STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwell Park Rehabilitation and Healthcare Center	**1930 West Sugar Creek Road , Charlotte, North Carolina, 28262**

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E0000	Initial Comments An unannounced onsite recertification survey was conducted on 03/23/26 through 03/27/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1FAFAC-H1.	E0000		04/09/2026
F0000	INITIAL COMMENTS An unannounced onsite recertification survey and complaint investigation was conducted on 03/23/26 through 03/27/26. Event ID# 1F4FAC-H1. The following intakes were investigated: 2727766, 2744493, 2799379 and 2809792. 3 of the 8 complaint allegations resulted in deficiency.	F0000		04/09/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered;	F0627	Resident #93 no longer resides at the facility. All residents have the potential to be affected. Beginning on 3/31/2026 the Social Services Director completed an audit of all facility discharges in the last 30 days to ensure all residents discharged were issued an appropriate discharge notice and were allowed to return to the facility per policy. No concerns were identified. This audit was completed on 3/31/2026.	04/10/2026

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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F0627 SS = D	Continued from page 1 (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this	F0627	Continued from page 1 On 3/27/2026 the Regional Clinical Director, educated the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Service Director on the facility Policy and procedure for Transfer/Discharge Notice, bed hold and returns. This education was completed on 3/27/2026 and will be added to the facility orientation program for any new staff in these positions. Beginning on 4/6/2026 the Social Services Director/Designee will audit all facility discharges weekly for 12 weeks to ensure discharge notices are completed and residents are allowed to return to the facility per policy. The Social Services Director will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated. Date of Compliance: 4/10/2026	

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F0627 SS = D	Continued from page 2 section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process	F0627		

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F0627 SS = D	Continued from page 3 The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F0627		

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F0627 SS = D	Continued from page 4 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Family Member #1, Family Member #2, Hospital Case Manager, and Regional Ombudsman interviews, the facility failed to readmit Resident #93 after being transferred to the hospital for an evaluation for agitation, wandering and unsteady gait for 1 of 3 residents reviewed for inappropriate discharges (Resident #93). Findings included: Resident #93 was admitted to the facility on 1/29/26	F0627		

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F0627 SS = D	Continued from page 5 with diagnoses which included dementia with other behavioral disturbances, dysphagia, and chronic kidney disease. Resident #93 was discharged on 2/28/26. Review of the admission Minimum Data Set (MDS) assessment dated 1/30/26 revealed Resident #93 was severely cognitively impaired and required assistance from staff with all activities of daily living (ADL). Resident #93 was not coded for any behaviors. The MDS indicated he was not coded for any discharge planning and wished to remain in the facility long-term. A review of Resident #93's care plans created on 2/3/26 revealed a focus area for the need and preference for long-term care placement due to medical, functional, and psychosocial needs. Interventions included addressing psychosocial, medical, and functional needs through individualized care planning, informing Resident #93 of rights, facility routines, and available resources, and providing emotional support and counseling to assist with adjustment to long-term care. Further review of care plans created on 2/3/26 revealed Resident #93 was a risk for wandering and elopement. Interventions included engaging in purposeful activity, identifying wandering and elopement deescalation behaviors, and providing reorientation to surroundings and environment. A review of Resident #93's Electronic Medical Record (EMR) revealed Resident #93 was given a 30-day discharge notice signed by the Administrator on 2/26/26 with a discharge date of 3/28/26. The reason for discharge was selected as "it is necessary for your welfare and your needs cannot be met in this facility." The discharge location was to Resident #93's home address. A copy of a revised 30-day discharge notice signed by the Administrator on 2/26/26 included the same information as the previous 30-day discharge notice but had a handwritten note next to the discharge date of 3/28/26 which read "or sooner with appropriate placement which has been found at [name redacted] memory care [address redacted]. Resident has been accepted for placement as of 2/26/26." The revised 30-day discharge notice revealed the listed discharge location was Resident #93's home. A review of a nursing progress note written on 2/28/26 by Nurse #5 revealed Resident #93 had increased confusion throughout the night and an unsteady gait. Nurse #5 noted Resident #93's agitation had become more violent toward staff, and he got as close as he could and tried to swing at staff. Nurse #5 noted she felt Resident #93 needed to be seen in the Emergency Room. Resident #93's Responsible Party was notified and	F0627		

