STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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
E 000	Initial Comments A recertification survey was conducted from 05/12/25 through 05/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ZI0N11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted at this facility from 05/12/25 through 05/15/25. Event ID #ZI0N11. The following intakes were investigated: NC00227452, NC00225633, NC00225211, NC00225184, NC00223345, NC00221514, and NC00217127. 1 of the 23 complaint allegations resulted in a deficiency.	F 000		
F 641 SS=D	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.	F 641		6/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/04/2025

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F 641	Continued From page 1 §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: Based on observations, record review and staff and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of vision for a resident with visual impairment. This was for 1 of 32 residents reviewed for MDS accuracy (Resident #61). Findings included: Resident #61 was admitted to the facility on 04/14/25 with diagnosis of glaucoma. The Minimum Data Set admission assessment dated 04/19/25 revealed Resident #61 was cognitively intact and was coded has having adequate vision. The care area assessment (CAA) indicated a care plan should be triggered for vision. An observation of Resident #61 on 05/12/25 at 11:30 AM revealed upon entry to his room it was noted to be very bright with all overhead lights on.	F 641	F641 1.On 5/15/25 Resident #61 Minimum Data Set for the Assessment Reference Date of 4/19/25 was modified to reflect the vision impairment and was transmitted by Minimum Data Set Coordinator. 2.Residents with Diagnosis of a vision impairment have been identified has having the potential to be affected. On or before 6/10/25 house wide audit is being conducted by the Social Service Coordinators to identify all Residents with vision impairments . 3.On 5/15/25 the Social Service Coordinators were educated by the Director of Nursing (DON) on the importance of assessing and coding Vision Impairments on the Minimum Data Set according to the Resident Assessment Instrument Manual. 4.The Social Service Director will randomly audit 3 residents a week for 12 weeks with a Diagnosis of vision impairments to validate accurate coding	

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F 641	Continued From page 2 An interview with Resident #61 on 05/12/25 at 11:30 AM was conducted. Resident #61 stated he needed all the lights on so that he could see. He stated he was nearly blind. Resident stated he had a reaction to cancer treatment to his brain and it affected his vision. An interview was conducted with the Social Worker Assistant on 05/15/25 at 10:25 AM. The Social Worker Assistant stated he was the one who completed the MDS assessment for vision and hearing and coded Resident #61's vision as adequate. He stated he was not made aware by the Resident that he was blind. The Social Worker Assistant stated he did not complete the care area assessment so he did not realize the resident had triggered for a vision care plan. The Social Worker Assistant stated he thought he had asked Resident #61 if he wore glasses and if he had any problems with his vision and he did not recall the resident saying he did. The Social Worker Assistant stated he did not remember if he was aware of the Resident's diagnoses or past history. A follow up interview was conducted with Social Worker Assistant on 05/15/24 at 1:15 PM. He stated he interviewed Resident #61 and Resident #61 shared with him that he was visually impaired. The Social Worker Assistant stated he should have coded the resident has having impaired vision and added, the resident had an issue with vision, and it was triggered on the CAA as a problem and should be reflected accurately on the vision section of the MDS assessment. An interview was conducted with the Administrator on 05/15/25 at 4:45 PM. The Administrator stated she expected the MDS	F 641	on the Minimum Data Set assessment. Results of the audits will be presented by the Director of Nursing in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The Quality Assurance and Performance Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 641	Continued From page 3 assessments to be coded accurately to make sure nursing staff were aware of the resident's care needs and safety.	F 641		
F 656 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. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		6/11/25

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F 656	Continued From page 4 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement care planned interventions by not placing a fall mat at the bedside of residents with a history of a fall with major injury. This occurred for 2 of 6 residents reviewed for accidents and care plan interventions (Residents #24 and #81). Findings included: 1. Resident #24 was admitted to the facility on 6/2/16 with diagnoses of Alzheimer's and muscle weakness. An incident note dated 10/12/2024 at 6:21 PM indicated Resident #24 had an unwitnessed fall from his bed and was sent to the hospital for evaluation. A care plan revised on 10/14/24 revealed Resident #24 was at risk of falls due to poor safety awareness, right sided hemiplegia, and poor communication and comprehension. Interventions included fall mat at the bedside and keep the call light within reach.	F 656	F656 1.and 2. 1.On 5/15/25 the Unit Manager placed the fall mat on left side of bed for Resident #24 . On 5/15/25 the Unit Manager placed the fall mat on left side of bed for Resident #81. 2.Residents with care plan interventions for fall mats have the potential to be affected. On or before 6/10/25 the Director of Nursing, Assistant Director of Nursing, Unit Managers reviewed care plans to identify Residents with interventions for fall mats; as these Residents have the potential to be affected. On or before 6/10/25 Physicians Orders will be entered in the Electronic Medical Record by the Director of Nurses, Assistant Director of Nurses and Unit Managers to validate the implementation and monitoring of fall mats. 3.On or before 6/10/25 Education will be provided by the Director of Nurses and or Nursing Management Designee for Nursing Staff on the importance of implementation and monitoring for fall	

