STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	**310 E Wardell Drive , Pembroke, North Carolina, 28372**

(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 The survey team entered the facility to conduct a recertification and complaint investigation survey on 9/29/25. The survey team was onsite 9/29/25 through 10/2/25 when the survey was paused in accordance with QSO-26-01-All as a result of the Federal Government shutdown. Based on CMS guidance, the survey team returned to the facility on 11/17/25 through 11/19/25 to complete the survey. The survey team exited on 11/19/25. Additional information was obtained on 11/21/25. Therefore, the exit date was 11/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D80E0-H1.	E0000		01/08/2026
F0000	INITIAL COMMENTS The survey team entered the facility to conduct a recertification and complaint investigation survey on 9/29/25. The survey team was onsite 9/29/25 through 10/2/25 when the survey was paused in accordance with QSO-26-01-All as a result of the Federal Government shutdown. Based on CMS guidance, the survey team returned to the facility on 11/17/25 through 11/19/25 to complete the survey. The survey team exited on 11/19/25. Additional information was obtained on 11/21/25. Therefore, the exit date was 11/21/25. Event ID #1D80E0-H1. The following intakes were investigated: 885101, 885111, 885114, 885104, 885112, 885086, 885109, 885081, 2644379, 2583512, 2613079, 2583064, 2616302, 2620161, 2623985, 2641756, 2662788, and 2663674. 20 of the 38 complaint allegations resulted in deficiency.	F0000		01/08/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F0558	F558- Reasonable Accommodation The air conditioner was turned on for Resident #21 on 09/29/25 by her Nurse Aide. NA #4 and NA #5 no longer work at the facility. The Executive Director, Social Worker or designee	01/08/2026

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

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

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F0558 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to honor a resident's right to make choices when a nurse aide (NA) turned off a resident's (Resident #21) air conditioning after she told them not to turn it off. This deficient practice occurred for 1 of 4 residents reviewed for choices. Findings included: Resident #21 was admitted to the facility on 5/15/23 with diagnoses to include hemiplegia affecting left side, cerebral infarction (stroke), and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 8/20/25 revealed Resident #21 was cognitively intact with no rejection of care behaviors in the lookback period. Resident #21's range of motion was impaired on both sides of the upper and lower extremities, she was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene. The care plan revised 7/24/25 revealed Resident #21 had a self-care deficit in performing activities of daily living (ADL) related to a stroke with hemiplegia and hemiparesis. The care plan interventions included Resident #21 was dependent on the assistance of two staff members with mechanical lift for all transfers. An interview and observation with Resident #21 occurred on 9/30/25 at 2:50 PM. Resident was crying and tearful during the interview. Resident #21 reported she had a terrible night last night. She indicated that she had turned on her call light after her tv show was over at 9:30 PM to request assistance getting ready for bed and that she needed incontinence care for her soiled brief. She stated the two NA's (NA #4 and NA#5) on the 3:00 PM to 11:00 PM shift had refused to provide care to her, because she told them not to turn her air conditioner off. She further stated that she was always hot and she liked her room temperature to be cool. Resident #21 stated the NAs had turned her air conditioner off after she told them not to turn it off. She explained the NAs had refused to provide care for her because she had said a curse word when they turned off her air conditioner. Resident #21 stated her room was her home and NA #4 and NA#5 should have respected her right to have the air conditioner turned on. An interview with NA #5 was completed on 9/30/25 at	F0558	Continued from page 1 conducted interviews with residents identified as having a BIMS (Brief Interview for Mental Status) 13 or higher to ensure residents rights are being honored related to room temperature by 12/16/25. The Executive Director, Social Worker or designee conducted a quality review of residents with a BIMS 12 or below to determine the residents room is appropriate temperature by 12/16/25. The Executive Director, Director of Nursing, Social Worker or Nurse Educator educated staff, including agency staff on reasonable accommodation needs/preferences related to honoring residents rights to make choices on temperature of residents room by 12/23/25. Newly hired staff will be educated upon hire during orientation. The Executive Director, Director of Nursing, Social Worker or designee will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure residents rights needs/preferences are being honored related to room temperature. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0558 SS = D	Continued from page 2 4:30 PM. NA #5 stated that she had been the NA assigned to care for Resident #21 last night. She further stated that at around 10:30 PM Resident #21 had requested to be assisted to bed and incontinence care be provided. NA #5 indicated that she asked NA #4 to help her with the mechanical lift to transfer Resident #21 to bed. She stated that when they came into the room with the mechanical lift the temperature in the room was cold, so they asked Resident #21 if they could turn off the air conditioner, and she told them no. NA #5 indicated she turned the air conditioner off anyway and Resident #21 had said a curse word and told them to turn the air conditioner back on. She stated that when Resident #21 cursed at them, she and NA #4 decided to leave the room, because they didn't want to argue with her. NA #5 indicated they left the room and reported the incident to the nurse. NA #5 further stated she had been a NA for approximately 1 year and that she had received training regarding resident rights. An interview with NA #4 occurred on 9/30/25 at 4:45 PM with NA #5 present. NA #4 stated that she was asked by NA #5 to help her assist Resident #21 to bed at approximately 10:30 PM last night. She further stated that she was only there to assist NA #5 and that she was just trying to help. NA #4 indicated that she was not the NA assigned to care for Resident #21. She stated when they entered the room to provide care for Resident #21 it was cold and they had asked her if they could turn off the air conditioner and she had stated no. NA #4 indicated that NA #5 had turned the air conditioner off and that the resident had said a curse word. She stated she didn't have to put up with anybody talking to her like that and that they had refused to provide care to Resident #21, and they had left the room. NA #4 stated she didn't feel like she had done anything wrong because she was not assigned to care for Resident #21. She further stated she had been a NA for approximately 3 months and that she had received training regarding resident rights to make their own choices. Resident #22 was admitted to the facility on 3/24 25 and her quarterly MDS assessment dated 7/7/25 revealed she was cognitively intact. An interview with Resident #22 was completed on 10/1/25 at 12:24 PM. Resident #22 stated she was Resident #21's roommate and was present when the incident occurred on 9/29/25 at approximately 9:30 PM between Resident #21 and NA #4 and NA #5. She stated that when NA #4 and NA #5 came into the room, they had asked Resident #21 if they could turn off the air conditioner and she had told them no. Resident #22 indicated that one of the	F0558		