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F0627 SS = D	Continued from page 6 Resident #93 left with emergency medical services (EMS). A telephone interview with Nurse #5 on 3/25/26 at 9:14 AM revealed she was Resident #93's nurse the morning of 2/28/26 when he was sent to the Emergency Room. She stated Resident #93 had been up all night, agitated, wandering and had unsteady gait. Nurse #5 reported at one point during the night he was falling into the wall while walking. She stated she called the medical provider and an order was given to send him to the Emergency Room for evaluation. Nurse #5 stated she called Family Member #1 to alert her to Resident #93's transfer to the hospital. A nursing progress note written on 2/28/26 by the Former Director of Nursing (DON) revealed the Former DON spoke with another Case Manager at the hospital regarding Resident #93. The Case Manager told the Former DON that Resident #93 needed to return to the facility on 2/28/26. The Former DON told the Case Manager that Resident #93 would not be returning due to safety concerns. The Former DON let the Case Manager know that the Regional Ombudsman was involved and understood the concern. The Former DON provided the Regional Ombudsman's name to the Case Manager. A review of email communication that included the Regional Ombudsman, the Administrator, the Social Worker (SW), and the Former DON revealed the SW sent a copy of the amended 30-day discharge notice on 2/28/26 at 4:14 PM to the Regional Ombudsman after Resident #93 was taken to the Emergency Room earlier that morning. The Regional Ombudsman stated in her email response on 3/2/26 at 10:28 AM that she had already been alerted by the Hospital Discharge Planner that Resident #93 was in the Emergency Room. The Regional Ombudsman sent a follow up email to include the Administrator, the Former DON, and the SW on 3/2/26 at 2:09 PM. The Regional Ombudsman stated the Hospital Case Manager informed her that Resident #93 was in the Emergency Room and was not admitted and unless Resident #93's family wanted to move him directly to the memory care, the obligation of the facility was to readmit him and have a sitter until he could move. The Administrator responded to the email on 3/2/26 at 2:13 PM and stated Resident #93 had been accepted to the memory care, and she was not sure if his family had visited the facility yet. The Regional Ombudsman responded on 3/2/26 at 3:19 PM that the Hospital Case Manager asked if the facility would readmit Resident #93 until the family had decided about the memory care. The Administrator responded on 3/2/26 at 2:37 PM stating Resident #93's family was at the facility and wanted to appeal the 30-day discharge	F0627		

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F0627 SS = D	Continued from page 7 notice. The Regional Ombudsman responded to the email on 3/2/26 at 2:38 PM and asked if Resident #93 was going to return to the facility later that day. The Administrator responded on 3/2/26 at 2:53 PM that she “guessed so” and asked the Former DON if staffing was in place for one-on-one care for Resident #93. The Former DON responded 3/2/26 at 3:14 PM that the facility was not able to take Resident #93 back. The Regional Ombudsman responded over email on 3/2/26 at 3:18 PM that the hospital could file a complaint with the State Survey Agency regarding Resident #93’s readmission. A review of Resident #93’s hospital record revealed he was brought to the Emergency Room on 2/28/26 for abnormal gait and increased agitation. The records further revealed he was medically cleared for discharge later in the day on 2/28/26 and it was noted Resident #93 was not an imminent threat to himself or anyone else. The hospital records noted Resident #93’s family planned to bring him to the facility, but the facility would not allow him to return her phone conversation with the Former DON. Resident #93’s hospital notes further revealed the Case Manager contacted the Regional Ombudsman on 2/28/26 due to the facility not readmitting Resident #93 while under a 30-day discharge notice written on 2/26/26. The hospital records revealed Resident #93 was discharged from the hospital on 3/6/26 to his home with Family Member #1. A combined telephone interview with Resident #93’s Family Member #1 and Family Member #2 on 3/24/26 at 2:46 PM revealed Resident #93 had received a discharge notice on 2/26/26. Family Member #2 stated the memory care facility that came to assess Resident #93 was not an acceptable placement for him, but Resident #93’s family was actively working to find another location. Family Member #1 stated she received a call the morning of 2/28/26 from Nurse #5 that Resident #93 was being sent to the hospital due to being unsteady on his feet and not knowing his name. Family Member #2 reported the facility would not readmit Resident #93 and he stayed in the Emergency Room until 3/6/26 when Family Member #1 took him home until Resident #93’s family found another facility for placement. Family Member #2 stated Resident #93 remained at home until placement at another memory care facility occurred on 3/17/26. A telephone interview with the Hospital Case Manager on 3/26/26 at 8:18 AM revealed Resident #93 arrived at the Emergency Room on 2/28/26 and was medically cleared for discharge later that day. The Hospital Case Manager stated Resident #93 was under a 30-day discharge notice issued on 2/26/26 from the facility and when the	F0627		

