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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Nursing Center	**1150 Pine Run Drive , Lumberton, North Carolina, 28358**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/26/2025 through 08/29/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D49F3-h1.	E0000		10/01/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/26/2025 through 08/29/2025. Event ID# ID49F3-H1 . The following intake was investigated 804180. 5 of the 5 allegations did not result in deficiency.	F0000		10/01/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident, staff and Medical Director interviews, the facility failed to assess whether the self-administration of medication was clinically appropriate before leaving medications at the bedside. This was for 2 of 2 residents reviewed for medication administration (Resident #3 and Resident #35). Findings included: a. Resident #3 was admitted to the facility on 5/30/25 with a diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease, stage 3 unspecified. A review of Resident #3's medical record did not reveal a self-administration of medication assessment.	F0554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F554 Resident Self-Admin Meds The facility failed to assess whether the self-administration of medication was clinically appropriate before leaving medications at the bedside. This was for 2 of 2 residents reviewed for medication administration (Resident #3 and Resident #35). 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/27/25, Nurse #1 removed medications from bedside for resident #3 and re-administered at a later time as requested by the resident. On 08/28/25, Resident #35 was observed taking her own medications without Nurse #2 being present. On 8/28/25, Resident #35 was assessed by the nursing team for self-administration of medications. Resident indicated she had no desire to self-administer medications.	10/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0554 SS = D	Continued from page 1 A review of Resident #3's physician's orders from 5/30/25 to 8/22/25 did not reveal a physician's order for Resident #3 to self-administer any medication. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 6/16/25 revealed she was severely cognitively impaired with no behaviors. The MDS also revealed Resident #3 received antidepressant and hypoglycemic medications. A review of Resident #3's active comprehensive care plan dated 6/10/25 did not have any goals or interventions for Resident #3 to self-administer medications. During an observation and interview with Resident #3 on 8/27/25 at 4:25 PM, resident was observed in bed. Medications were left on her bedside table in a medication cup. There was a total of 3 white pills- 2 were round and 1 was oval shaped. An interview with Resident #3 during the observation revealed she told staff to leave her medications, and she would take her medications later. Resident #3 stated that some nurses would leave the medications, and some would not. On 8/27/25 at 4:40 PM a phone interview with Nurse #1 indicated she was assigned to care for Resident #3 on 8/27/25 from 7:00 AM to 3:00 PM. Nurse #1 stated she was PRN (worked as needed). She indicated that there needed to be a physician's order for residents to self-medicate. There were no residents on her hall who self-medicated. Nurse #1 was aware she left medications in Resident #3's room and she should have taken them out. Per Nurse #1, the resident specifically stated what time she wanted to be bothered and then told her to get out. She went to her cart and left the medications in Resident #3's room. Nurse #1 stated she knew it was wrong and should not have left the medications. Medications left per Nurse #1 were Metformin (diabetic medicine), Amlodipine (blood pressure medicine), and Jardiance (diabetic medicine). Nurse #1 was not aware if Resident #3 had a self-medication assessment, physician order, or care plan related to self-administration of medications. Nurse #1 stated she spoke with the Unit Manager about it once she realized the medications were left in the room. The medications were removed and re-administered at a later time as requested by the resident. Nurse #1 stated the Unit Manager updated the time for Resident	F0554	Continued from page 1 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 09/02/25, the Director of Nursing (DON), Staff Development Coordinator (SDC) and Unit Support Nurses, completed an observation of 100% of all current resident rooms to ensure there were no unsecured medications at the bedside. Results: There were no medications observed at the bedside. On 09/02/25, the DON, SDC, and Unit Support Nurses, initiated interviews with residents that were cognitively intact with BIMS of 13-15 regarding their desire to self-administer medication. Results: There were no residents who desired to self-administer their medications. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/27/25, the SDC began education of all Full Time, Part Time, PRN licensed nurses (Registered Nurses and Licensed Practical Nurses) and medication aides including agency staff on facility policy related to self -administration of medication process. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/01/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Monitoring will be completed using the F554 Quality assurance tool. The Director of Nurses or designee will monitor compliance of the medication self-administration process and that no other meds are at bedside if the resident has not been assessed for self-administration. Monitoring of 5 resident rooms will be completed on various days of the week and shifts to assure compliance with the self-administration of medication policy. Monitoring	

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F0554 SS = D	Continued from page 2 #3 to receive medications. 8/28/25 at1:56 PM an interview occurred with the facility's Medical Director. Per the Medical Director, it was expected that medications were not left at the bedside for resident self-administration. Medication administration should be witnessed. b. Resident #35 was admitted to the facility on 5/6/25 with a diagnosis of type 2 diabetes mellitus without complications, unspecified dementia, unspecified severity, with mood disturbance. A review of Resident #35's medical record did not reveal a self-administration of medication assessment. Assessments were reviewed from 5/6/25 to 8/28/25. A review of Resident #35's physician's orders from 5/6/25 to 8/28/25 did not reveal a physician's order to self-administer any medications. A review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated 8/6/25 revealed Resident #35 was cognitively intact with no refusals of care. Resident #35 received antiplatelet, opioids, and antidepressant medications. A review of Resident #35's active comprehensive care plan dated 8/11/25 did not have any goals or interventions for Resident #35 to self-administer medications. On 8/28/25 at 8:45 AM Resident #35 was observed in bed and Nurse #2 left medications on Resident #35's bedside table. Nurse #2 stated to Resident #35 that she needed to get a blood pressure (BP) machine to take the resident's BP and exited the room leaving the medications on the resident's bedside table at 8:47 AM. Resident #35 was observed taking her own medications without Nurse #2 being present. Nurse #2 returned to Resident #35's room at 8:49 AM with the BP machine and took the resident's BP. On 8/28/25 at 9:25 AM an interview with Nurse #2 indicated that if a resident was going to self-administer medications, staff would need to look	F0554	Continued from page 2 will be completed weekly x 2 weeks then monthly x 3 months or until resolved for compliance with facility policy on self- administration of medication process. The ongoing audits will begin week of 9/1/25. Reports will be presented to the QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the QA Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/01/25	