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F0558 SS = D	Continued from page 3 NAs turned off the air conditioner anyway, and Resident #21 had said a curse word. She stated that the NAs told Resident #21 they didn’t have to put up with anyone talking to them like that and disrespecting them. An interview with Nurse #7 who was working the 7:00 PM to 7:00 AM shift on 9/29/25 occurred on 10/2/25 at 1:29 PM. Nurse #7 indicated she was unaware that the NA had turned Resident #21’s air conditioner off without her permission. An interview was completed with the Director of Nursing (DON) on 11/18.25 at 3:15 PM. The DON stated NA #5 should not have turned off Resident #21’s air conditioner without her permission. She further stated the NAs should have provided the care that Resident #21 requested, regardless of her use of a curse word. The DON stated she expected the nursing staff to respect the residents’ rights to choices. An interview was conducted with the Administrator on 11/18/25 at 3:55 PM. The Administrator stated the facility was Resident #21’s home and NA #5 should not have turned off Resident #21’s air conditioner after she told her not to turn it off. She stated that she expected the staff to provide care for the residents, regardless of the residents’ behavior. The Administrator indicated that it was a resident right to make choices regarding their care.	F0558		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F0580	F-580 Notify of Changes 1. The Physician was notified on 10/1/25 by the Director of Nursing of Resident #62 weight gain. No other residents were affected by this occurrence. 2. A quality review was completed by the Director of Nursing by 12/15/25. to ensure that the physician has been notified about any weight loss/ weight gain within the last 30 days. 3. The Market Clinical Lead educated the Director of Nursing on the importance of notifying the physician on weight gain / weight loss on 12/02/25. The Director of Nursing educated licensed nurses to include agency staff on the importance of notifying the physician when there is a weight gain / weight loss by 12/23/25. Newly hired staff will be educated upon hire during orientation. The Director of Nursing or Nurse managers will conduct a quality review of weights to ensure the physician is notified of weight gain / weight loss 5x	01/08/2026

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F0580 SS = D	Continued from page 4 treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and Nurse Practitioner (NP) interview, the facility failed to notify the provider of significant weight gain for a resident with Congestive Heart Failure (CHF) and on diuretic medication (a medication that helps the body remove excess fluid) for 1 of 1 sampled resident reviewed for notification of change. (Resident #62) Findings included: Resident #62 was admitted to the facility on 04/08/25 with a cumulative diagnosis including atrial	F0580	Continued from page 4 per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks . 4. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. 5.Compliance Date (01/08/26)	