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F0627 SS = D	Continued from page 8 facility was contacted to readmit him on 2/28/26, the Former DON refused to take him back. She stated Resident #93 remained in the Emergency Room until 3/6/26 when his family took him home and eventually found placement in a memory care facility. A telephone interview with the Regional Ombudsman occurred on 3/26/2026 at 9:49 AM. She stated she was made aware of Resident #93's transfer to the hospital from the Hospital Case Manager when she returned to her office on 3/2/26 from the weekend. The Regional Ombudsman stated she emailed the facility management staff to inform them of Resident #93's right to return to the facility and the Former DON stated the facility would not readmit him. She stated she reminded the facility management staff that the Hospital Case Manager may file a complaint with the State Survey Agency for failure to readmit Resident #93. An interview with the SW on 3/26/26 at 10:21 AM revealed she started working at the facility at the tail end of Resident #93's stay at the facility. She stated she sent the revised 30-day discharge notice to the Regional Ombudsman on 2/28/26 with a memory care facility location after a video assessment was completed with the memory care. The SW stated that the Regional Ombudsman told the facility staff over email that they should take Resident #93 back from the hospital. A telephone interview with the Former DON occurred on 3/26/26 at 1:27 PM. She stated Resident #93 had exhibited many behaviors to include wandering, agitation, and delusions and he would be better suited for a smaller environment like a memory care. The Former DON stated discissions were held with Family Member #1 and Family Member #2 about Resident #93 moving to another facility and the family was not agreeable to a move and wanted him to stay at the facility. The Former DON stated Resident #93 was sent to the Emergency Room on 2/28/26 for a change in condition regarding an unsteady gait and increased agitation and Resident #93 was given a 30-day discharge notice on 2/26/26 for 30 days or until another facility was found. She stated the Regional Ombudsman agreed that he could go from the hospital to the new facility. A telephone interview with the Administrator on 3/27/26 at 10:03 AM revealed Resident #93 had increasing behaviors such as agitation, wandering and eventually hypersexual behaviors towards staff. She stated Resident #93 was seen by psychiatric services and the Interdisciplinary Team (IDT) decided on a 30-day discharge notice to another facility such as a memory	F0627		

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F0627 SS = D	Continued from page 9 care. The Administrator stated Resident #93's family disclosed to them that Resident #93 was in a memory care facility in the past. She stated the facility located a memory care placement for Resident #93 and Family Member #1 and Family Member #2 were going to go look at it. The Administrator noted she told Family Member #1 2/26/26 that the facility was going to send Resident #93 to her home and Family Member #1 wanted to look at other facility placements. The Administrator stated Resident #93 was sent to the hospital for evaluation on 2/28/26 and she was told by the Regional Ombudsman by email that it was up to the facility to decide about readmitting Resident #93, but the facility may have to take Resident #93 back from the hospital.	F0627		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F0656	On 3/25/2026 the MDS Coordinator updated the care plan for resident #14 to reflect the use of an immobilizer. All residents with immobilizers have the potential to be affected. Beginning on 4/1/2026 the Regional Director of Clinical Reimbursement completed an audit to ensure all residents requiring immobilizer devices care plans were in place and accurate. No concerns were identified. This audit was completed on 4/1/2026. On 4/2/2026 the Regional Director of Clinical Reimbursement provided education to the MDS Coordinator and MDS Nurse on the facility policy and procedures for care plan timing and revision. This was completed on 4/3/2026 and will be added to the facility orientation program for all newly hired MDS staff. Beginning on 4/6/2026 the Regional Director of Clinical Reimbursement/Designee will randomly audit 10 care plans weekly for 12 weeks to ensure residents requiring immobilizers care plans are accurate and complete. The MDS Coordinator/ Designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes based upon the findings of these audits. Date of Compliance 4/10/2026	04/10/2026

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F0656 SS = D	Continued from page 10 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized comprehensive care plan to include immobilizer care for 1 of 1 resident reviewed for positioning and mobility (Resident #14). The findings included: Resident #14 was admitted to the facility on 2/16/2026 with diagnoses that included fracture of upper end of right tibia (shin bone). A physician's order dated 2/17/2026 for a right lower extremity knee immobilizer to be worn at all times and removed for skin checks and hygiene, with the right lower extremity maintained in extension. The order further instructed staff to document skin integrity every morning and at bedtime, related to a fracture of the upper end of the right tibia and to notify the provider if the skin was not intact. Resident #14's comprehensive care plan dated 2/17/2026 revealed no goals or interventions related to the right knee immobilizer. The admission Minimum Data Set (MDS) assessment dated 2/20/2026 indicated Resident #14 was cognitively intact. An interview was conducted on 3/24/2026 at 1:55 PM with Nurse #4 who was assigned to Resident #14. Nurse #4 stated she did not know if Resident #14 was care planned for her knee immobilizer and stated the resident should have a care plan in place.	F0656		

