no negative outcomes were identified. Other residents who could be affected 100% of all new medication orders entered into the electronic health record for the past 14 days were reviewed by the Director of Nursing (DON) and/or the Nurse in Charge to ensure medication orders were complete and accurate and were transmitted to the pharmacy timely. This was completed on 2/27/26. No additional residents were found to have experienced delays in medication dispensing due to incomplete orders. Systemic changes to prevent recurrence On 2/26/2026, the Staff Development Coordinator (SDC), the DON, and/or the Nurse in Charge educated all licensed nurses and medication aides on the following: A complete prescription order consists of the following: Medication name, strength, dosage, form, route, and directions for administration	03/03/2026

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F0755 SS = D	Continued from page 12 The findings included: Resident #75 was admitted to the facility on 3/14/25 with diagnoses that included type 2 diabetes. The Physician Assistant note dated 11/25/25 revealed Resident #75 was evaluated due to a weight gain of approximately 15 pounds in 3 months. Resident #75 had a diagnosis of type 2 diabetes and was receiving scheduled insulin but was not complying with a diabetic diet which likely contributed to the weight gain. Resident #75 was agreeable to starting semaglutide (medication used to control diabetes and to lose weight) to help with regulating her blood sugars and to assist with weight loss. A new order was given to start semaglutide 0.25 mg once a week on Mondays. Review of a physician order dated 11/25/25 read; semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays and the order was discontinued on 12/22/25. The MAR indicated the medication was administered on 12/01/25 at 8:00 AM (documented it was given in error by Nurse #2), was not administered on 12/08/25 due to resident refusal (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 from 7:00 AM to 7:00 PM as needed to assist with medication administration. Nurse #2 indicated on 12/01/25 or 12/08/25 or 12/15/25 she did not administer the semaglutide to Resident #75 because it was not available in the medication room. Nurse #2 revealed when a medication was unavailable for a resident, she sent a refill request to the pharmacy in the electronic medical record (EMR) and notified Nurse #1 and the provider if the resident missed a dose of the medication. Nurse #2 stated because the semaglutide was a new medication order she just thought it had not been delivered yet and she did not call the pharmacy to check on the status. Nurse #2 revealed she did not recall if she notified the Physician Assistant that Resident #75 had not received the semaglutide, but Nurse #1 was aware. An interview conducted with Nurse #1 on 2/11/26 at 8:56 AM revealed she was the unit manager from 7:00 AM to 3:00 PM. Nurse #1 stated when a resident had a new medication order it was entered, verified and sent to the pharmacy in the EMR. Nurse #1 revealed the Physician Assistant entered the order for Resident #75 to start semaglutide in the EMR on 11/25/25. Nurse #1 indicated she verified the order in the EMR and sent it	F0755	Continued from page 12 Verifying the accuracy of medication orders placed by the Physician and/or PA to ensure the order is complete as above. Notifying the Physician and/or PA to clarify any medication orders that are incomplete Ensure that all medication orders are transmitted to the pharmacy timely and are received Any licensed nursing staff or medication aide out of leave or PRN (as needed) status will be educated prior to returning to duty by the DON, Nurse in Charge and/or their designee. Newly hired licensed nursing staff, medication aides and agency nursing staff are educated on this process during orientation by the SDC. Monitoring to ensure ongoing compliance The DON or designee will audit 25% of new medication orders weekly for 4 weeks, then biweekly for 4 weeks, then monthly for 1 month to ensure continued compliance with the plan of correction. QAPI The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly x 3 months for further review and recommendations. Date of Compliance The facility will be in full compliance by: 3/3/26	

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F0755 SS = D	Continued from page 13 to the pharmacy on 11/28/25. Nurse #1 stated she was not aware the order for semaglutide did not have the complete dosage information or that the pharmacy requested a new order. Nurse #1 revealed she thought Resident #75's semaglutide was not delivered because it was unavailable, but she did not follow up with the pharmacy to check on the status of the medication. During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the complete dosage information. He stated the pharmacy attempted to call the facility, sent a fax notification and emailed the Former Director of Nursing (DON) and the Administrator on 11/25/25, 12/03/25, 12/17/25 and 12/22/25 that the semaglutide order for Resident #75 needed to be clarified so the medication could be dispensed and delivered to the facility. The Pharmacist revealed the facility responded to the pharmacy's requests and sent a new order for the semaglutide with the dosage information on 12/29/25 and the medication was delivered to the facility the same day. An attempt made to contact the Former DON on 2/11/26 at 1:55 PM was unsuccessful. An interview was conducted with the Administrator on 2/11/26 at 3:42 PM. She revealed the Former DON's last day working at the facility was on 1/23/26. The Administrator stated she had not received an email from the pharmacy in November 2025 or December 2025 that a medication order for Resident #75 needed to be clarified and she could not say if the Former DON received the email or if she was aware. The Administrator indicated when a medication was not available the assigned nurse, Nurse#1 and/or the DON should contact the pharmacy to check on the status of the medication or send a refill request in the EMR to ensure medications were available and administered to the residents as ordered by the physician.	F0755		
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.	F0761	POC F761 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law.	02/27/2026