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F0580 SS = D	Continued from page 5 fibrillation (A-fib), hypertension (HTN), congestive heart failure (CHF), and peripheral vascular disease (PVD). A physician order dated 04/28/25 revealed an order to weigh Resident #62 every day, with start date of 04/28/2025. Give Furosemide (a diuretic medication) oral tablet 40 milligrams (MG),1 tablet by mouth one time a day for HTN, with a start date of 4/10/2025. Give Spironolactone (a diuretic medication) oral tablet 25 MG,1 tablet by mouth in the morning for CHF. Review of Resident #62's weekly/monthly weights revealed: 09/09/25 was 220.2 pounds (lbs). 09/28/25 was 247 lbs. a weight gain of 26.8 lbs. in 19 days Further review of Resident #162's medical record on 09/29/25 revealed there were no additional weights, and no documentation the physician was notified of the significant weight gain. An interview was conducted on 09/30/25 at 3:55 PM with the Director of Nursing (DON). She revealed it was her expectation that Resident #62's physician should have been notified by his nurse of the Resident's greater than 5% weight gain, given the Resident's history of CHF. An interview was conducted on 10/01/25 at 9:20 AM with the Nurse Practitioner (NP) The NP stated this was the first time she heard of Resident #62's nineteen-day weight gain of 26.8 pounds since admission. She stated no staff had reported to her any weight concerns. The NP expected she or the medical director to be notified if Resident #62's weekly/monthly weights were greater than 5 lbs. from the previous weight, since the resident had a diagnosis of CHF. The NP said she expected the MD to have been notified, in order to treat the weight gain and to determine if it was related to CHF, and if additional medication was to be ordered or a change in treatment needed. An interview was conducted on 10/01/25 at 2:00 PM with the Nursing Unit Manager #1. She stated on 09/28/25 she entered Resident #62's weight of 247 lbs. into the electronic medical record. She said she noticed when she entered the weight that the weight number entered had turned red indicating a significant weight gain, but she did not check resident's previous weight to determine how significant of a weight gain it was and	F0580		

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F0580 SS = D	Continued from page 6 should have. The nurse stated she did not notify the MD or RD because she did not compare the two weights to confirm resident's weight gain was greater than 5% in one month. She said it was her fault for not comparing previous weights to the ones she was entering for significant weight changes, especially with residents with edema or CHF.	F0580		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with	F0585	Resident #10 and Resident #62 were provided written grievance summaries/ resolution on 9/30/25 by the Administrator. A copy of the summaries/resolution was sent to resident's Representative 9/30/25. The Administrator conducted a quality review on 12/03/25 of the last 30 days of grievances to ensure written grievances summaries were provided. Any discrepancies identified were corrected. The Administrator was educated by the Market Resource Operator on 12/03/25 on the Grievance/ Concern policy with emphasis on issuing written grievance decision/resolution, date the written resolution was provided and prompt receipt of the written resolution. The Social worker was provided the same education by the Administrator on 12/02/25. The Executive Director or designee will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure written grievances summaries/ resolutions are provided to the resident or resident representative. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	01/08/2026

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F0585 SS = D	Continued from page 7 whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by:	F0585		

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F0585 SS = D	Continued from page 8 Based on record review and staff interviews, the facility failed to provide written grievance summaries for 2 out of 2 residents reviewed (Resident #10 and #62). Findings included: Review of facility policy dated 10/15/24 titled Center Operations Policies and Procedures Grievance/Concern read in part: The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process including receiving and tracking grievances through their conclusion, issuing written grievance decision to the resident with a date the written resolution was issued with the purpose to assure prompt receipt and resolution of resident and representative grievance/concern. 1. Resident #10 was admitted to the facility on 12/26/24. The Minimum Data Set quarterly assessment dated 08/26/25 revealed resident #10 was severely cognitively impaired. A review of the facility's grievance log since 11/21/24 revealed a grievance dated 03/31/25 for Resident #10 by the Responsible Party (RP) regarding a concern that Resident #10 had an appointment and the RP stated his nails were very long and needed trimming. The action taken to investigate the grievance was that the Director of Nursing checked residents' nails, Nurse Aide clipped his nails and shaved his face with a recommended correction action to include providing nail care and rounds to inspect nail care needs. The resolution of the grievance under "Written notification provided on (insert date)" was noted to be blank. The Administrator signed the grievance. An undated grievance written by the Responsible Party was reviewed for Resident #10. The grievance/concern was that Resident #10 had an appointment and was sent to the appointment without being dressed properly. The recommended correction action was education provided to all staff during an all staff meeting by the Director of Nursing. The resolution of the grievance under "Written notification provided on (insert date)" was noted to have a date of 07/01/25. On the bottom page of the grievance read, "Additional methods that may have been used to discuss resolution with the resident/representative, was checked "written." The attached written summary was dated 07/01/25, however it did not correspond to the concern regarding being sent	F0585		

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F0585 SS = D	Continued from page 9 to appointment without being dressed properly. The grievance was signed by the Administrator. An interview with the Administrator on 09/30/25 at 2:10 PM revealed she should have sent a written response to the Responsible Party regarding both concerns. She stated the letter dated 07/01/25 was a written response to a grievance that was filed on 07/01/25 and did not relate to the concern of being sent to appointment without being dressed properly. 2. Resident #62 was admitted to the facility on 04/08/25. The Minimum Data Set quarterly assessment dated 07/16/25 revealed Resident #62 was severely cognitively impaired. A review of the facility's grievance log revealed a grievance from Resident #62 for needing help transferring to bathroom. On the bottom page of the grievance dated 05/27/25 read, "Date written notification provided," was left blank. Also, on the bottom page of the grievance read, "Additional methods that may have been used to discuss resolution with the resident/representative," was checked "Face to face. The grievance/concern form reviewed had no back page summary or findings/recommended corrective action(s) filled out. An interview was conducted on 10/01/25 at 10:30 AM with the Director of Nursing (DON). The DON stated she did not know the resident/representative needed to receive a written summary of their grievance resolutions. The DON acknowledged Resident #62 should have been provided with a written resolution and summary. An interview was conducted on 10/01/25 at 10:40 AM with the Administrator. The Administrator confirmed Resident #62 did not receive a written grievance summary of the resolution. An interview on 10/02/25 at 8:17 AM with the Social Worker (SW) revealed that she did not know until today that she needed to provide a written grievance summary to the resident or representative who filed the concern. The SW stated she thought the verbal summary was okay. The SW stated before today, she had only called or verbally spoken to the complainant in person and verbally summarized the grievance, with nothing given to them in writing. The SW added, now she knows to provide a written grievance summary to complainants.	F0585		
F0600 SS = D	Free from Abuse and Neglect	F0600	Resident #21 was transferred from her electric	01/08/2026