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F0656 SS = D	Continued from page 11 On 3/26/2026 at 9:24 AM, an interview was conducted with Nurse #3 who was the Unit Manager of the West and North units. Nurse #3 stated that upon admission, the nurse who completes the admission assessment, the MDS Coordinator and the Director of Nursing (DON) review the orthopedic orders to determine care needs for the resident. She stated anything related to the resident's care should be reflected in the care plan. Nurse #3 indicated she was not aware that Resident #14's knee immobilizer was not on the care plan, and she did not know how it was missed. During an interview with the MDS Coordinator on 3/25/2026 at 10:16 AM, he confirmed that he developed comprehensive care plans for residents based on diagnoses, triggers from the MDS, medical records, and he visited the residents in their room upon admission. The MDS Coordinator stated he did not recall seeing a right knee immobilizer on Resident #14 when he spoke with her. He confirmed interventions related to the right knee immobilizer should be in Resident #14's care plan, which was an oversight on his part. An interview conducted with the Director of Nursing (DON) on 3/25/2026 at 10:34 AM. She stated the MDS Coordinator developed care plans that were reviewed and discussed by the interdisciplinary team during morning and care plan meetings. Resident #14's right knee immobilizer was a significant part of her care and should have been included in the comprehensive care plan.	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide a safe transfer using the mechanical lift for 1 of 4 residents reviewed for accidents (Resident #8).	F0689	"Past Noncompliance - no plan of correction required"	12/19/2025

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F0689 SS = D	Continued from page 12 The findings included: A review of the manufacturer's instruction manual dated 2015 for the mechanical lift provided by the facility read in part: When using the lift for a bed transfer, position the legs under the bed and open the legs to a widened position for stability. Do not position the lift by pushing or pulling on the lift arm or the patient. Resident #8 was admitted to the facility on 11/22/22 with diagnoses that included end stage renal disease, right below the knee amputation, abnormalities of gait/mobility and muscle weakness. The annual Minimum Data Set (MDS) assessment dated 10/21/25 revealed Resident #8 was cognitively intact, had lower extremity range of motion impairment on both sides, and required substantial to maximal assistance with transfers. The care plan dated 10/30/25 indicated Resident #8 had an activities of daily living self-care deficit due to right below knee amputation and required 2-person assistance and the use of a mechanical lift for transfers. An incident report dated 12/15/25 completed by the Former Director of Nursing (DON) revealed Nurse Aide (NA) #1 and NA #2 were transferring Resident #8 into bed using the mechanical lift and while attempting to position the resident over the center of the bed, the lift tipped to the side and the arm of the lift hit NA #1 in the chest and came to rest on Resident #8's left knee. Resident #8 was assessed by Nurse #1 and the Former DON, had no complaints of pain or discomfort and no visible injuries were noted. The Nurse Practitioner (NP) was notified, and an order was received to obtain an x-ray of Resident #8's left knee as a precautionary measure. An interview was conducted with NA #1 on 3/24/26 at 2:16 PM. NA #1 stated on 12/15/25 sometime after lunch, NA #2 requested assistance transferring Resident #8 into the bed using the mechanical lift. She indicated NA #2 was positioning the lift beside the bed and she was helping position Resident #8 over the center of the	F0689		

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F0689 SS = D	Continued from page 13 bed when the lift tipped to the side. She stated the arm of the lift hit her in the chest and came to rest on Resident #8's left leg. NA #1 revealed Resident #8 was approximately two inches above the bed and was laid down onto the mattress when the lift tipped. NA #1 revealed she and NA #2 placed the lift back into an upright position and notified Nurse #1 of the incident. She stated Resident #8 had no complaints of pain and was not injured during the incident. NA #1 indicated she was holding on to the lift pad to guide Resident #8 over the center of the bed but did not recall pulling on the lift sling and thought the lift tilted because it was off balance due to not being positioned correctly on the other side of the bed. A phone interview was conducted with NA #2 on 3/25/26 at 10:08 AM revealed she was assigned to Resident #8 on 12/15/25 from 7:00 AM to 3:00 PM. She stated at approximately 1:30 PM she requested NA #1 assist her with transferring Resident #8 into bed using the mechanical lift. NA #2 indicated she lifted Resident #8 out of the wheelchair with the mechanical lift and was positioning the lift on the left side of the bed while NA #1 went on the other side of the bed to help position Resident #8 over the center of the bed. NA #2 revealed before she had the lift positioned correctly with the legs horizontally under the bed, NA #1 began pulling on the lift sling attempting to center Resident #8 over the bed which caused the lift to tilt over, and the arm of the lift hit NA #1 in the chest and came to rest on Resident #8's leg. NA #2 stated she and NA #1 were able to pull the lift back into an upright position and called Nurse #1 from the room. She indicated Nurse #1 immediately responded, assessed Resident #8 and then notified the Former DON of the incident. NA #2 revealed Resident #8 had no complaints of pain and was not injured. Nurse #1 was no longer employed at the facility and unavailable for an interview. An interview was conducted with Resident #8 on 3/24/26 at 1:57 PM. Resident #8 stated he did not recall the exact date, but a few months ago NA #1 and NA #2 were transferring him into bed using the mechanical lift and it tipped sideways, and the lift arm hit NA #1 in the chest and came to rest on his left knee. Resident #8 indicated he was about two inches above the bed and when the lift tilted to the side he was lowered down on the mattress. Resident #8 revealed he had no pain or discomfort and was not injured during the incident.	F0689		