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F0554 SS = D	Continued from page 3 at the residents' cognition, complete an assessment, and do a return demonstration. Nurse #2 stated she did not know if there were any residents on her hall that self-administered medications. Nurse #2 confirmed she left medications at Resident #35's bedside. She also named the medications that were left at the bedside (Iron, Linzess (constipation), Tylenol, Amlodipine (blood pressure), Aspirin, B12, Colace, Gabapentin (pain), Losartan (blood pressure), Magnesium, Vit D, Effexor (antidepressant), and Miralax). Nurse #2 stated she left the medications because she had to "get something". Nurse #2 stated she was not worried because Resident #35 was alert and oriented, and she would know if the resident took the medication because the cup would be empty. 8/28/25 at1:56 PM an interview occurred with the facility's Medical Director. Per the Medical Director, it was expected that medications were not left at the bedside for resident self-administration. Medication administration should be witnessed. 8/29/25 at 4:46 PM an interview occurred with the Administrator. The Administrator stated that the process for a resident to self-administer medications was that an assessment needed to be done. The facility needed to contact the provider to ensure that the residents were able to take their own medications. Also, an Interdisciplinary Team (IDT) review would be completed for those residents. There were currently no residents in the facility who were able to self-administer medications. Per the Administrator, there was not a breakdown in their process, the nurse just forgot the medications. No one can self-administer medications. The facility did not expect anyone to leave medications at a resident's bedside.	F0554		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by	F0732	The facility failed to ensure the daily posting of health care staff form had the correct resident census for 15 of 29 days. 1. Immediate Correction of the Deficient Practice On 08/29/25, The facility ensured that the current resident census was accurately reflected on the daily posting for all units. 2. Systemic Changes to Prevent Recurrence On 08/29/25, The Administrator implemented requiring the daily census to be verified by the charge nurse or designee before the healthcare staff posting is	10/01/2025

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F0732 SS = C	Continued from page 4 the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the daily posting of health care staff form had the correct resident census for 15 of 29 days. The findings included: A review of the facilities daily posting of health care staff from 7/30/2025 through 08/29/2025 revealed the following: a. Daily posting of health care staff dated 7/31/2025 revealed a census of 107. Review of the detailed census	F0732	Continued from page 4 finalized. The census will be cross-checked with the facility's electronic health record (EHR) and admissions/discharges log to ensure accuracy. 3. Education and Training On 8/29/25, The Administrator began educating All staff responsible for completing and posting the daily healthcare staff form: Director of Nursing (DON), Staff Development Coordinator (SDC), scheduler and unit managers received training on F732 requirements, including the importance of accurate census reporting. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/01/25. 4. Monitoring and Quality Assurance Beginning the week of 09/01/25, The Administrator or designee will monitor compliance utilizing the F732 Quality Assurance Tool 5 days a weekly x 2 weeks then monthly x 3 months. The Administrator or designee will audit the posted healthcare staff form for accuracy. Any discrepancies will be addressed immediately. Reports will be presented to the Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/01/2025	

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F0732 SS = C	Continued from page 5 report dated 7/31/2025 revealed a census of 104. b. Daily posting of health care staff dated 8/1/2025 revealed a census of 107. Review of the detailed census report dated 8/1/2025 revealed a census of 105. c. Daily posting of health care staff dated 8/2/2025 revealed a census of 106. Review of the detailed census report dated 8/2/2025 revealed a census of 104. d. Daily posting of health care staff dated 8/3/2025 revealed a census of 105. Review of the detailed census report dated 8/3/2025 revealed a census of 102. e. Daily posting of health care staff dated 8/4/2025 revealed a census of 105. Review of the detailed census report dated 8/4/2025 revealed a census of 101. f. Daily posting of health care staff dated 8/6/2025 revealed a census of 103. Review of the detailed census report dated 8/6/2025 revealed a census of 105. g. Daily posting of health care staff dated 8/7/2025 revealed a census of 106. Review of the detailed census report dated 8/7/2025 revealed a census of 107. h. Daily posting of health care staff dated 8/10/2025 revealed a census of 106. Review of the detailed census report dated 8/10/2025 revealed a census of 107. i. Daily posting of health care staff dated 8/11/2025 revealed a census of 106. Review of the detailed census report dated 8/11/2025 revealed a census of 108. j. Daily posting of health care staff dated 8/12/2025 revealed a census of 108. Review of the detailed census report dated 8/12/2025 revealed a census of 109. k. Daily posting of health care staff dated 8/18/2025 revealed a census of 110. Review of the detailed census report dated 8/18/2025 revealed a census of 108. l. Daily posting of health care staff dated 8/20/2025 revealed a census of 108. Review of the detailed census report dated 8/20/2025 revealed a census of 106. m. Daily posting of health care staff dated 8/21/2025 revealed a census of 105. Review of the detailed census report dated 8/21/2025 revealed a census of 107. n. Daily posting of health care staff dated 8/27/2025 revealed a census of 106. Review of the detailed census report dated 8/27/2025 revealed a census of 107.	F0732		