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F0761 SS = D	Continued from page 14 §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 observation, staff interviews and Pharmacist interviews, the facility failed to remove an expired medication stored in 1 of 1 medication room refrigerator reviewed for medication storage (Medication Room #1) The findings included: An observation of Medication Room #1 was conducted on 2/9/2026 at 11:52 AM in the presence of Medication Aide (MA) #1. The following medication was found in the medication room refrigerator in a locked bin: one vial of Lorazepam 2 mg/ml (milligrams/ milliliter). The expiration date on the vial was August 2025 and was not opened. MA #1 confirmed the expiration date by reading aloud the date printed on the vial. An interview with the MA #1 was completed on 2/9/2026 at 11:53 AM. MA #1 stated that she was not sure who would check the medication room for expired medications and thought it was a night shift staff member that checked the temperature for the refrigerator. MA #1 reported that the Pharmacist would check the medication room monthly but would need to confirm with the Director of Nursing (DON). The interview conducted with the DON on 2/11/2026 at 2:50 PM revealed that the Pharmacist visits the facility once per month to check for expired medications. The DON reported once a medication was discontinued the nurse should have removed the medication from the cart or refrigerator and placed the	F0761	Continued from page 14 Affected residents: Expired medication was removed from the medication room refrigerator locked bin immediately on February 9th, 2026, by the Director of Nursing (DON). Resident with Potential to be Affected: The DON and Nurse in Charge checked all medication carts, med room and refrigerator in the facility to ensure that there were no expired medications on February 10th, 2026. No additional expired medications were observed in the facility. No residents were adversely affected by the alleged deficient practice. Systemic Changes: All licensed nurses and medication aides were educated on the policy regarding proper disposal of expired medications by the DON, Staff Development Coordinator (SDC) and/or their designee. This education included that all expired medications must be removed from the medication carts, medication room and medication room refrigerator locked bin prior to or by the expiration date. This education was completed by February 16th, 2026. Any licensed nursing staff or medication aide out on leave or PRN (as needed) status will be educated prior to returning to duty by DON, SDC, and/or their designee. Newly hired licensed nursing staff and medication aids including agency are educated on this process during orientation by the Staff Development Coordinator/DON. Monitoring: An audit tool was developed to ensure compliance with the plan of correction. The audit tool contains the following: 1. Are there any expired medication on the medication carts, medication room or medication room refrigerator locked bin? The DON/designee will audit 50% of all medication carts, medication room and medication room refrigerator locked bin weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. QAPI:	

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F0761 SS = D	Continued from page 15 medication in pharmacy container for medications to be returned to the pharmacy. An interview was completed with the Administrator on 2/11/2026 at 3:30 PM. The Administrator stated that expired medication should be sent back to pharmacy. The Administrator reported that each nurse should check medication orders each shift and send back discontinued medication to the pharmacy. The Administrator stated that she expected staff to check carts for expired and discontinued medications prior to dispensing medications to residents. A phone interview was completed with the Pharmacist on 02/11/2026 at 4:47 PM. The Pharmacist stated that he visits the facility once a month to complete medication administration observations with medication aides and nurses. The Pharmacist also reported that he had a team member that would visit the facility every other month to check the medication room for expired medications and medications that required more stock. The Pharmacist stated that he would check the medication in the medication carts during the medication administration observations for expired medications. The Pharmacist stated that the facility should not rely on pharmacy visits to review medication stock for expired medication because his team may not check the medication stock every month.	F0761	Continued from page 15 The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting x 3 months for further review and recommendations. Completion date: February 27th, 2026	
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F0842	POC F842 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Residents: Resident #75 medication administration record (MAR) was amended by Nurse #2 on 02/11/2026, to reflect accurate information. Nurse #2 was provided education on 2/11/26 by the Staff Development Coordinator (SDC) for medication administration general guidelines, including accurate medication administration documentation. Resident #75 did not suffer any adverse effect related to the alleged deficient practice. Other Residents Potentially Affected The Director of Nursing reviewed the MAR’s for all	03/04/2026