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F 656	Continued From page 5 The hospital discharge summary dated 10/22/24 revealed Resident #24 was discharged with a diagnosis of a femur fracture sustained from the fall. The Minimum Data Set (MDS) quarterly assessment dated 04/17/25 revealed Resident #24 was severely cognitively impaired. He required staff assistance with activities of daily living and had no falls during this assessment period. An observation was conducted on 05/14/25 at 10:04 AM of Resident #24. He was in bed and in no distress. He was unable to communicate due to severe cognitive impairment. There was no fall mat at the bedside. During an interview on 05/14/25 at 4:20 PM, Nurse Aide #1 stated she provided care to Resident #24 at times. She stated she was not aware there was no fall mat at his bedside, but stated that he used to have one. She stated the nurses usually put the fall mats down when needed. She indicated she was not aware of any further falls. During an interview on 05/14/25 at 4:30 PM, Nurse #2 stated she was routinely assigned to Resident #24 and was not aware he was supposed to have a fall mat at the bedside. She stated usually when fall mats were initiated the nurse would make sure it was placed by the bed. She stated she would get a fall mat placed on both sides of his bed now. She indicated he has had no recent falls. During an interview on 05/15/25 at 11:32 AM, the	F 656	mats. During classroom orientation for newly hired nursing staff will be educated on the importance and monitoring for fall mats. 4.Weekly for twelve weeks the Director of Nurses, the Assistant Director of Nurses , Unit Managers, supervisors will randomly audit each Resident with a care plan intervention for a fall mat. If fall mat is not in place then a fall mat will immediately be placed by the bedside for compliance and the Director of Nurses, the Assistant Director of Nurses, the Unit Manager, Nursing Supervisor will immediately re educate the Nurse and the nursing assistant on the importance of implementation and monitoring of fall mats. The Results of the audits will be presented by the Director of Nurses in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 656	Continued From page 6	F 656		

Director of Nursing stated during morning standup meetings they discussed falls and reviewed and added interventions. If fall mats were added to the care plan the Nurse Manager, Assistant Director of Nursing, or the Rehab Director would get the fall mat from central supply and place at the bedside. She stated she did not know why it was missed but she expected care plan interventions to be followed. She stated education would be provided.

2. Resident #81 was admitted to the facility on 10/14/24 with diagnoses that included altered mental status.

A progress note written on 11/21/24 indicated Resident #81 had an unwitnessed fall from his bed during the night and he was transferred to the hospital for evaluation.

A care plan initiated on 10/15/24 and revised on 11/21/24 revealed Resident #81 was at risk for falls related to history of falls, weakness, and impaired mobility and had an actual fall with subdural (part of the brain) bleed related to poor balance and unsteady gait. Resident #81's goal was that he would be free from major injury from falls related to history of falls. Interventions included a fall mat next to his bed.

The hospital discharge summary dated 11/26/2024 revealed Resident #81 was discharged back to facility with diagnoses of left hip hematoma and stable traumatic subdural (location in brain) hemorrhage (bleed).

The Minimum Data Set quarterly assessment dated 04/28/25 revealed Resident #81 was cognitively impaired, required supervision or

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F 656	Continued From page 7	F 656		

touching assistance with ambulation, toileting and transferring from chair to bed. Resident #81 used a walker and had no falls during this assessment period.

An observation of Resident #81 was conducted on 05/12/25 at 11:00 AM. Resident #81 was lying in his bed and not have any fall mats beside his bed or anywhere stored in his room.

An observation was conducted on 05/15/25 at 9:37 AM of Resident #81's room. Resident was out of bed, standing next to his food tray. He was noted to have a steady gait and not using his wheelchair which was located beside him. Observation of the room revealed there was no fall mat in the room or stored in the bathroom.

During an interview with Nurse Aide #5 on 05/15/25 at 2:10 PM, Nurse Aide #5 revealed she usually worked on a different hall and had only been on the hall Resident #81 resided on for a couple of weeks. Nurse Aide #5 stated if she needed to know how to take care of a resident she would either look at a resident's Kardex (a care card about resident's activity of daily living care needs) or ask other nurse aides, the nurses, or therapy how residents transfer, eat, bath, etc. Nurse Aide #5 stated she did not know Resident #81 needed a fall mat and had never seen one his room. Nurse Aide #5 reviewed the Kardex and saw that Resident #81 required a fall mat.