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F0732 SS = C	Continued from page 6 o. Daily posting of health care staff dated 8/28/2025 revealed a census of 107. Review of the detailed census report dated 8/28/2025 revealed a census of 108. An interview with the Staffing Scheduler was conducted on 8/29/2025 at 5:50pm. The Staffing Scheduler revealed she was responsible for completing the daily posting for health care staff. The census number was provided to the Staffing Scheduler during the daily morning meeting from the Admission Director. The census included residents in the building as of midnight the prior day. The Staffing Scheduler stated she did not change the daily posting of health care staff if the census changed with any admission or discharges; and was unsure why the census number did not match the daily detailed census report. An interview with the Admission Director was conducted on 8/29/2025 at 4:56pm. The Admission Director stated every morning she obtained the census number by the total number of residents that were in the building at midnight. She stated the census number provided to her in morning meeting did not include residents who were discharged or admitted. The Administrator was interviewed on 8/29/2025 at 5:21pm. She stated she was unaware of the discrepancy with the census number that was placed on the daily posting of health care staff. The census number posted on the daily posting of health care staff was not the resident census for the day, but the census at midnight.	F0732		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of wrong route and medications to be	F0759	The facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of wrong route and medications to be taken with food. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/28/25, Nurse # 3 was immediately re- educated on preventing medication errors to include administering medications per the correct route as per the physician directive. Nurse #3 provided resident #24 medications per the correct route. On 08/28/25, Resident #47 was assessed by the unit manager for any adverse events related to receiving medication without food. There were no identified concerns.	10/01/2025

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F0759 SS = E	Continued from page 7 taken with food (5 medication errors out of 31 opportunities), resulting in a medication error rate of 16.13% for 2 of 5 residents observed during medication pass (Resident #24 and Resident #47). The findings included: 1. Resident #24 was admitted to the facility on 4/11/25 with diagnoses that included stroke, hypertension, depression, and respiratory failure. a. A Physician order dated 5/6/25 revealed Resident #24 was to receive folic acid (dietary supplement) one (1) milligram (mg) via gastrointestinal tube (G-Tube) once a day. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. b. Resident #24's Physician order dated 5/5/25 was reviewed and revealed Resident #24 was to receive docusate sodium liquid (constipation medication) 50mg per 5 milliliters (ml) twice a day via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. c. Review of Resident #24's Physician order dated 5/6/25 revealed Resident #24 was to receive sertraline (antidepressant) 25mg daily via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. d. A Physician order dated 5/5/25 revealed Resident #24 was to receive carvedilol (blood pressure medication) 25mg twice a day via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. e. Review of Resident #24's Physician orders dated 6/25/25 revealed Resident #24 was to receive famotidine (acid reflux medication) 20mg via gastrointestinal tube (a tube inserted through the abdomen to the stomach) twice a day for 90 days. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. On 8/28/25 at 9:56 AM Nurse #3 was observed preparing Resident #24's medications for administration. She was observed placing folic acid, docusate sodium liquid, sertraline, carvedilol, and famotidine into the	F0759	Continued from page 7 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 09/04/25, All residents with G-tubes will have their medication administration routes reviewed and verified against physician orders. Additionally, medication administration instructions, such as timing with food (e.g., Glucophage), will be audited to ensure compliance with prescribed directives. The results included: There were no identified concerns. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/25, the SDC began education of all Full Time, Part Time, PRN licensed nurses (Registered Nurses and Licensed Practical Nurses) and medication aides including agency staff on Preventing Medication Errors. The topics included: · What is a Medication Error? · Types of Medication Errors · What to do once a Medication Error is Discovered? · How can I avoid making a medication error? · How to Avoid Medication Errors during administration. The 6 rights. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/01/25. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 9/8/25, The Director of Nursing or designee will monitor compliance utilizing the F759 Quality Assurance Tool weekly x 2weeks then monthly x 3 months. The DON or designee will monitor 5 residents for compliance of medication administration to include following physician ordered route and directive of	