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F0842 SS = D	Continued from page 16 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F0842	Continued from page 16 residents administered medications by Nurse #2 from 2/12/26 to 2/27/26 to identify any additional discrepancies in the medication administration record. There were no additional inaccurate medication administration records identified. No other resident suffered any adverse effect related to the alleged deficient practice. Systemic Changes to Prevent Recurrence All licensed nursing staff and Medication Aides received education on accurate and timely MAR documentation. This education included that all licensed nursing staff and medication aides will review the medication administration record prior to the end of their shift to ensure the accuracy of MAR documentation. This was completed by Nurse in Charge on 02/27/2026. Any licensed nurse or medication aide out on leave or PRN status will be educated prior to returning to duty by the SDC. Newly hired licensed nursing staff and medication aides as well as agency nurses are educated on this during orientation by the SDC during orientation. Monitoring to Ensure Compliance The SDC, Pharmacy Nurse Consultant or Nurse in Charge will observe medication passes and complete audit of MAR documentation on 2 employees weekly x 4 weeks, biweekly x 4 weeks, then monthly x 1 month to ensure accuracy of MAR. These audits will occur on all shifts, including weekends. QAPI The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly x 3 months for further review and recommendations. Date of Compliance The facility will be in full compliance by: 3/4/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

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F0842 SS = D	Continued from page 17 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, resident and pharmacist interviews, the facility failed to maintain accurate records related to medication administration for 1 of 1 resident reviewed for accurate medical records (Resident #75). The findings included: Resident #75 was admitted to the facility on 3/14/25 with diagnoses including type 2 diabetes. Resident #75's physician orders and Medication Administration Record (MAR) revealed the following: 11/25/25 semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays. The MAR indicated semaglutide was administered on 12/01/25 at 8:00 AM (Nurse #2), was not administered on 12/08/25 with a note the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). The quarterly Minimum Data Set (MDS) assessment dated 1/25/26 revealed Resident #75 was cognitively intact. An interview was conducted with Resident #75 on 2/09/26 at 3:09 PM. Resident #75 revealed on 11/25/25 the Physician Assistant ordered semaglutide to help regulate her blood sugars and assist with weight loss. Resident #75 indicated the medication was not administered until January 2026.	F0842		

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F0842 SS = D	Continued from page 18 An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available on 12/01/25 or 12/08/25 or 12/15/25 and was not administeredNurse #2 stated she documented on the MAR in error that she administered semaglutide to Resident #75 on 12/01/25 and that it was refused on 12/08/25 and she should have documented on the MAR that the medication was unavailable. During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the dosage information. The Pharmacist revealed the facility sent a new order on for semaglutide 0.25 mg and the medication was delivered to the facility on 12/29/25. Several attempts made to contact the Former DON were unsuccessful. An interview conducted with the Administrator on 2/11/26 at 3:42 PM revealed she was not aware that Resident #75 was not administered semaglutide as ordered because it was not delivered by the pharmacy and unavailable. The Administrator stated when a medication was not administered it should be documented accurately in the resident record and on the MAR.	F0842		
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:	F0880	POC F880 This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Resident Affected: Resident #4, Resident #62, and Resident #103 were assessed by the Nurse in Charge on 02/12/2026 for signs and symptoms of infection. Resident #4, Resident #62, and Resident #103 did not display any signs of infection and continue to reside in the facility. They did not suffer any adverse effects related to the alleged deficient practice.	02/16/2026

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F0880 SS = D	Continued from page 19 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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.	F0880	Continued from page 19 The treatment nurse was educated by the Staff Development Coordinator (SDC) on 2/12/2026 regarding infection prevention procedures for hand hygiene during wound care. Other Residents with potential to be affected: All residents receiving wound care have the potential to be affected. Residents receiving wound care were observed by the SDC on 2/12/26 to ensure that proper hand hygiene was being performed during wound care. Proper hand hygiene was performed by the nurse for all other residents. No other resident suffered any adverse effects related to the alleged deficient practice. Systemic changes: All licensed nurses, including agency nurses, were educated on infection control procedures and hand hygiene during wound care by the SDC. This was completed on 2/12/26. Any licensed nursing staff out on leave or PRN (as needed) status will be educated prior to returning to duty by the Director of Nursing (DON) or SDC/designee prior to returning to duty. Newly hired licensed nursing staff and agency nursing staff are educated on this process during orientation by the SDC. Monitoring to ensure ongoing compliance The DON, SDC or designee will audit random wound care observations on at least 5 residents weekly for 4 weeks, biweekly for 4 weeks and then monthly for 1 month to verify compliance with hand hygiene during wound care. QAPI: The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting monthly x 3 months for further review and recommendations. Date of Compliance The facility will be in full compliance by: 2/16/26	

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F0880 SS = D	Continued from page 20	F0880		

§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 record review, observations and staff interviews, the facility failed to follow their infection control policy for three residents (Resident #4, Resident #62 and Resident #103) when the Treatment Nurse failed to change her gloves and perform hand hygiene during wound care. This deficiency occurred for 1 of 3 staff members reviewed for infection control practices (Treatment Nurse).