During an interview with Nurse Aide #4 on 05/15/25 at 2:30 PM, Nurse Aide #4 revealed he was assigned to Resident #81 and was familiar with him. Nurse Aide #4 stated he was not aware nor has he ever seen a fall mat in Resident #81's room. Nurse Aide #4 stated he had access to the

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F 656	Continued From page 8 Kardex to review if he was unsure how to provide care to a resident, but he did not review Resident #81's care card. He added, if he was unsure how to take care of a resident he would ask the staff nurse or other nurse aides. During an interview with Nurse #5 on 05/15/25 at 3:00 PM, Nurse #5 revealed she was familiar with Resident #81 and worked with him frequently. Nurse #5 stated she was not aware that Resident #81 needed a fall mat and did not look at the care plan and that this was the first time she was hearing about it. Nurse #5 stated she would make sure a fall mat was in his room and at his bedside while he was in bed. During an interview with the Director of Nursing on 05/15/25 at 4:32 PM, the Director of Nursing stated during morning standup meetings they discussed falls and reviewed and added interventions. If fall mats were added to the care plan the Nurse Manager, Assistant Director of Nursing, or the Rehab Director would get the fall mat from central supply and place at the bedside. She stated she did not know why it was missed but she expected care plan interventions to be followed. She stated education would be provided.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		6/11/25

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F 695	Continued From page 9 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, family and physician interviews, the facility failed to obtain orders from a Pulmonologist for the appropriate setting for a resident's (Resident #189) Continuous Positive Airway Pressure (CPAP) machine (used as a type of ventilator with diagnoses of obstructive sleep apnea; a health condition that causes brief pauses in breathing during sleep) upon resident's admission and during the resident's stay at the facility for 8 days. This was for 1 of 1 resident reviewed that utilized a CPAP machine. Findings included: Review of the discharge summary from the hospital Resident #189 was discharged from on 11/23/24 revealed there were no orders written for Resident #189 for a CPAP machine. Resident #189 was admitted to the facility on 11/23/24 and discharged to the hospital on 12/02/24. Diagnoses included, in part, obstructive sleep apnea (OSA). The admitting physician orders revealed there were no orders written for CPAP use. The physician orders dated 11/23/24 included: Advair discus 100-50 microgram (mcg) per dose - 1 inhalation orally one time daily for shortness of breath Albuterol Sulfate 108 mcg - 2 puffs inhale orally every 4 hours as needed for shortness of breath or wheezing Albuterol Sulfate 2.5 milligrams (mg) /3 milliliters	F 695	F695 1.Resident #189 was discharged from the facility on 12/2/2024 and has not returned. 2.Residents with physician orders for Continuous Positive Airway Pressure (CPAP) machines have been identified by the Director of Nursing as having the potential to be affected. These identified residents had their physician's orders reviewed by the Director of Nursing to validate there are current physician's orders for settings. No other residents were identified as not having CPAP settings ordered. 3.On or before 6/10/25 Licensed Nursing staff will be re-educated by the Director of Nursing (DON), Assistant Director of Nursing (ADON), or designated nursing manager on the importance of obtaining orders for CPAP settings and actions to take if the orders are not available to include reaching out to the Medical Director as well as the resident's pulmonologist. As a new standard of practice, Monday – Friday in the Clinical Morning Meeting, the DON, ADON, or Nursing Administration Designee will review newly admitted residents physician orders to validate residents with physician orders for CPAP machines include the orders for settings. 4.Weekly for twelve weeks the DON, ADON, or Nursing Administration Designee will audit residents with physician orders for CPAP machines to	

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F 695	Continued From page 10 (ml) 0.083% nebulization solution inhale 3 ml by mouth every 6 hours as needed for bronchospasm Spiriva Respimat 2.5 mcg -1 inhalation inhale orally twice a day for shortness of breath. A nursing note written on 11/23/24 by Nurse #4 revealed Resident was alert and oriented and was able to make all his needs known with clear speech. Resident was aware of his medication list and vital signs were stable. Resident vocalized no discomforts. Nurse will ask for an order for resident's CPAP that he brought from home. An interview was attempted with Nurse #4 who wrote the nursing note on 11/23/24 regarding obtaining an order for the resident's CPAP that he brought in from home. A voicemail message and text message were left for a returned call on 05/15/25 at 9:48 AM. Nurse #4 did not respond to voicemail message or text message. Review of Resident #189's care plan dated 11/23/24 revealed a plan of care was in place for altered respiratory status related to obstructive sleep apnea, shortness of breath, and bronchospasm (constriction of the smooth muscle layers of the small airways that can cause swelling or irritation of the airway). Interventions included administering medications as ordered and monitor, elevate head of bed to prevent shortness of breath, pace and schedule activities providing rest periods. There was no plan of care in place for the use of a CPAP machine. Review of a hand written form titled "Resident Personal Possessions Inventory" dated 11/23/24 under the clothing and shoes section the	F 695	validate physician orders include settings. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 695	Continued From page 11	F 695		