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F0600 SS = D	Continued from page 10 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with residents and staff, the facility failed to protect a resident's right to be free from neglect when two nurse aides (NA) on the 3:00 PM to 11:00 PM shift refused a dependent resident's (Resident #21) requests for transferring her to bed and incontinence care. Resident #21 was left sitting up in her electric wheelchair in her room that had a strong odor resembling bowel incontinence. When Resident #21's incontinence care was provided her brief was heavily soiled with a bowel movement that was caked and dried on her skin. Resident #21 was in a semi-private room, and she stated she was embarrassed and humiliated in front of her roommate by the NAs refusal of care. The deficient practice occurred for 1 of 4 residents reviewed for neglect. Findings included: Resident #21 was admitted to the facility on 5/15/23 with diagnoses to include hemiplegia affecting left side, cerebral infarction (stroke), and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 8/20/25 revealed Resident #21 was cognitively intact with no rejection of care behaviors in the lookback period. Resident #21's range of motion was impaired on both sides of the upper and lower extremities, she was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene.	F0600	Continued from page 10 wheelchair to her bed and incontinence care was provided by Nurse Aide on 09/30/25. The Executive Director, Social Worker or designee conducted interviews with residents identified as having a BIMS (Brief Interview for Mental Status) 13 or above to ensure incontinence care is provided by 9/30/25. The Director of Nursing or Nurse Manager to conduct skin checks by 10/01/25 on residents with a BIMS 12 or below to ensure no signs or symptoms of neglect and to ensure incontinence care provided. The Market Resource operator educated the Administrator and Director of Nursing on 12/3/25 regarding the abuse policy with emphasis on neglect. The Administrator, Director of Nursing or designee will educate staff, including agency staff by 12/23/25 on the abuse policy with emphasis on neglect. The Director of nursing or designee will educate licensed nurses, certified nursing assistants and agency nursing staff on providing care to residents by 12/23/25. Newly hired staff to include newly hired agency staff will be educated upon hire during orientation. The Executive Director, Director of Nursing, or designee will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure residents are provided assistance and incontinence care. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0600 SS = D	Continued from page 11	F0600		

The care plan revised 7/24/25 revealed Resident #21 had a self-care deficit in performing activities of daily living (ADL) related to a stroke with hemiplegia and hemiparesis. The care plan interventions included Resident #21 was dependent on the assistance of two staff members with mechanical lift for all transfers.

An interview with Resident #21 occurred on 9/30/25 at 2:50 PM. Resident #21 reported she had a terrible night last night. She stated that she was a smoker and that she usually gets ready for bed after she goes outside for the last supervised smoke break scheduled at 8:30 PM. Resident #21 indicated that she had turned on her call light after her tv show was over at 9:30 PM to request assistance getting ready for bed and that she needed incontinence care for her soiled brief. She stated the two NA's (NA #4 and NA#5) on the 3:00 PM to 11:00 PM shift had refused to provide care to her. She further stated that she had to wait until after 12:30 AM to finally get changed and to go to bed. Resident #21 explained the NAs had refused to provide care for her because she had said a curse word when they turned off her air conditioner. She stated the NAs turned around with the mechanical lift and said they were not going to provide care for anyone who was cursing them and being disrespectful to them. Resident #21 stated she was left in her electric wheelchair in her room facing the tv. Resident #21 indicated that she was in a semi-private room and that the NAs had embarrassed her and humiliated her in front of her roommate, by treating her like a child. She stated that the incident had made her sad and mad at the same time.

The Administrator was immediately notified on 9/30/25 at 3:30 PM of Resident #21's allegation of neglect involving NA #4 and NA#5. The Administrator stated she was immediately suspending NA #4 and NA #5 pending the investigation and she was filing a report with the state agency.