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F0759 SS = E	Continued from page 8 medication cup. Review of the resident’s electronic MAR during medication pass observation, Resident #24’s medications were ordered to be administered via G-Tube. The directions on the medication bottles also stated medications were to be administered via G-Tube. Nurse #3 voluntarily explained that she was advised during morning report that Resident #24 no longer had his G-Tube and that medications were administered orally. Nurse #3 stated she was going to obtain two medications that were not available on her cart. She stepped away from her medication cart at 10:02 AM. On 8/28/25 at 10:04 AM, an interview with Resident #24 confirmed that he still had his G-Tube and that he continued to take his medications via that route. Nurse #3 was not present during that interview with Resident #24. On 8/28/25 at 10:08 AM, Nurse #3 returned to her medication cart without the two medications that were not available. She took the previously filled medication cup containing folic acid, docusate sodium liquid, sertraline, carvedilol, and famotidine into Resident #24’s room. Nurse #3 was observed handing Resident #24 his medications to be taken by mouth, the surveyor intervened and stopped Nurse #3 and asked her to step outside into the hall. Resident #24's route of medication was discussed. Nurse #3 explained she reviewed the physician’s order on the MAR while preparing Resident #24’s medications and was aware the order stated medications were to be administered by a G-tube. However, Nurse #3 stated again that during the morning report, it was reported to her that Resident #24 was on oral medications and that he no longer had his G-Tube. Nurse #3 confirmed she had not assessed the resident prior to administering the medications. During the continued observation Nurse #3 approached the Administrator and Unit Manager as they walked through the hall and asked the Administrator and Unit Manager if the resident’s medications were supposed to be administered orally or through G-tube as she was told during the morning report the medications were to be given by mouth. The Administrator and Unit Manager stated they would follow up to confirm. During an interview with Nurse #3 present on 8/28/25 at 10:37 AM, the Unit Manager confirmed Resident #24’s G-Tube was still in place, and he continued to receive his medications via G-Tube. The Unit Manager stated the order was verified via call to the Physician’s office.	F0759	Continued from page 8 administration with food/meals. Reports will be presented to the Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/04/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345054**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/29/2025**
NAME OF PROVIDER OR SUPPLIER **Woodhaven Nursing Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **1150 Pine Run Drive , Lumberton, North Carolina, 28358**	

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F0759 SS = E	Continued from page 9 2. Resident #47 was admitted to the facility on 5/8/25 with diagnoses that included diabetes mellitus. A review of Resident #47's medical record indicated an active physician's order dated 6/3/25 for Glucophage Tablet 500 milligrams (mg) (oral diabetes medication), give one (1) tablet by mouth two times a day for diabetes. Take with meals. The order was transcribed on the electronic MAR (eMAR) accurately. On 8/28/25 at 10:50 AM, during medication pass observation, Nurse #3 prepared Resident #47's medications at the medication cart. The medications observed included Glucophage, oxycodone hydrochloride, furosemide, gabapentin, empagliflozin, metoprolol tartrate, spironolactone. Nurse #3 also prepared polyethylene glycol (laxative) that was dissolved in water. Nurse #3 entered Resident #47's room with the medication cups that contained all the resident's medications including Metformin. The resident was observed not to have any food/meal available. Nurse #3 provided Resident #47 her medications without providing food/meal. On 8/28/25 at 6:06 PM a telephone interview occurred with Nurse #3. She stated if medications were ordered to be given with meals or food, she would provide the medication with meals and/or food. Nurse #3 stated she was unaware there was a physician order for Resident #47's Metformin to be given with meals/food. Nurse #3 stated she did not read Resident #47's entire medication order and she was unaware Glucophage was to be given with meals/food. The Director of Nursing was not available for interview during the survey. On 8/29/25 at 4:46 PM an interview occurred with the Administrator. The Administrator stated medication error rates were discussed in Quality Assurance (QA) and they completed incident reports. The Administrator indicated they hold discussions one-on-one with the individual, then with all staff if needed. Policy and process were changed if needed. The Administrator indicated the Director of Nursing would lead education pertaining to medication error rates when identified. The Administrator stated there was a "lack of critical thinking" on the nurse's part during the observation of	F0759		

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F0759 SS = E	Continued from page 10 Resident #24 and Resident #47, as the orders and chart were there. Per the Administrator, this was “reckless behavior” on the nurse's part.	F0759		
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 secure a cup of medications stored in 1 of 5 medication carts reviewed for medication storage (medication cart for Hall 1600). The findings included: An observation of the medication cart for Hall 1600 occurred on 8/28/25 at 8:15 AM. The Medication Aide (MA) #1 opened the top drawer of her medication cart and an unlabeled cup of medications was observed in the front left corner of the medication cart drawer. On 8/28/25 at 8:36 AM an interview occurred with MA #1	F0761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility failed to discard open unused medications and failed to ensure medications were labeled. Medication Aide (MA) #1 opened the top drawer of her medication cart and an unlabeled cup of medications was observed in the front left corner of the medication cart drawer. On 08/28/25 MA #1 disposed of the medications as appropriate in the approved medication waste bin. • Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 09/03/25 the Director of Nurses / Unit Managers audited all medication carts to ensure that all medications were labeled as appropriate and no loose medications noted in the medication cart. The results included: 1100 med carts with no deficient practice, 1200 med carts with no deficient practice, Rehab med cart with no deficient practice, and Memory Care med cart with no deficient practice. • Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/28/25 the Director of Nurses and Staff Development Coordinator began education of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included safely securing and storing medications and labeling of medications. The Director of Nursing and the Staff Development Coordinator (SDC) will ensure that any of the above identified staff who does not complete the in-service training will not be	10/01/2025