following was included: 1 pair of shoes, 3 bibs, 8 shirts, 9 pair of pants, 1 underwear, 9 socks, 3 tanks. In the equipment section of the form the list included a knee Brace, phone and charger. In the other personals section, the list included CPAP, electric razor, shoe horn and wedge. The form was not signed by staff or resident.

A physician note written on 11/27/24 revealed, in part, resident was feeling okay overall and denied any shortness of breath. Resident knew his history and had been asking about his prescribed medications. Resident stated he had obstructive sleep apnea and has a CPAP machine next to his bed but did not use it last night because it was too far away for him to reach. Resident stated he has had the same settings on his CPAP for four years and used the machine while in hospital with no changes. Will recommend he start CPAP at night.

The Minimum Data Set admission assessment dated 11/29/24 revealed Resident #189 was alert and cognitively intact. Resident #189 was coded as having shortness of breath and required extensive assistance with one staff physical assistance with bed mobility, and supervision with two staff physical assistance with transfers.

A physician note written on 11/29/24 revealed, in part, resident stated he has not used his CPAP as yet. Discussed CPAP issue with nursing and they will be getting a hold of resident's pulmonary doctor to see what his settings are supposed to be. Resident denied any current shortness of breath or complaints of pain. Resident stated he has had same settings for four years and used the CPAP machine while in the hospital with no changes. Will recommend he start CPAP at night

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and discussed with nursing to reach out to his pulmonary doctor.

Review of the hospital emergency room (ER) admission note on 12/02/24 revealed the resident presented with increased confusion. Resident had a history of sleep apnea and reportedly uses CPAP at night but did not use it last night (12/01/24). The emergency note indicated that "the facility reported resident was refusing CPAP, resident reported facility denied giving CPAP." Under the Past Medical History section of the ER note sleep apnea was listed as a diagnosis with a sentence in italics "pt. states that he does not wear CPAP." There were no other notes regarding use of CPAP at this local hospital.

An interview was conducted with the Physician who wrote the progress notes on 11/27/24 and 11/29/24 on 05/14/25 at 11:20 AM. The Physician stated that anytime a resident was on a CPAP machine, the settings for the CPAP had to be ordered by a Pulmonologist. The Physician stated the nursing staff had called the pulmonologist and were waiting to hear back from the office to get the settings so that the order could be entered. The Physician stated he was not able to set the settings and although Resident #189 was aware of the settings for his CPAP, the settings needed to be confirmed with a pulmonologist. The Physician stated the nurses did their due diligence to obtain the settings. The Physician stated Resident #189 was discharged to the hospital for acute kidney injury and it was not related to not using his CPAP. The Physician also added that the resident was known to be non-compliant with the CPAP. The Physician stated when the resident was sent to the local hospital on 12/02/24 there were notes indicating

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that he was non-compliant.

An interview with a family member via phone on 05/14/25 at 2:44 PM stated Resident #189 was using the CPAP machine at the hospital prior to his admission to the facility and he was admitted to the facility with his CPAP machine. The family member stated whenever she visited, the CPAP machine was unplugged and Resident #189 stated he had not been using it. The family member stated Resident #189 had been using the CPAP for 4 years and used it every night.

An interview was attempted with Nurse #6 who worked with Resident #189 on the night of 11/27/24 and 11/29/24. A voicemail message and text message were left for a returned call on 05/15/25 at 10:17 AM. Nurse #6 did not response to voicemail message or text message.