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F0689 SS = D	Continued from page 14 Resident #8 had a physician order dated 12/15/25 to obtain an x-ray of the left knee. The x-ray results report dated 12/15/25 revealed Resident #8's left knee arthroplasty was intact and there was no acute fracture or injury. An investigation summary dated 12/15/25 written by the Former DON revealed NA #1 and NA #2 were transferring Resident #8 into bed using the mechanical lift when the lift tilted and the arm of the lift hit NA #1 in the chest and came to rest on Resident #8's left knee. During a reenactment it was determined the mechanical lift was positioned beside the bed with the legs parallel to the bed and not horizontally underneath the bed, and NA #1 and NA #2 were pulling on the lift sling to position Resident #8 over the center of the bed which caused the lift to tilt. A phone interview was conducted with the Former DON on 3/25/26 at 1:41 PM. She stated on 12/15/25 Nurse #1 notified her immediately that an incident occurred while Resident #8 was transferred into bed with the mechanical lift. The Former DON stated she responded to Resident #8's room and he was lying in bed, had no complaints of pain or discomfort and no visible injuries. The Former DON indicated she obtained statements from NA #1 and NA #2 and had them perform a reenactment of what occurred. The Former DON revealed NA #2 was positioning the lift beside the left side of the bed with the legs parallel to the bed and NA #1 was on the right side of the bed pulling on the lift sling to position Resident #8 over the center which caused the lift to tilt. The Former DON stated the mechanical lift legs should have been placed horizontally underneath the bed and been widened or opened to provide stability before NA #1 attempted to position Resident #8 over the bed and should not have been pulling on the lift sling to position the resident. An interview conducted with the Administrator on 03/26/26 at 12:00 PM revealed nursing staff should follow the facility's mechanical lift policy and operate the mechanical lift per the manufacturer's instructions to ensure residents were transferred in a safe manner.	F0689		

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F0689 SS = D	Continued from page 15 The facility provided the following corrective action plan. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 12/15/2025, Nurse Aide (NA) #1 and Nurse Aide (NA) #2 were transferring Resident #1 from the wheelchair to the bed. The mechanical lift legs were positioned parallel to Resident #1's bed and not under the bed separated and locked per the manufacturer's recommendations and when NA #1 and NA #2 attempted to position Resident #1 over the center of the bed the mechanical lift tilted and the arm of the lift hit NA #1 in the chest and came to rest on Resident #1's left knee. On 12/15/2025, Nurse #1 immediately assessed Resident #1 and had no complaints of pain or visible injuries. Resident #1 was also assessed by the Director of Nursing and noted to be without injury or complaints of pain. On 12/15/2025, the Nurse Practitioner was notified of the incident, and orders were received to obtain an x-ray of Resident #1's left knee as a precautionary measure. On 12/15/2025, Nurse #1 notified the Resident Representative of the incident and order to obtain x-ray as precautionary measure. On 12/15/2025, The x-ray was obtained of a Resident #1's left knee and the results showed the left knee arthroplasty was intact and there were no injuries. On 12/15/2025 the mechanical lift that was used to transfer Resident #1 was removed from service by the Director of Nursing, inspected by the Maintenance Director and was in good working order with no concerns were identified. On 12/15/2025 Nursing Aide (NA) #1 and Nursing Aide (NA) #2 were immediately re-educated by the DON on the facility mechanical lift policy, and proper use of the	F0689		

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F0689 SS = D	Continued from page 16 mechanical lift which included positioning the mechanical lift and lift legs per the manufacturer's instructions, adjusting the mechanical lift height for resident safety during movement, slowly lifting the resident, only lifting as high as necessary to complete transfer, proper positioning of the resident at the transfer destination (bed, chair etc.), slowly lowering resident to their ending position (sitting upright in wheelchair, laying in the bed, etc.), removing any objects prior to lifting resident (fall mats, trash cans, wires, etc.) and inspecting the mechanical lift and lift equipment prior to use to ensure it was in proper working order. On 12/15/2025, the Director of Nursing completed mechanical lift transfer competencies for Nursing Aide (NA) #1 and Nursing Aide (NA) #2 with all competencies met and no concerns identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using mechanical lifts have the potential to be affected. On 12/15/2025 the Regional Clinical Director and the Director of Nursing reviewed the facility Mechanical Lift Policy. No changes were implemented. On 12/15/2025, the Maintenance Director completed a 100% audit of all mechanical lifts. All lifts were in proper working order and no concerns were identified. On 12/15/2025 the Director of Nursing/Designee interviewed residents with a Brief Interview for Mental Status (BIMs) score of 13 or higher that per the care plan and Kardex utilized a mechanical lift to ensure no safety issues with transfers. No concerns were identified. This was completed on 12/16/2025. On 12/15/2025 the Director of Nursing/Designee completed a head-to-toe skin assessment for all residents that utilize a mechanical lift to ensure no injuries or issues occurred related to transfers. No concerns were identified. This was completed on 12/16/2025.	F0689		