An interview with NA #5 was completed on 9/30/25 at 4:30 PM. NA #5 stated that she had been the NA assigned to care for Resident #21 last night. She further stated that at around 10:30 PM Resident #21 had requested to be assisted to bed and incontinence care be provided. NA #5 indicated that she asked NA #4 to help her with the mechanical lift to transfer Resident #21 to bed. She stated that when they came into the room with the mechanical lift the temperature in the room was cold, so they asked Resident #21 if they could turn off the air conditioner, and she told them "no". NA #5 indicated she turned the air conditioner off anyway and Resident #21 had said a curse word and told them to

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F0600 SS = D	Continued from page 12 turn the air conditioner back on. She stated that when Resident #21 cursed at them, she and NA #4 decided to leave the room, because they didn't want to argue with her. NA #5 further stated that she felt like she was disrespected by Resident #21 and that is why she had refused to provide her care. She indicated they left the room and reported the incident to the nurse. NA #5 stated that she and NA #4 left the facility at 11:00 PM without providing care for Resident #21. NA #5 further stated she had been a NA for approximately 1 year and that she had received training on abuse/neglect. An interview with NA #4 occurred on 9/30/25 at 4:45 PM with NA #5 present. NA #4 stated that she was asked by NA #5 to help her assist Resident #21 to bed at approximately 10:30 PM last night. She further stated that she was only there to assist NA #5 and that she was just trying to help. NA #4 indicated that she was not the NA assigned to care for Resident #21. She stated when they entered the room to provide care for Resident #21 it was cold and they had asked her if they could turn off the air conditioner and she had stated, "no". NA #4 indicated that NA #5 had turned the air conditioner off and that the resident had said a curse word. She stated she didn't have to put up with anybody talking to her like that and that they had refused to provide care to Resident #21, and they had left the room. NA #4 stated she didn't feel like she had done anything wrong because she was not assigned to care for Resident #21. She stated that she and NA #5 clocked out at 11:00 PM and left the building without providing care to Resident #21. NA #4 further stated she had been a NA for approximately 3 months and that she had received training regarding abuse/neglect. Resident #22 was admitted to the facility on 3/24 25 and her quarterly MDS assessment dated 7/7/25 revealed she was cognitively intact. An interview with Resident #22 was completed on 10/1/25 at 12:24 PM. Resident #22 stated she was Resident #21's roommate and was present when the incident occurred on 9/29/25 at approximately 9:30 PM between Resident #21 and NA #4 and NA #5. She stated that when NA #4 and NA #5 came into the room, they had asked Resident #21 if they could turn off the air conditioner and she had told them no. Resident #22 indicated that one of the NAs turned off the air conditioner and Resident #21 had said a curse word. She stated that the NAs told Resident #21 they didn't have to put up with anyone talking to them like that and disrespecting them. Resident #22 indicated the NAs had taken the mechanical lift out of the room and left Resident #21 sitting in her wheelchair. She stated that according to the time	F0600		

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F0600 SS = D	Continued from page 13 on her cell phone it was around 12:30 AM when the 1100 PM to 7:00 AM NAs got Resident #21 into bed and provided care. An interview was completed with NA #6 on 10/1/25 at 11:16 AM. NA #6 stated she was supposed to be at work at 11:00 PM on 9/29/25 but that she arrived about an hour late. She further stated that when she went to Resident #21's room she was still up in her wheelchair waiting to go to bed. NA #6 stated she and NA #7 transferred Resident #21 to bed at approximately 12:30 AM. She indicated that Resident #21 was incontinent with bowel and it looked like it had been there for a while because it was caked and dried on her skin. NA #6 stated that Resident #21 was usually in bed when she came in at 11:00 M and that was the first time she had to put her to bed on 11:00 PM to 7:00 AM shift. She further stated that Resident #21 informed her that the NA from 3:00 PM to 11:00 PM shift had refused to provide care for her. She indicated Resident #21 was very upset about the incident and she was crying. NA #6 stated Resident #21 had never been disrespectful or rude to her. An interview with Nurse #7 who was working the 7:00 PM to 7:00 AM shift on 9/29/25 occurred on 10/2/25 at 1:29 PM. Nurse #7 stated she recalled the incident with Resident #21 and NA #4 and NA #5 occurred on 9/29/25 at approximately 10:30 PM. She stated the NAs reported to her that Resident #21 had cursed them when they went into her room to transfer her to bed. Nurse #7 further stated that she had told the NA's she would speak to Resident #21 about the incident. She indicated she was unaware that NA #4 and NA #5 were not going to provide Resident #21 care prior to them leaving their shift. Nurse #7 explained that one of the NAs on the 11:00 PM to 7:00 AM shift was late for work on 9/29/25 and Resident #21 was not assisted to bed until around 12:30 AM. She stated that the NA's had not asked her to assist them with transferring Resident #21 to bed or providing incontinence care. Nurse #7 indicated she was unaware that Resident #21 had a bowel movement and needed incontinence care. An interview was completed with NA #7 on 10/2/25 at 8:10 AM. NA #7 stated that she was working the 11:00 PM to 7:00 AM shift on 9/29/25. She further stated that there was only 2 NA assigned to the 300 and 400 halls at night, and that NA #6 was approximately an hour late for work on 9/29/25. NA #7 indicated Resident #21 was still up in her electric wheelchair when she came on shift at 11:00 PM. She stated that Resident #21 was very upset and was crying that she was left up in her wheelchair and she needed incontinent care. NA #7	F0600		