An interview was conducted with the Unit Manager on 05/15/25 at 12:45 PM. The Unit Manager stated there were no orders for the residents' CPAP so the nursing staff could not allow the resident to use it. She stated there were no orders written on the discharge summary from the hospital. The Unit Manager stated she believed the resident was not admitted with the CPAP and that the family member had brought it in a couple days after Resident #189 was admitted. She stated the family member gave her the number to the Pulmonologist. The Unit Manager stated she tried to contact the Pulmonologist to get the settings for the CPAP machine and had left a message but no one returned her call. The Unit Manager stated she only tried one time to reach the Pulmonologist. She stated she did not remember who the Pulmonologist was, which day she tried to call or

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F 695	Continued From page 14 the phone number of the pulmonologist, but that it was in Onslow County. The Unit Manager stated she should have followed up with the pulmonology office, but the resident was discharged after only a short stay at the facility. An interview was conducted with the Director of Nursing on 05/15/25 at 4:30 PM. The Director of Nursing stated she believed that the family brought the CPAP in after the resident was at the facility for a few days and that he was not admitted with the CPAP. She stated she thought the nurses were making an effort to reach the Pulmonologist to get the settings for the CPAP machine and did not realize the Unit Manager only tried once. The DON stated she would have expected the nursing staff to follow up with the Pulmonologist until they obtained the settings for the CPAP.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies	F 726		6/11/25

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F 726	Continued From page 15 and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to have a system in place to train nurses and nursing assistants (NAs) and verify their competency with infection control procedures necessary for providing care to meet residents' needs. Nurse #4 failed to follow infection control protocol by not wearing a gown and not changing gloves after touching items in the resident's environment while providing care to a peripherally inserted central catheter (PICC) line, a thin flexible tube inserted into a vein in the arm and threaded up to a larger vein in the chest close to the heart used for long term intravenous therapy. NA #2 and NA #4 failed to follow infection control protocol by repositioning a resident on Enhanced Barrier Precautions due to a feeding tube and a wound that was positive for MRSA (Methicillin Resistant Staphylococcus Aureus) without the required Personal Protective Equipment (PPE). The deficient practice was identified for 1 of 1 nurse	F 726	F726 1.(A) Resident #46 has is not currently a Resident in the Facility. On 5/13/25 Nurse # 4 was provided one-to-one education by the Director of Nursing following infection control protocol by wearing a gown and changing gloves after touching items in the resident's environment while providing care, with an emphasis to adhering to infection control standards and precautions while providing care to a peripherally inserted central catheter (PICC) line. (B) On 5/13/25 Nursing Assistant #2 and Nursing assistant #4 were provided one-to-one education by the Director of Nursing on following infection control protocols to include the use of required	

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F 726	Continued From page 16 (Nurse #4) and 2 of 2 NAs (NA #2 and NA #4) reviewed for competency. Findings included: This tag is cross referenced to: F880: Based on observations, record review, and staff interviews the facility failed to implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to residents. 1. Nurse # 4 provided care to a resident with a peripherally inserted central catheter (PICC) line, a thin flexible tube inserted into a vein in the arm and threaded up to a larger vein in the chest close to the heart used for long term intravenous therapy. The nurse donned gloves but no gown during the procedure and did not change gloves after obtaining items from the bedside table. 2. Nursing Assistant #2 and Nursing Assistant # 4 provided turning and repositioning for a resident on EBP due to a gastrostomy tube and a wound to the right upper chest that was positive for MRSA (methicillin resistant staphylococcus aureus) without donning gowns or gloves. This occurred for 3 of 3 staff members who were observed for infection control practices. a. Review of Nurse #4's employee record revealed she was hired on 9/23/24 as a Registered Nurse (RN). There was no evidence of competency and training regarding administration of medication via a PICC line. An interview with Nurse #4 on 5/13/25 at 3:00 PM revealed she had worked previously as an RN and had worked with PICC lines in the past. Nurse #4 stated she was in her position as an RN	F 726	Personal Protective Equipment (PPE) when providing care for residents on Enhanced Barrier Precautions. 2.On or before 6/10/25 residents with PICC lines and residents who meet the requirement for Enhanced Barrier Precautions have been identified through medical record review by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or designated member of the Nursing Administration Team as having the potential to be affected by this deficient practice. On 5/15/25 the DON or Infection Preventionist validated each identified resident had Enhanced Barrier Precautions signage on the resident room door. 3.On or before 6/10/25 the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors will educate Nursing staff including Licensed Nurses and Certified Nursing Assistants on adhering to Infection control guidelines for Enhanced Barrier Precautions, Prevention of Infection, and Usage of Gloves/Personal Protective Equipment. Competencies on Infection Prevention, use of gloves and hand-washing will be conducted by the Nursing Administration Team to include the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors upon hire during orientation and annually for all Licensed Nurses and Certified Nursing	