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F0689 SS = D	Continued from page 17 On 12/15/2025 the Director of Nursing/Designee reviewed care plans for all residents that utilize mechanical lifts to ensure transfer status was documented accurately. No concerns were identified. This audit was completed on 12/16/2025. On 12/15/2025 The Regional Clinical Director reviewed all incident reports for the last 30 days to ensure there were no incidents related to transfers using mechanical lifts. No concerns were identified. This audit was completed on 12/16/2025. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/15/2025, the Director of Nursing/Designee began re-educating all nursing staff on the facility mechanical lift policy, and proper use of the mechanical lift which included positioning the mechanical lift and lift legs per the manufacturer's instructions, adjusting the mechanical lift height for resident safety during movement, slowly lifting the resident, only lifting as high as necessary to complete transfer, proper positioning of the resident at the transfer destination (bed, chair etc.), slowly lowering resident to their ending position (sitting upright in wheelchair, laying in the bed, etc.), removing any objects prior to lifting resident (fall mats, trash cans, wires, etc.) and inspecting the mechanical lift and lift equipment prior to use to ensure it was in proper working order. This was completed on 12/18/2025. Nursing staff that did receive this education by 12/18/2025 will receive the education prior to the start of their next shift and the Director of Nursing will be responsible for ensuring they receive the education. On 12/15/2025 the Director of Nursing/Designee completed mechanical lift competencies with all Licensed Nurses and all Nurse Aides (NA). This was completed on 12/18/2025. Nursing staff that did not complete a mechanical lift competency by 12/18/2025 will complete prior to the start of their shift. The Director of Nursing will be responsible for ensuring competencies are completed prior to the start of the next shift. Mechanical lift competencies will be completed during the facility orientation program for	F0689		

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F0689 SS = D	Continued from page 18 all newly hired nursing staff and will be the responsibility of the Director of Nursing. An ADHOC Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 12/16/2025. A Root Cause Analysis was completed and determined that the mechanical lift was not in the correct position with the legs not being under the bed prior to positioning the resident. The QAPI committee discussed, reviewed and approved the correction plan that was initiated by the Regional Clinical Director and the Director of Nursing on 12/15/2025 and decided on how to monitor the plan going forward. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. Beginning 12/22/2025 the Director of Nursing/Designee will observe 2 lift transfers weekly on all three shifts for 12 weeks to ensure proper use of the mechanical lift, including ensuring proper mechanical lift positioning. This will be completed on 3/15/2026. The DON or designee will be responsible for reporting results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of these audits. Compliance Date: 12/19/2025 The facility's corrective action plan was validated on 3/26/26. A phone interview conducted with the Former DON revealed on 12/15/25 through 12/18/25 she provided education to all nursing staff on the facility's mechanical lift policy and proper use of the mechanical lift and observed all nursing staff perform return demonstration of a safe resident transfer using the mechanical lift with no concerns identified. An interview conducted with the Maintenance Director indicated on 12/15/25 he inspected all the facility's mechanical lifts, and all the lifts were in good working condition. Interviews conducted with NA #1 and NA #2 revealed on 12/15/25 the Former DON provided education on the facility's mechanical lift policy and proper use of the mechanical lift during a resident transfer, and they were observed by the Former DON	F0689		

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F0689 SS = D	Continued from page 19 performing return demonstration of a safe resident transfer using the mechanical lift. Interviews conducted with Nurses and NAs revealed they received education on the facility's mechanical lift policy and proper use of the mechanical lift and performed return demonstration of a safe resident transfer using the mechanical lift. A review of the facility's audit records revealed observations of lift transfers were completed twice a week on all three shifts from 12/22/25 through 3/15/26 and no concerns were identified. An observation was conducted on 3/26/26 of two NAs transferring Resident #8 from the wheelchair into bed using the mechanical lift. The NAs used the mechanical lift per the manufacturer's instructions and transferred Resident #8 safely into bed with no concerns identified. The facility's compliance date of 12/19/25 was validated.	F0689		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to remove expired medications stored in	F0761	On 3/24/2026 all expired medications were removed from the medication room and medication storage room by Unit Managers #1 and #2. All residents have the potential to be affected. Beginning on 3/30/2026 all medication rooms, including the medication storage room was audited by the Unit Managers and the Central Supply Coordinator. No additional concerns were identified. This audit was completed 4/2/2026. Beginning on 3/26/2026 the Staff Development Coordinator/Designee re-educated all Licensed Nurses, Unit Managers, Medication Aides and the Central Supply Coordinator on the facility Medication Storage Policy. This education was completed on 4/2/2026and will be added to the facility orientation program for all newly hired Licensed Nurses, Unit Managers, Medication Aides and Central Supply Coordinators. Beginning on 4/6/2026 the Director of Nursing/ Designee will audit medication rooms and the medication storage room 2 times a week for 12 weeks to ensure there are no expired medications. The Director of Nursing or Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the	04/15/2026