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F0600 SS = D	Continued from page 14 further stated that she and NA #6 did transfer Resident #21 to bed and provide incontinence care at approximately 12:30 AM. She explained that she had not asked Nurse #7 to assist her with transferring Resident #21 to bed because she was busy with new admissions and other work. An interview was completed with the Director of Nursing (DON) on 11/18/25 at 3:15 PM. The DON stated that NA #4 and NA #5 were suspended pending an investigation on 9/30/25 after becoming aware of the allegation of neglect for Resident #21. She further stated the NAs should have provided the care that Resident #21 requested, regardless of her use of a curse word. The DON stated the facility did not tolerate the type of unprofessional behavior that was displayed by the NAs. An interview was conducted with the Administrator on 11/18/25 at 3:55 PM. The Administrator reported that NA #4 and NA #5 were suspended on 9/30/25 after she was made aware of the allegation of neglect involving Resident #21. She stated that she expected the staff to provide care for the residents, regardless of the residents' behavior. The Administrator stated that the police were notified and a report was filed with the state. She indicated that the facility took allegations of abuse and neglect very seriously and an investigation was conducted.	F0600		
F0637 SS = A	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete the required Significant Change in Status Assessment (SCSA) within 14 days of the Assessment Reference Date (ARD-referring to the last day of the observation period) for 1 of 22 residents reviewed for assessments (Resident #3)	F0637		01/08/2026

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F0637 SS = A	Continued from page 15 Findings included: Resident #3 was admitted to the facility on 12/14/24. Diagnoses included bilateral lower extremity amputation. Resident #3 required a SCSA due to changes of decline of ADL and weight loss. The ARD for Resident #3's SCSA was 7/16/25 and it was completed on 8/4/25. An interview with the Minimum Data Set (MDS) Clinical Reimbursement Coordinator (CRC) occurred on 11/16/25 at 9:19 AM. The MDS CRC stated that she knew several residents' MDS assessments had been completed late. She further stated that she worked for the company and traveled between several facilities and was not always able to get the assessments completed on time. The MDS CRC indicated the facility had hired a full-time MDS CRC a few weeks ago and that the assessments would be completed on time in the future. An interview with the Director of Nursing (DON) was completed on 11/18/25 at 2:52 PM. The DON stated she was aware that the MDS assessments were not being completed on time. She further stated she expected the assessments to be completed on time. An interview with the Administrator was completed on 11/18/25 at 3:55 PM The Administrator stated that the reason the MDS assessments were late was due to a vacant MDS CRC position. She further stated the MDS assessments should be completed on time.	F0637		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD-referring to the last day of the observation period for 2 of 22 residents sampled for assessments (Resident #17 and Resident #21). Findings included: 1a. Resident #17 was admitted to the facility on	F0638	Resident #17 and Resident # 21 was not affected by the deficient practice of the quarterly Minimum Data Set (MDS) assessment not completed within 14 days of the Assessment Reference Date (ARD). The facility hired a permanent MDS Nurse on 10/27/25. On 10/10/25, the MDS Nurse will conduct a quality review audited of all current residents to ensure residents quarterly MDS assessment is completed within the 14 days of the ARD. The Regional MDS Nurse Consultant educated the interdisciplinary team members and the traveling MDS Nurse on completing the quarterly MDS assessment within the 14 days of the ARD on 10/13/25. Newly hired MDS Nurse will be educated upon hire during orientation. The Executive Director, Director of Nursing or designee will conduct quality reviews of quarterly MDS assessments to ensure MDS assessments are completed within the 14 days of the ARD on 2 random residents 5x	01/08/2026

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F0638 SS = D	Continued from page 16 1/7/25. Review of Resident #17's MDS assessments revealed that quarterly assessment with an ARD of 7/10/25 and the completion date was 7/30/25. b. Resident #21 was admitted to the facility on 5/15/23. Review of Resident #21's MDS assessments revealed a quarterly MDS assessment with an ARD of 7/23/25 and it was completed on 8/20/25. An interview with the MDS Clinical Reimbursement Coordinator (CRC) occurred on 11/16/25 at 9:19 AM. The MDS CRC stated that she knew several residents' quarterly MDS assessments had been completed late. She further stated that she worked for the company and traveled between several facilities and was not always able to get the assessments completed on time. The MDS CRC indicated the facility had hired a full-time MDS CRC a few weeks ago and that the assessments would be completed on time in the future. An interview with the Director of Nursing (DON) was completed on 11/18/25 at 2:52 PM. The DON stated she was aware that the MDS assessments were not being completed on time. She further stated she expected the assessments to be completed on time. An interview with the Administrator was completed on 11/18/25 at 3:55 PM The Administrator stated that the reason the MDS assessments were late was due to a vacant MDS CRC position. She further stated the MDS assessments should be completed on time.	F0638	Continued from page 16 per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date: 1/08/2026	
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff interviews, Physician and Consulting Pharmacist interviews, the facility administered an expired medication that was stored in the medication cart to Resident #10 via enteral tube feeding for 9 days for a total of 18	F0658	Resident #10 was not affected related to the deficient practice. . A quality review was completed by the Director of Nursing or Nurse Managers on current prescribed medications to ensure no expired medications are on the medication carts or the medication storage room on 10/01/25. No issues identified. The Regional Clinical Lead educated the Director of Nursing on 12/08/25 on removing expired medication from the medication cart and medication storage room and verifying the medication expiration date prior to administration. The Director of Nursing or Nurse Managers educated licensed nurses and medication aides, including agency staff on removing expired medications	01/08/2026