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F 726	Continued From page 17 at the facility since September 2024. Nurse #4 indicated she did not recall if she received training regarding administration of medication via a PICC line or if her skills were verified upon hire. b. Review of NA #2's employee file revealed she was employed since 2022, and the file did not contain evidence that the NAs skills or competencies were checked. The file did not contain infection control in-service education. c. Review of NA #4's employee file revealed he was employed since 2024, and the file did not contain evidence that the NAs skills or competencies were checked. The file did not contain infection control in-service education. Review of a mandatory Inservice Education sign in sheet regarding infection control dated 1/31/25 indicated the sheet was signed by 3 Licensed Practical Nurses (LPNs) and 10 NAs. The sign in sheet was not signed by Nurse #4, NA #2 or NA #4. Review of an Inservice Education sign in sheet dated 5/12/25 revealed that Personal Protective Equipment, contact precautions, and hand washing was reviewed. The sign in sheet indicated that the Social Services Assistant, a housekeeper, 2 nurses and 1 NA signed the sheet. Nurse #4, NA #2 and NA #4 did not sign that they received the in-service education. An interview with the Infection Preventionist on 5/15/25 at 1:00 PM revealed that she was in the position since last year and she was responsible for staff education. The Infection Preventionist stated that education regarding Personal	F 726	Assistants. During orientation and annually Licensed Nurses will be assessed for PICC Line competencies skills by the Nursing Administration Team to include the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors. As a new practice, Monday – Friday in the Clinical Morning Meeting the Director of Nursing, (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will audit physician's orders to validate resident's with physician orders for PICC lines also have orders for Enhanced Barrier Precautions. Follow up will be conducted, as needed, by the Nursing Administration Team. 4.Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will audit each resident with a PICC Line to validate the resident has physician orders for Enhanced Barrier Precautions. Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will perform random observation audits of two different Licensed Nurses caring for residents' who have PICC Lines to validate infection control protocols are followed when caring for a PICC line. Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will perform random observation audits of each resident with physician orders for Enhanced Barrier Precautions to validate	

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F 726	Continued From page 18 Protective Equipment (PPE), Infection Control precautions and Enhanced Barrier Precautions was provided to all staff on hire and as needed. The Infection Preventionist indicated that education modules were assigned on-line randomly for all staff to complete. The Infection Preventionist was unable to explain how training was tracked to ensure all nursing staff received the training required to meet residents' needs and how competencies were verified. An interview with the Director of Nursing (DON) on 5/15/25 at 6:15 PM revealed that she was not aware of any training provided or verification of skills to provide PICC line care and the need to change gloves after touching items in the resident's environment while providing care. The DON stated that adherence to infection control protocols during PICC line care and while repositioning residents on Enhanced Barrier Precautions was important to prevent infection. The DON indicated that Nurse #4, NA #2, and NA #4 should have been trained in infection control protocols and been competent to provide care to meet resident needs.	F 726	Nursing staff is adhering to Enhanced Barrier Precautions during provision of care. While performing audits; if noncompliance has resulted, then immediate correction with be initiated and Licensed Nursing and or Nursing Assistants will be removed form assignment until and one on one education was provided by the Director of Nurses/Assistant Director of Nurse and or Nurse Management Designee to ensure compliance has been met in adherence to Enhanced Barrier Precautions Protocols. Results of the audits will be presented by the DON in the monthly Quality Assurance and Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 880 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.	F 880		6/11/25

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 20 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to residents. 1. Nurse # 4 provided care to a resident with a peripherally inserted central catheter (PICC) line, a thin flexible tube inserted into a vein in the arm and threaded up to a larger vein in the chest close to the heart used for long term intravenous therapy. The nurse donned gloves but no gown during the procedure and did not change gloves after obtaining items from the bedside table. 2. Nursing Assistant #2 and Nursing Assistant # 4 provided turning and repositioning for a resident on EBP due to a gastrostomy tube and a wound to the right upper chest that was positive for MRSA (methicillin resistant staphylococcus aureus) without donning gowns or gloves. This occurred for 3 of 3 staff members who were observed for infection control practices.	F 880	F880 1.(A) Resident #46 has is not currently a Resident in the Facility. On 5/13/25 Nurse # 4 was provided one-to-one education by the Director of Nursing following infection control protocol by wearing a gown and changing gloves after touching items in the resident's environment while providing care, with an emphasis to adhering to infection control standards and precautions while providing care to a peripherally inserted central catheter (PICC) line. (B) On 5/13/25 Nursing Assistant #2 and Nursing assistant #4 were provided one-to-one education by the Director of Nursing on following infection control protocols to include the use of required Personal Protective Equipment (PPE)	