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F0761 SS = D	Continued from page 11 who confirmed she had left the medications in the top drawer of her medication cart for Resident #121. MA #1 explained the medications were centrum (vitamin supplement), clonazepam (seizure medication), fluoxetine (antidepressant medication), MiraLAX (constipation medication), and modafinil (central nervous system stimulant medication). She explained she had poured the medications and then realized the resident was in the shower, so she placed the medications in the medication cart drawer to provide Resident #121 with the medications later. MA #1 stated she did not know what the proper procedure was but was aware the medications should not have been left in her medication drawer. On 8/29/25 at 4:46 PM an interview occurred the Administrator. The Administrator explained the process for medication storage, stating medication bottles were properly labeled, medications were not to be left out, managers completed periodic audits to check for loose medications, education on medication storage included onboarding during orientation, and then as needed. The Administrator added, the Staff Development Coordinator provided education, and the Director of Nursing oversaw the medication storage process. Per the Administrator, this was "reckless behavior" on the Nurse's part. She explained MA #1 was new to their facility. The interview further revealed nurses should be prepared to know what to do if they pulled medications that they cannot use.	F0761	Continued from page 11 allowed to work on 09/01/25 or until the training is completed. Education on Medication Labeling and Storage is incorporated in the new employee facility orientation for clinical staff and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Quality assurance audits will be completed by the Director of Nurses or designee for F761 Adequate Label/Store Drugs and Biologicals to assess that all medications are safely and appropriately stored and labeled. Audits of medication carts to ensure locked, no loose unidentifiable pills, safe storage of medications, appropriate labeling will be completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. This audit will begin week of 09/08/25. Reports will be presented to the Quality Assurance committee by the Administrator and/or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. Date of Compliance: 09/03/25	
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by:	F0804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 11/04/2024 and 11/05/2024. Based on observation, Resident Council review, and staff interviews it was noted the facility failed to	10/01/2025

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F0804 SS = E	Continued from page 12 Based on record review, observations, and staff, Resident Council and Resident Representative interviews, and test tray, the facility failed to provide palatable foods for 7 of 7 residents reviewed for food palatability (Residents #14, #41, #50, #63, #96, #107 and #109). The findings included: Resident #14 was admitted to the facility on 1/10/24 with multiple diagnoses that included unspecified dementia and Type 2 diabetes. The medical record indicted Resident #14 resided in the dementia unit. The quarterly Minimum Data Set (MDS) dated 7/25/25 documented that Resident #14 was severely cognitively impaired. During an interview on 8/26/2025 at 10:58 AM, the Representative of Resident #14 stated she was often there at mealtimes and the Resident complained of the food being cold during those visits. She stated this occurred frequently and most often during breakfast. The representative did not say if she touched or sampled the food to confirm that it was cold. She stated that she had observed the staff taking Resident #14's tray out of the room and heat it up on occasion. An attempt to interview Resident #14 was made but the Resident was unable to describe the palatability of food. On 8/29/25 from 7:57 AM to 8:15 AM, the plating of breakfast food items for the dementia unit was observed. Observations included: -8:13 AM, all resident breakfast plates were placed in individual insulated dome bases and with lids then loaded into an enclosed metal food cart. -8:14 AM, the test tray was plated and placed in the food cart. -8:15 AM, the food cart left the kitchen for delivery to the dementia unit. -8:17 AM the unit staff began serving trays. The test tray food items were sampled and observed in the presence of the Food Service Supervisor on 8/29/25	F0804	Continued from page 12 provide palatable food to 7 of 7 residents. During interviews on 08/26/2025 Resident #14 noted food often cold. Food test tray on 08/29/2025 was acquired following the last plated tray and delivered to the dining room; no notable steam from food and food cold to touch. Upon tasting, Dietary Manager conferred the items on the plate were cold. Dietary Manager met with residents #14, #41, #50, #63, #96, #107, and #109 to review dietary concerns on 09/18/25. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 09/09/2025 the Senior Nutrition Service Coordinator completed a test tray and discussed findings with Dietary Service Director. Steam table replaced 08/30/25 and proofing cabinet repaired 08/30/2025 to ensure equipment working and meeting appropriate temperatures. Senior Nutrition Service Coordinator educated staff to take end point cooking temperatures, holding temperatures, and to properly fill wells with sufficient water on 09/09/25. Insulated bowls purchased for items such as oatmeal, side items, and vegetables on 09/22/25. Upon arrival, insulated bowls will be used to help maintain temperature of hot items. Plate warmer purchased 09/22/25 with estimated date of arrival on 10/15/25. Plate warmer will be installed upon arrival. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff by the Dietary Manager. Topics included: · Meal objectives and procedures · Holding and cooking temperatures. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be	