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F0761 SS = D	Continued from page 20 2 of 3 medication rooms reviewed for medication storage (Medication Room for West Hall and Over the Counter (OTC) Medication Storage Room) and failed to date a vial Tuberculin Purified Protein Derivative (PPD) used for tuberculosis testing when opened in 1 of 2 medication refrigerators (West Hall Medication Room refrigerator). The findings included:An observation of the “Over the Counter” Medication Storage room was conducted on 3/24/2026 at 2:49 PM in the presence of Unit Manager #1. The following medication was found in the medication room: four boxes of bisacodyl suppositories (a medication used as a stimulant laxative for constipation)10 milligrams (mg) with 12 suppositories per box. The expiration date on the boxes was November 2025. Unit Manager #1 confirmed the expiration date by reading aloud the date printed on the box. An interview with Unit Manager #1 was completed on 3/24/2026 at 2:49 PM. Unit Manager #1 stated the Over-the-Counter Medication Room was checked frequently by the Central Supply staff member. She stated typically if nurses removed a medication from the medication room they would ensure it was not expired prior to administration. An interview with Central Supply Staff Member #1 was completed on 3/25/26 at 10:09 AM. Central Supply Staff Member #1 confirmed that he stocked the “Over the Counter” Medication Storage room weekly as well as checked for expiration dates on the medication stored in the room. He stated he checked the room the week prior and did not see the expired bisacodyl suppositories.An observation of the West Medication Storage room was conducted on 3/24/2026 at 3:05 PM in the presence of Unit Manager #2. The following medication was found in the medication room: two bottles of Calcium 600 mg 60 tablets per bottle (a dietary supplement medication). The expiration date on the bottles was February 2026. Unit Manager #2 confirmed the expiration date by reading aloud the date printed on the bottles.An observation of the West Medication Storage room was continued on 3/24/26 at 3:10 PM in the presence of Unit Manager #2. The following medication was found in the refrigerator of the medication storage room: a vial of aplisol (tuberculin PPD, diluted) 5 TU/0.1 milliliter. The vial was opened and undated. Unit Manager #2 confirmed the vial was opened and undated. An interview with Unit Manager #2 was completed on 3/24/2026 at 3:15 PM. Unit Manager #2 stated that the Unit Managers were responsible for checking the medication rooms including the refrigerator for expired medications weekly and a night shift nurse should also check the medication room	F0761	Continued from page 20 audits. Date of Compliance: 4/15/2026	

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F0761 SS = D	Continued from page 21 each night shift. Unit Manager #2 reported that if an expired medication was found, a return form should be completed and placed in the return tote for the pharmacy to pick up on night shift. The interview revealed Unit Manager #2 had checked the Medication room the week prior and had overlooked the expired medication. She stated the tuberculin vial should have been dated once it was opened and placed back into the refrigerator. An interview conducted with the Director of Nursing (DON) on 3/25/2026 at 9:54 AM revealed that the Unit Managers were responsible for checking the medication expiration dates weekly in the medication rooms including the refrigerator. She also stated the Unit Managers were responsible for the Over-the-Counter medication storage room. The DON indicated nursing staff was expected to check the medication expiration date prior to placing it on their medication carts or administering it to residents. The DON explained all medication vials should be dated when opened and were only good for a duration of 28 days per the facility policy. The DON stated without an “open date” on the vial of tuberculin serum the facility would not know if the medication was expired or not. An interview was completed on 3/25/2026 at 10:51 AM with the Administrator. The Administrator stated the Medication Storage rooms should have been checked on a weekly basis for expiration dates. If a medication had expired, it should have been removed from the medication storage room. The Administrator indicated any vials of medication that had been opened should be dated when it was opened and used.	F0761		
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	Resident #53 did not have any adverse effects from the alleged deficient practice. CNA # 3 was re-educated on 3/26/2026 by the Assistant Director of Nursing on the Facility Policy and Procedure for Contact Precautions, including wearing an isolation gown while providing care. All residents that require Contact Precautions have the potential to affect. On 3/26/2026 the Director of Nursing/Designee assessed all residents, requiring contact precautions to ensure no signs/symptoms of infection. These assessments included vital signs. No concerns were identified. On 3/26/2026 all staff, including Nursing staff, Housekeeping, Dietary, Maintenance, Therapy and Department Managers were re-educated on the facility	04/15/2026