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F 880	Continued From page 21 Findings included: The facility's Guidelines for Preventing Intravenous Catheter-related Infections Policy dated April 2017 indicated in part that aseptic technique (a set of techniques used to prevent contamination of objects with microorganisms) shall be observed at all times when working with IV (intravenous) equipment and that all times equipment shall remain aseptic (free from microorganisms) and if it becomes contaminated it must be changed. Hand hygiene is to be completed either by hand washing or with alcohol-based hand rub before and after intravenous catheter care. Clean, non-sterile gloves are to be worn. The facility's Enhanced Barrier Precautions policy dated 3/20/24 revealed it was the policy of the facility to utilize Enhanced Barrier Precautions (EBP), an infection control intervention intended to prevent the transmission of multi-drug-resistant organisms (MDRO's) via contaminated hands and clothing to high-risk residents. Enhanced Barrier Precautions were indicated for high contact care activities for residents with wounds or indwelling medical devices including central lines and gastrostomy feeding tubes and required hand hygiene before and after leaving the room and the use of gloves and a gown. 1. Observation of Resident #46's room on 5/13/25 at 2:50 PM revealed that there was no signage outside the resident's room indicating that Enhanced Barrier Precautions (EBP) were to be used. An observation was conducted with Nurse # 4, the nurse assigned to Resident #46 on 5/13/25 at	F 880	when providing care for residents on Enhanced Barrier Precautions. 2.On or before 6/10/25 residents with PICC lines and resident who meet the requirement for Enhanced Barrier Precautions have been identified through medical record review by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or designated member of the Nursing Administration Team as having the potential to be affected by this deficient practice. On 5/15/25 the DON or Infection Preventionist validated each identified resident had Enhanced Barrier Precautions signage on the resident room door. 3.On or before 6/10/25 the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors will educate Nursing staff including Licensed Nurses and Certified Nursing Assistants on adhering to Infection control guidelines for Enhanced Barrier Precautions, Prevention of Infection, and Usage of Gloves/Personal Protective Equipment. Competencies on Infection Prevention, use of gloves and hand-washing will be conducted by the Nursing Administration Team to include the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors upon hire during orientation and annually for all Licensed Nurses and Certified Nursing Assistants. During orientation and	

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F 880	Continued From page 22 2:50 PM. Nurse #4 entered Resident #46's room to administer the normal saline and heparin flushes, a procedure to maintain patency of the PICC line, following the completion of the intravenous antibiotic. Nurse #4 entered Resident #46's room with gloves on. Nurse #4 with gloved hands opened the drawer to resident's bedside table to obtain alcohol wipes and a cap for the resident's peripherally inserted central catheter. Nurse #4 did not change gloves after touching the items in the bedside table. Nurse #4 disconnected the intravenous tubing and administered the normal saline and heparin flush via the PICC line with the same gloves on, opened the new cap and applied it to the end of the tubing. An interview with Nurse # 4 on 5/13/25 at 3:00 PM revealed she was unaware that she was supposed to wear a protective gown while performing procedures involving a PICC line. Nurse #4 stated she went by the sign outside the door to know if a resident required any type of precautions while providing care. Nurse #4 stated she thought precautions were required for residents with wounds and Clostridium difficile (C. diff) but she did not know if a PICC line or any drains or tubes required precautions. Nurse #4 stated she did not realize she should have changed gloves after obtaining the items from the bedside table or that she should have had the needed supplies prior to beginning the procedure. Nurse #4 stated she received training on the computer and by the Infection Preventionist regarding Enhanced Barrier Precautions and that she worked at the facility since September of 2024. An interview with the Assistant Director of Nursing	F 880	annually Licensed Nurses will be assessed for PICC Line competencies skills by the Nursing Administration Team to include the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Unit Managers, or Nursing Administration Supervisors. As a new practice, Monday – Friday in the Clinical Morning Meeting the Director of Nursing, (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will audit physician's orders to validate resident's with physician orders for PICC lines also have orders for Enhanced Barrier Precautions. Follow up will be conducted, as needed, by the Nursing Administration Team. 4.Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will audit each resident with a PICC Line to validate the resident has physician orders for Enhanced Barrier Precautions. Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will perform random observation audits of two different Licensed Nurses caring for residents' who have PICC Lines to validate infection control protocols are followed when caring for a PICC line. Weekly for twelve weeks the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Nursing Administration Designee will perform random observation audits of each resident with physician orders for Enhanced Barrier Precautions to validate Nursing staff is adhering to Enhanced	