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F0804 SS = E	Continued from page 13 at 8:32 AM. The observation revealed there was no steam rising from the food when the dome lid was removed and no condensation on the dome lid. The bacon, eggs, grits, and pancakes were all cold to touch and taste. The Food Service Supervisor did not taste the food but touched the pancakes and bacon. During an interview with the Food Service Supervisor on 8/29/25 at 8:34 AM, she stated that food served to residents should be at a temperature that was both safe and that contributed to an enjoyable dining experience. She confirmed the pancakes and bacon that she touched on the test tray were cold to the touch. The Food Service Supervisor also discussed not knowing how to keep the food at the correct holding temperature once the tray was placed on the food cart. She shared that she was not aware of resident complaints of cold food. During the Resident Council meeting on 8/29/25 at 10:28 AM, Resident #41, Resident # 50, Resident #63, Resident #96, Resident #107, and Resident #109 stated that they consistently had to request that staff reheat their meals and that cold food occurred most often at breakfast. On 8/29/25 at 2:36 PM, an interview was conducted with the Administrator who acknowledged awareness of cold food complaints from residents and stated the issues in the kitchen were caused by a combination of new staff, less than ideal staffing levels, lack of training, and the need for repairs to the existing steam table.	F0804	Continued from page 13 allowed to work until training has been completed by 09/23/25. Test Trays will be completed to ensure satisfactory dining experience. Dietary Manager, Administrator, and/or Dietitian will attend Resident Council as invited and follow up with any food complaints as identified. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will complete a test tray weekly x 4 weeks and then monthly x 2 month. Monitoring will include reviewing food items for appearance and taste as well as visiting with residents and attending resident meetings when to address concerns and complaints in a timely manner. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. Date of Compliance: 10/01/25	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 8/26/25, 8/28/25, and 8/29/25. During initial walk through of the kitchen on 08/26/25, it was noted dietary services had failed to properly label/date/discard expired food, failed to properly	10/01/2025

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F0812 SS = E	Continued from page 14 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure dishware was clean, in good condition and not stacked wet, failed to maintain food preparation areas clean and free from dried debris, failed to label and date leftover food stored for use in 1 of 1 walk-in cooler and 1 of 2 walk-in freezers, failed to monitor and record the internal temperatures of food for 2 of 2 tray line observations and failed to ensure hot food was served at or above 135 degrees Fahrenheit (F). These practices had the potential to affect food served to residents. The findings included: a. During the initial tour of the kitchen with the Food Service Supervisor, on 8/26/25 from 9:45 AM to 10:00 AM, the following concerns were observed: - Three out of 8 steam pans that were ready to be used contained yellow and white sticky residue when touched. - Two out of 104 plastic dome lids that were on the tray line ready for use were stacked wet. - Seven out of 24 plates on the tray line ready for meal service had dried, yellow and red residue. - Seven out of 21 sectioned plates on the tray line ready for meal service had dried, yellow residue. - Seven out of 27 stacked serving trays that were on the tray line ready for use were wet and had approximately 50% of the plastic protective covering peeling away, leaving the tray base visible. These findings were discussed with the Food Services Supervisor on 8/26/25 at 10:00 AM and she removed these dishes from service. She stated that the dietary aides were responsible for checking dishes after being washed	F0812	Continued from page 14 clean/dry dishware, failed to maintain clean working areas, and failed to maintain and monitor food temperatures for service. On 08/26/25 the Dietary Manager discarded all improperly stored, unlabeled, and expired food items. All uncleaned and improperly dried items rewashed, sanitized, and left to air dry. On 08/27/25 the Dietary Manager and Dietitian completed a walk-through of the kitchen to ensure all food items were stored properly, dishware was cleaned, dried, and stored properly; and all damaged service ware thrown age. During 08/28/25 and 08/29/25 observation of tray line dietary staff failed to maintain and monitor proper meal times and served food below safe temperatures. On 08/28/25 food removed from line and reheated to appropriate temperatures. Maintenance replaced steamtable and fixed proofing cabinet 08/30/25. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 08/27/25 and 08/28/25, the Dietitian Consultant completed a kitchen and nourishment walk through with the Dietary Manager to ensure all food items were stored properly. Dish machine vendor, Hobart, contacted on 08/28/25 and ensured dish machine is in proper working order. On 8/30/2025 maintenance replaced the steam table and repaired the proofing cabinet. On 09/09/25 Thermometers and tray line temp logs replaced. On 09/22/25 new trays purchased, upon arrival, will replaced old trays with new trays. On 09/22/25 tray drying rack purchased, estimated arrival date is 10/15/25. Will be used to allow full air drying of meal trays. On 09/23/25 Dietary Manager began use of a cleaning schedule for staff assignments.	

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F0812 SS = E	Continued from page 15 for overall cleanliness and no dried food particles because there was no designated dish room staff. b. During the initial tour of the kitchen on 8/26/25 from 10:00 AM to 10:30 AM, the food preparation areas were observed and revealed the following: - The entire back splash of the food preparation table (approximately 15 feet) had thick greasy residue and raised dried brown and yellow residue. - The ledge above the stove had visible dried brown and white particles and was covered with thick, shiny residue. - The steam table cover had visible dried brown particles. - The underside of the steam table cover had a thick layer of shiny brown residue and raised, dried, brown residue. - The left side panel of the warmer oven was entirely covered with raised, dried brown and white particles and a thick, shiny residue. - The front panel of the warmer oven had raised, dry black residue approximately half inch wide and dried yellow residue extending from the door handle to the bottom of the panel. - Four out of 5 ceiling level air vents, located on the right wall when entering the kitchen, had black and green raised matter observed on all perimeters and each slat. - A dry storage container labeled fish fry batter had a scoop inside that was submerged under the dry batter mix. These findings were discussed with the Food Services Supervisor on 8/26/25 at 10:00 AM. She shared she and the dietary aides were responsible for cleanliness of the kitchen. c. During the initial tour of the kitchen on 8/26/25 from 10:30 AM to 11:00 AM, the walk-in refrigerator and freezer observations included: - A package of 10 hot dogs wrapped in plastic wrap with no date. - A plastic wrapped package labeled shredded parmesan cheese dated as opened on 8/8/25 and good until	F0812	Continued from page 15 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 09/19/25. Topics included: · Storage and dating policies and regulations. · Inspections on shifts to observe all food are within their dates and tossed if out of date. · Procedures for alerting PIC/maintenance when equipment out of working order. · Sanitation processes in dish room. · Proper thermometer handling, temp monitoring, and log completion. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/24/25. Maintenance to maintain kitchen equipment by keeping up to day on audits and maintenance request through TELS program. 4. Quality Assurance monitoring procedure. The Dietary Manager or assignee will monitor procedures for proper food storage, preparation, distribution, and service daily x2 weeks and weekly x4. Dietary QA Tool which will observe that all food is labeled, dated, tempted correctly, and stored in clean and working equipment. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. Date of Compliance: 10/01/25	