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F0658 SS = E	Continued from page 17 doses. Resident #10 was sent to the Emergency Department and had no adverse outcome as a result of receiving this expired medication. Findings included: Resident # 10 was admitted to the facility on 12/26/24. Diagnoses included stroke with aphasia (a language disorder that affects a person's ability to communicate), gastrostomy (tube feed) and gastroenteric reflux disease (GERD). Review of a physician's order written on 12/27/24 for Pantoprazole Sodium Oral (also known as Protonix) Suspension 4 milligrams/milliliter. Give 10 milliliters enterally (via tube feed) two times a day for GERD. The Minimum Data Set admission assessment dated 12/31/24 revealed Resident #10 was coded as severely impaired and was coded as having a feeding tube. A hospital emergency department note dated 01/19/25 revealed, in part, per nursing facility staff, resident was given his daily dose of Protonix this morning and it was noted after administering that the medication had expired 9 days ago (01/10/25). Resident was currently resting comfortably, nonverbal but able to answer questions by nodding or shaking his head and had no acute complaints. Resident's Responsible Party requested that resident be sent to the emergency department to make sure resident was okay after receiving the expired medication. The hospital course indicated the only side effect from this expired medication would be that it may not be as effective as usual. Resident was discharged back to the facility. Review of the January Medication Administration Record revealed Resident #10 received the Protonix medication twice daily from 01/11/25 through 01/19/25 to include a total of 18 doses. Review of a grievance concern form dated 07/01/25 filed by the Responsible Party (RP) revealed Resident#10 received medications that were expired. The investigation was addressed to the Director of Nursing on 07/01/25 and the action taken for this concern was that education was provided to all nursing staff during an all-staff meeting. A written summary was attached and addressed to the RP stating, in part, "we are contacting you to notify of the outcome to your concern regarding [Resident #10] receiving an expired medication. [Resident #10] had no adverse effects from the medication being given and 72-hour charting was completed to ensure there were no signs or symptoms of	F0658	Continued from page 17 from the medication cart and medication storage room and verifying the medication expiration date prior to administration. Newly hired licensed nurses and medication aides, including agency staff will be educated in orientation. Current licensed nurses and medication aides received education by 1/07/25. The Director of Nursing or Nurse managers will conduct a quality review of medication carts and medication storage rooms 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure expired medications are removed and not administered. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date 01/08/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

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F0658 SS = E	Continued from page 18 adverse effects. As a facility, we have measures in place to ensure this does not happen again. We have educated the staff and will be conducting medications cart checks for expired medications." Education in-service record dated 07/01/25 revealed the nursing staff were in serviced to ensure expired medications were discarded and not given to residents. The in-service included checking expiration dates on medications and discard any expired medications to avoid the administration of expired medications. Each of the nurses who administered the expired medication signed the in-service sheet. An interview with the Director of Nursing (DON) on 10/02/25 at 3:00 PM revealed she had started working at the facility in March of 2025. She stated on 07/01/25 she was made aware via a grievance from the Responsible Party of Resident #10 that he received expired medications that had occurred in January 2025. She stated she initiated an in-service with each nurse who signed off that they administered the medication from 01/11/25 through 01/19/25 on 07/01/25 and began medication cart audits. The DON stated she did not know what the previous DON did when this error occurred back in January 2025. A phone interview with Consulting Pharmacist #1 on 11/18/25 at 2:36 PM revealed the ordered liquid Protonix had a shortened expiration date because it was a compound (mixed with another medication) medication, so it did not have a long shelf life. Consulting Pharmacist #1 stated nursing staff should be monitoring the expirations on all medications before administration. She stated she was not sure about the adverse effects of receiving the medication, but that the expired medications could have been contaminated due to the short shelf life. An interview with the Physician on 11/17/25 at 1:10 PM revealed there would be no adverse effects from receiving the expired medication, but that nursing staff needed to follow the regulations and ensure there were no expired medications on the medication carts to avoid the administration of expired medications.	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F0677	Resident #21 was provided incontinence care on 09/30/25 by Nurse Aide. The Director of Nursing or Nurse managers conducted a quality review of ADL documentation in the last 30 days on residents identified as requiring ADL care related to incontinence care to ensure care provided and	01/08/2026