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F0880 SS = D	Continued from page 22 §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	F0880	Continued from page 22 policy and procedure for Contact Precautions, including utilizing the appropriate Personal Protective Equipment (PPE) upon entering resident's room. This education was completed on 4/2/2026 and will be added to the facility orientation program for all newly hired staff. Beginning on 4/6/2026 the Director of Nursing/Designee will observe 3 staff members weekly for 12 weeks to ensure the appropriate Personal Protective Equipment (PPE) are being worn while providing care for residents on Contact Precautions. The Director of Nursing/ Designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of Compliance: 4/15/2026	

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F0880 SS = D	Continued from page 23 linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to follow their infection control policy and procedures for Contact Precautions when Nurse Aide (NA) #3 did not wear all necessary Personal Protective Equipment (PPE) while providing incontinence care for Resident #53. The deficiency occurred for 1 of 4 staff members observed for infection control practices (NA #3). The findings included: A review of the facility's policy that was revised in October 2018 titled "Contact Precautions," indicated:Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors will wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves will be removed and hand hygiene performed before leaving the room. Staff will avoid touching potentially contaminated environmental surfaces or items in the residents' room after gloves are removed. Staff and visitors will wear disposable gown upon entering the room and remove gloves and gown before leaving the room and avoid touching potentially contaminated surfaces or items in the resident's room after gloves are removed. An observation of Resident #53's room door occurred on 3/23/2026 at 11:00 AM. Resident #53's room had a Contact Precaution sign posted on the front of the door, and personal protective equipment (PPE) was hanging next to the Contact Precaution sign. The Contact Precaution sign located on Resident #53's door revealed that all healthcare personnel must wear gloves and a gown when entering the resident's room and remove before leaving the room. An observation of Nurse Aide (NA) #3 finishing up incontinence care for Resident #53 occurred on 3/23/2026 at 11:00 AM. NA #3 was wearing gloves but did	F0880		

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F0880 SS = D	Continued from page 24 not have a gown on. An interview with NA #3 on 3/23/2026 at 11:04 AM revealed she was aware that Resident #53 was on Contact Precautions. NA #3 confirmed she had just completed incontinence care for Resident #53. NA #3 stated, “I was moving fast and just forgot to put a gown on”. NA #3 stated she had received infection control training last week (week of 3/16/2026). On 03/25/2026 at 2:59 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who was also the Infection Preventionist (IP). The ADON/IP confirmed Resident #53 was on Contact Precautions for Extended Spectrum Beta-Lactamase (ESBL-infection of the urine). The ADON/IP explained that when Contact Precaution signage was posted outside a resident’s door, all staff were required to wear a gown and gloves upon each entry into the room for any activity. The ADON/IP stated that all staff were educated on new precautions through multiple methods, including monthly town hall meetings, communication boards, phone notifications, and direct education from supervisors on each shift. The ADON/IP confirmed that the most recent town hall meeting was held on 3/19/2026 and that all staff were educated and expected to attend which included NA #3. The ADON/IP confirmed that Nurse Aides were required to wear a gown and gloves when providing incontinence care to Resident #53. The ADON/IP further stated that there was no acceptable reason for staff not to follow the policy. On 03/25/2026 at 3:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff were expected to follow the precaution signage posted on residents’ doors and adhere to the required PPE indicated. The DON reported that staff education was provided through skills fairs and monthly town hall meetings. The DON stated that during the most recent town hall on 03/19/26, topics reviewed included use of PPE as indicated on door signage. The DON confirmed that all shifts and staff had received this education including NA #3. The DON stated that she would want staff to always wear the required PPE when indicated. The DON stated that Nurse Aides may rush to attend to other time-sensitive residents. The DON further stated that staff should feel comfortable asking for assistance when needed to ensure proper care and adherence to infection control protocols. An interview was conducted on 3/26/2026 at 9:36 AM with Nurse #2 who was assigned to Resident #53 on 3/23/2026. Nurse #2 stated that the required personal protective equipment (PPE) depended on the residents’ precautions.	F0880		

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F0880 SS = D	Continued from page 25 She stated, Contact Precautions consisted of a gown, gloves, and whatever the door sign instructed. Nurse #2 confirmed Resident #53 was on Contact Precautions for ESBL. Nurse #2 stated that she did not observe any instances on 03/23/2026 of Nurse Aides failing to wear the appropriate PPE while providing care to Resident #53. Nurse #2 further stated that if she were to observe a Nurse Aide not wearing the appropriate PPE, she would instruct them to put on the required PPE per facility protocol. An interview was conducted on 03/26/2026 at 9:46 AM, with the Administrator. The Administrator stated that proper procedure required staff to put on appropriate PPE when precaution signage was posted outside a resident's door. The Administrator reported that staff training on infection control and PPE use was provided during orientation, annually, as needed, and through ongoing methods such as town hall meetings and skills fairs. The Administrator confirmed that all staff were included in this training. The Administrator stated that Nurse Aides should follow established protocols. The Administrator further stated that NA #3 should have worn a gown for compliance with the posted precautions.	F0880		