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F0812 SS = E	Continued from page 16 8/14/25. - One clear plastic 10-quart container contained shredded orange soft strips but had no date or label and the top was not secured. - An open bag labeled tator tots was not dated. - A plastic wrapped bag labeled green beans was not dated. - A bag identified by the Food Service Supervisor as French toast was not sealed and had no label and no date. - A plastic wrapped bag identified by the Food Service Supervisor as fried rice had no label and no date. - A three-inch-deep metal baking container identified by the Food Service Supervisor as fish had no label and no date. During an interview with the Food Service Supervisor on 8/26/25 at 11:49 AM, she stated that all food items should be sealed, labeled, and dated when stored. She stated all dietary aides were to check food items daily and immediately discard any items that were not sealed, labeled, or dated but labeling and cleaning the kitchen was a challenge with limited staff. d. On 8/28/25 at 11:49 AM during an observation of the lunch tray line, Cook #1 was asked to test the internal temperatures of the lunch food items. Cook #1 used a thermometer to test the internal temperature. There were two pans of meatloaf; pan #1 was noted to be 130.4 degrees Fahrenheit (F) and pan #2 was 114 degrees F. Cook #1 reported she thought the internal temperature was supposed to be 140 degrees F and stated the food would need to be reheated. The Food Service Supervisor was notified of the meatloaf's temperature on 8/28/25 at 11:50 AM and the items were removed and put back in the oven to reheat. When the pans of meatloaf were removed, no steam was observed rising from the middle section of the steam table, but steam was observed in the two other sections of the steam table. Cook #1 and the Food Service Supervisor were interviewed on 8/28/25 at 12:00 PM and they both stated the middle section of the steam table did not hold temperatures; the water would stay warm but not hot. The Food Service Supervisor stated the Administrator was aware of the steam table issues. She stated a	F0812		

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F0812 SS = E	Continued from page 17 Corporate Maintenance Director had looked at the table “a few months ago” and said that replacement parts were needed for the electrical board that controlled the heating elements. The Food Service Supervisor stated she had heard nothing further since the visit by the Corporate Maintenance Director. The Food Service Supervisor explained she only obtained the internal temperature of the food when the items were removed from the oven and that she had never obtained temperatures of the food once they were placed on the steam table. She stated that she did not keep food temperature logs and that she did not know that she needed to. The Food Service Supervisor stated she had not had any in-house training. She explained that when the Dietitian comes to the facility, the Dietitian would speak with her about the menu but nothing else. During an interview on 8/28/25 at 2:36 PM, the Administrator confirmed that she was aware of the steam table issues. The Administrator provided an email dated 8/27/25 at 9:31 AM from a refrigeration company and a copy of a signed estimate to fix the steam table element that confirmed parts had been ordered. This email also verified that the Administrator spoke with a vendor on 8/14/25 and asked the company to proceed with ordering the parts. The Administrator stated that a Corporate Dietitian trained the Food Service Supervisor which included keeping daily food temperature logs. On 8/29/25 at 7:15 AM, during a kitchen observation and interview, Cook #2 was asked to obtain the internal temperatures of the breakfast food items. Cook #2 used a thermometer to test the internal temperatures of the breakfast food items. The pancakes were noted to be 110 degrees Fahrenheit (F). Cook #2 reported that the pancakes should be reheated, however, proceeded to plate the pancakes and placed two trays into the tray cart. The surveyor asked for the tray line to be stopped, requested the two trays be removed from the food cart and the Food Service Supervisor was informed of the incident. The pancakes were reheated and returned to the tray line. On 8/29/25 at 2:36 PM, an interview was conducted with the Administrator. The Administrator stated the issues in the kitchen were a combination of new staff, less than ideal staffing levels, lack of training, and lack of routine scheduling of deep cleaning.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with	10/01/2025