The findings included:

A review of the facility's policy titled "Infection Prevention and Control Program," reviewed and revised on 10/28/24, indicated:

Gloves must be worn when handling blood and/or other potentially infectious material and if the employee has non-intact skin. Touch clean body sites or surfaces before you touch dirty or heavily contaminated areas. If gloves become torn or heavily soiled and additional resident care tasks must be performed, then change the gloves before starting the next task. Always change gloves after use on each resident and discard them in the nearest appropriate receptacle. Perform hand hygiene before and after donning gloves.

1. An observation of wound care for Resident #4 by the Treatment Nurse was made on 2/10/26 at 9:30 AM. The Treatment Nurse was already in the resident's room when the surveyor entered the room and was observed with a gown already on. The Treatment nurse sanitized her hands and donned clean gloves. The dressing was already removed from Resident #4's wound. The Treatment Nurse stated the dressing had come off during incontinence care earlier that morning. She proceeded to clean the pressure ulcer to Resident #4's coccyx with gauze soaked with wound cleaner. While wearing the same gloves the Treatment Nurse then applied Santyl (ointment used to remove dead tissue) ointment, wet to moist Dakin's (antiseptic wound cleaning solution) solution and packed the wound bed. She then applied a super absorbent pad over it. The Treatment Nurse then

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F0880 SS = D	Continued from page 21 collected all of her supplies and threw them into the trash can. The Treatment Nurse doffed her gown, gloves and washed her hands with soap and water. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #4's wound and before applying the new clean dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated, "I had some training on infection control, but it obviously wasn't enough." An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Resident #4's wound and before applying the clean dressing. An interview with the Director of Nursing (DON) on 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and performed hand hygiene before putting a new dressing on Resident #4's wound. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene. 2. An observation of wound care for Resident #62 by the Treatment Nurse was made on 2/10/26 at 12:47 PM. The Treatment Nurse donned a clean gown and clean gloves. She then removed the old dressing from Resident #62's right ankle. She proceeded to clean the wound to Resident #62's right ankle with gauze soaked with wound cleaner. While wearing the same gloves the Treatment Nurse then applied a xeroform petrolatum dressing (mesh dressing impregnated with petrolatum). She then collected all of her supplies and threw them into the trash can. The Treatment Nurse doffed her gown, gloves and washed her hands with soap and water. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #62's wound and before applying the new dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated, "I had some training on infection control, but it obviously wasn't enough." An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Residents #62's wounds and before applying the clean dressing.	F0880		

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F0880 SS = D	Continued from page 22 An interview with the Director of Nursing (DON) on 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and performed hand hygiene before putting a new dressing on Resident #62’s wound. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene. 3. An observation of wound care for Resident #103 by the Treatment Nurse was made on 2/10/26 at 10:30 AM. The Treatment Nurse entered the room after putting a gown on. She washed her hands and put gloves on. She removed the dressing from Resident #103’s right heel pressure ulcer. The Treatment Nurse took her gloves off and rubbed hand sanitizer to both hands. She then applied another set of gloves and proceeded to clean the ulcer with gauze soaked with wound cleaner. Without removing gloves and performing hand hygiene, the Treatment Nurse patted the ulcer with a dry gauze and applied collagenase ointment using a cotton swab to the wound bed. She then covered the wound with calcium alginate, applied an abdominal pad over it and wrapped the right foot with a woven gauze bandage. She removed both gloves and applied hand sanitizer to both hands. She donned a new set of gloves and removed the dressing from Resident #103’s left foot. Resident #103 had a surgical wound on his left foot which had staples from where his toes were amputated. The Treatment Nurse removed her gloves and rubbed hand sanitizer to both hands before applying another set of gloves. She then cleaned the wound with gauze moistened with wound cleaner. Without removing gloves and performing hand hygiene, the Treatment Nurse covered the wound with an abdominal pad and wrapped Resident #103’s left foot with a woven gauze bandage. She then removed her gloves and washed her hands with soap and water at the sink inside the room. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #103’s wounds and before applying the dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated that she had some training on infection control, but it obviously wasn’t enough. An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Resident #103’s wounds and before applying the dressing. An interview with the Director of Nursing (DON) on	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0880 SS = D	Continued from page 23 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and done hand hygiene before putting new dressings on Resident #103's wounds. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene.	F0880		