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	345236	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 880	Continued From page 23 was conducted on 5/14/25 at 5:00 PM. The Assistant Director of Nursing stated the staff should follow the EBP and wear the personal protective equipment as designated for care activities including intravenous catheter care and turning and repositioning as well as handling of bed linens. An interview with the Unit Manager on 5/15/25 at 10:15 AM revealed that precautions were determined based on the residents' condition. The Infection Preventionist determined what type of precautions were required and placed the signage outside the resident rooms. The Unit Manager stated that a resident with a PICC line should be placed on Enhanced Barrier Precautions and a mask, gown and gloves were required to provide PICC line care. The Unit Manager indicated that she did not know why Resident #46 was not placed on precautions. An interview was conducted with the Wound Care Nurse on 5/15/25 at 12:30 PM. The Wound Care Nurse revealed that residents with open wounds and invasive lines such as a PICC line required Enhanced Barrier Precautions. The Wound Care Nurse stated she reviewed the residents with wounds weekly with the Infection Preventionist to ensure that residents were placed on precautions as needed. The Wound Care Nurse indicated that Resident #46 should have been placed on Enhanced Barrier Precautions, and she did not know why he was not. An interview with the Infection Preventionist on 5/15/25 at 1:00 PM revealed that she was in the position for nearly a year. She stated she was also the Staff Development Coordinator (SDC) and was responsible for staff education and	F 880	Barrier Precautions during provision of care. While performing audits; if noncompliance has resulted, then immediate correction with be initiated and Licensed Nursing and or Nursing Assistants will be removed form assignment until and one on one education was provided by the Director of Nurses/Assistant Director of Nurse and or Nurse Management Designee to ensure compliance has been met in adherence to Enhanced Barrier Precautions Protocols. Results of the audits will be presented by the DON in the monthly Quality Assurance and Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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training. The Infection Preventionist stated the nursing staff were educated regarding Enhanced Barrier Precautions through in-person and on-line in-services. The Infection Preventionist stated Nurse #4 should have worn a protective gown while performing PICC line care for Resident #46.

An interview was conducted with the Director of Nursing (DON) on 5/15/25 at 1:30 PM. The DON stated that she expected that appropriate personal protective equipment would be used when providing care to a resident with a peripheral intravenous central catheter. The DON indicated that the PICC line was invasive and presented an increased risk of infection therefore Enhanced Barrier Precautions should be maintained. The DON indicated that she was not aware of the training provided or verification of skill to provide intravenous care.

2. A blue Enhanced Barrier Precautions (EBP) sign was noted outside Resident #7's door on 5/13/25 at 1:25 PM. The sign read in part, "Everyone must clean hands before entering and after leaving the room ...Wear gown and gloves for the following High Contact Resident Care Activities which include: Dressing, bathing/showering, Transferring, changing linens, changing briefs or assisting with toileting, and Device care or use; central lines, urinary catheter, feeding tubes, tracheostomy, Wound care: any skin opening requiring a dressing.

An interview and observation was conducted on 5/13/25 at 1:30 PM with Nursing Assistants (NA) #2 and NA #4. Resident #7 requested to be moved up and repositioned in bed prior to eating her lunch. NA's #2 and NA #4 were observed entering Resident #7's room and did not wash

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their hands and did not don gowns or gloves. NA #2 and NA #4 approached Resident #7's bed with no Personal Protective Equipment (PPE) on and with one NA on each side of the bed used the draw sheet, a sheet placed under the resident's mid-section, standing close to the resident, grabbed the sheet and moved the resident up towards the head of the bed. The NAs adjusted Resident #7's pillows, elevated the head of the bed and exited the room. After exiting the room, the NAs applied alcohol based handrub to their hands. NA #2 and NA #4 stated they thought repositioning a resident using a draw sheet wasn't direct care and did not require PPE. NA #2 and NA #4 stated they had received training regarding Enhanced Barrier Precautions, but it was confusing which activities required PPE. Handling bed linens and high contact care activities required PPE according to the EBP signage.

An interview with the Assistant Director of Nursing was conducted on 5/14/25 at 5:00 PM. The Assistant Director of Nursing stated the staff should follow the EBP and wear the personal protective equipment as designated for care activities including intravenous catheter care and turning and repositioning as well as handling of bed linens.

An interview was conducted with the DON on 5/15/25 at 1:30 PM. The DON stated that residents on Enhanced Barrier Precautions required PPE for all high-contact resident care activities. The DON indicated she expected that these precautions would be maintained. The DON indicated that EBP should be followed as written and this included gloves and gown for high contact resident care activities including using the

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F 880	Continued From page 26 bed linens to move a resident. The DON indicated that Resident #46 was receiving intravenous antibiotics due to endocarditis and he was a high risk for further infection and complications and therefor adherence with infection control measures was important. The DON stated that Resident #7 was on Enhanced Barrier Precautions due to a gastrostomy tube and a wound that was positive for MRSA (Methicillin Resistant Staphylococcus Aureus).	F 880		