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F0880 SS = D	Continued from page 18 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing 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	F0880	Continued from page 18 all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F880 • Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility failed to implement the enhanced barrier precaution (EBP) policy regarding applying personal protective equipment (PPE) to include applying gowns during high contact care activity. One nurse was observed providing medications to a resident with a g-tube not wearing a gown per EBP policy for resident #37. Staff were made aware after the deficiency was noted and no other deficiencies noted with other residents during high contact care activity. 1:1 education was completed with nurse noted with deficient practice on 08/28/25. • Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing and Staff Development Coordinator assessed all residents to identify if the resident met CDC criteria for Enhanced Barrier Precautions on 08/28/25. The findings included 39 residents were identified to meet the need for Enhanced Barrier Precautions. On 08/28/25 the staff development coordinator ensured that all 39 identified residents that met the need for Enhanced Barrier Precautions had appropriate signage placed at the room entrance, appropriate PPE placed inside the room per CDC recommendations, resident and/or family member were notified of precautions. This was completed on 08/28/25. On 08/28/25, MDS ensured all identified residents that met criteria for Enhanced Barrier Precautions were care planned as appropriate. This was 100% completed on 08/28/25. • Address what measures will be put into place or systemic changes made to ensure that the deficient	

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F0880 SS = D	Continued from page 19 infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 their infection control policies when Nurse #2 did not don (put on) a gown while administering medications via a gastrointestinal tube (a tube inserted through the abdomen to the stomach) to Resident #37 who required enhanced barrier precautions (EBP) due to the presence of a gastrointestinal tube (G-tube). This practice occurred for 1 of 3 staff members observed for infection control. The findings included: Review of the facility's Enhanced Barrier Precautions door sign dated 1/20/2022 stated that all healthcare personnel must wear gloves and gown for the following High Contact-Resident Care Activities: Device care or use: central line, urinary catheter, feeding tube, and tracheostomy care. Review of the facility's "Infection Prevention and Control Standards" policy (last approved 11/2024), and the "Initiating Transmission Based Precautions" policy (last approved 06/2025) stated Transmission-Based Precautions will be utilized in addition to Standard Precautions when the route of transmission is not	F0880	Continued from page 19 practice will not recur; On 08/28/25, the Director of Nursing and the Staff Development Coordinator (SDC) began in-servicing all clinical staff to include agency staff on Enhanced Barrier Precautions. The Director of Nursing and the Staff Development Coordinator (SDC) will ensure that any of the above identified staff who does not complete the in-service training will not be allowed to work on 09/01/25 or until the training is completed. Education on Enhanced Barrier Precautions is incorporated in the new employee facility orientation for clinical staff and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. • Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Administrator and Director of Nursing and/or designee will monitor tag F880 to ensure Enhanced Barrier Precautions are followed daily x 7 days, biweekly for 2 weeks, and then monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator and/or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director. • Date of Compliance The facility is compliant on 09/02/25. The facility will continue to monitor the situation beyond this date to ensure ongoing compliance.	

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F0880 SS = D	Continued from page 20 completely interrupted using Standard Precautions alone. This type of Transmission-Based Precautions includes Enhanced Barrier Precautions. Additional policy and procedures include Appropriate use of personal protective equipment. An observation of Resident #37's door on 8/28/25 at 9:00 AM revealed a sign taped on the door indicating she was on Enhanced Barrier Precautions (EBP) and a cady containing gowns and gloves was hanging on the door. Nurse #2 was observed entering Resident #37's room to administer medications via G-tube without donning a gown. Once Nurse #2 was in the room, she donned her gloves, pulled the resident's bedding back to expose the G-Tube. She then obtained the syringe from the protective bag hanging from a pole, began detaching the catheter from the G-Tube and placing it over the pole. Nurse #2 placed one end of the syringe into the G-Tube and began administering Resident #37's medication. When Nurse #2 had completed providing Resident #37 with her medication, she attached the catheter back to the G-Tube, covered the resident with her bedding, washed the syringe, placed it back into the protective bag, and left the room. On 8/28/25 9:25 AM an interview occurred with Nurse #2. Nurse #2 discussed being an agency nurse and that it was her second time working in the facility. She confirmed Resident #37 was on Enhanced Barrier Precautions (EBP). She also confirmed she did not put on a gown when providing medications through Resident #37's feeding tube. Nurse #2 stated she was aware she should have gowned but "just forgot". On 8/29/25 at 2:20 PM an interview was held with the Staff Development Coordinator (SDC)/Infection Preventionist (IP). She explained if agency staff were not present when education was provided to all staff, the information was provided to the agency to follow up with agency staff. Documentation of the completed training was required, and proof must be given to the facility. If agency staff were new to their facility, education was completed prior to staff arriving at work. The SDC/IP sometimes provided education when the agency staff arrived onsite prior to them starting their assignment and EBP was included in the infection control education. The SDC/IP stated staff were required to wear a gown and gloves while performing direct care, including G-tubes. Nurse #2 was educated during orientation, before she went onto the floor, and afterwards. The SDC/IP discussed Nurse #2 was educated	F0880		

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F0880 SS = D	Continued from page 21 on EBP on 8/23/25, and on contact versus enhanced precautions on 8/28/25. The SDC/IC provided evidence of orientation education for Nurse #2. On 8/29/25 at 4:46 PM an interview occurred with the Administrator. The Administrator stated the process for donning gowns during tube feedings/Infection Control was that staff must wear a gown and signs were on the door. Management also routinely spoke with staff during their staff meetings regarding infection control. The Staff Development Coordinator provided education on infection control. The Administrator stated there was no excuse why the nurse did not wear a gown. The Administrator stated she had quarterly facility-wide meetings regarding infection control, and the department heads/unit managers have monthly department meetings as well. The facility also had staff huddles as needed to provide education related to infection control.	F0880		