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F0677 SS = D	Continued from page 19 This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with resident and staff, the facility failed to provide incontinence care to a dependent resident for 1 of 4 residents reviewed for activities of daily living (ADL) care (Resident #21). Findings included: Resident #21 was admitted to the facility on 5/15/23 with diagnoses to include hemiplegia affecting left side, cerebral infarction (stroke), and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 8/20/25 revealed Resident #21 was cognitively intact with no rejection of care behaviors in the lookback period. Resident #21 was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene. The care plan revised 7/24/25 revealed Resident #21 had a self-care deficit in performing ADL related to a stroke with hemiplegia and hemiparesis. The care plan interventions included Resident #21 was dependent on the assistance of two staff members with the mechanical lift for all transfers and to provide incontinence care as needed. An interview with Resident #21 occurred on 9/30/25 at 2:50 PM. Resident #21 reported that two nurse aides (NA) on the 3:00 PM to 11:00 PM shift had refused to transfer her to bed and provide incontinence care for her. She stated that she had turned on her call light around 9:30 PM and requested assistance getting ready for bed and that she needed incontinence care for her soiled brief. Resident #21 indicated that the two NAs (NA #4 and NA #5) had refused to provide care for her, because she had said a curse word when they turned off her air conditioner without her permission. She stated she had to wait until approximately 12:30 AM for the NAs on the 11:00 PM to 7:00 AM shift to transfer her to bed and provide incontinent care. An interview with NA #5 was completed on 9/30/25 at 4:30 PM. NA #5 stated that she had been the NA assigned to care for Resident #21 last night. She further stated that at around 10:30 PM Resident #21 had requested to be assisted to bed and incontinence care be provided. NA #5 indicated that she asked NA #4 to help her with the mechanical lift to transfer Resident #21 to bed. She stated that when they came into the room with the	F0677	Continued from page 19 documented in EMR (Electronic Medical Record) by 12/15/25. The Executive Director, Social Worker or designee conducted interviews with residents identified as having a BIMS (Brief Interview for Mental Status) 13 or above to ensure incontinence care is provided by 12/15/25. The Director of Nursing or Nurse Manager to conduct skin checks on residents with a BIMS 12 or below to ensure incontinence care provided. The Market Clinical Lead educated the Director of Nursing on ADL care specific to incontinence care by 12/02/25. The Director of Nursing or designee educated licensed nurses and certified nurse aides, including agency staff on ADL care specific to incontinence care by 12/23/25 to ensure residents are receiving adequate care in a timely manner with validation of understanding. Newly hired staff will be educated upon hire during orientation. The Director of Nursing, Nurse Manager or designee will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0677 SS = D	Continued from page 20 mechanical lift the temperature in the room was cold, so they asked Resident #21 if they could turn off the air conditioner, and she told them no. NA #5 indicated she turned the air conditioner off anyway and Resident #21 had said a curse word and told them to turn the air conditioner back on. She stated that when Resident #21 cursed at them, she and NA #4 decided to leave the room, because they didn't want to argue with her. NA #5 further stated that she felt like she was disrespected by Resident #21 and that is why she refused to provide care for her. An interview with NA #4 occurred on 9/30/25 at 4:45 PM with NA #5 present. NA #4 stated that she was asked by NA #5 to help her assist Resident #21 to bed at approximately 10:30 PM last night. She further stated that she was only there to assist NA #5 and that she was just trying to help. NA #4 indicated that she was not the NA assigned to care for Resident #21. She stated when they entered the room to provide care for Resident #21 it was cold and they had asked her if they could turn off the air conditioner and she had stated, no. NA #4 indicated that NA #5 had turned the air conditioner off and that the resident had said a curse word. She stated she didn't have to put up with anybody talking to her like that and that they had refused to provide care to Resident #21, and they had left the room. An interview was completed with NA #6 on 10/1/25 at 11:16 AM. NA #6 stated she was supposed to be at work at 11:00 PM on 9/29/25 but that she arrived about an hour late. She further stated that when she went to Resident #21's room she was still up in her wheelchair waiting to go to bed. NA #6 stated she and NA #7 transferred Resident #21 to bed at approximately 12:30 AM. She indicated that Resident #21 was incontinent with bowel and it looked like it had been there for a while because it was caked and dried on her skin. NA #6 stated that Resident #21 was usually in bed when she came in at 11:00 M and that was the first time she had to put her to bed on 11:00 PM to 7:00 AM shift. She further stated that Resident #21 informed her that the NA from 3:00 PM to 11:00 PM shift had refused to provide care for her. An interview with Nurse #7 who was working the 7:00 PM to 7:00 AM shift on 9/29/25 occurred on 10/2/25 at 1:29 PM. Nurse #7 stated she recalled the incident with Resident #21 and NA #4 and NA #5 occurred on 9/29/25 at approximately 10:30 PM. She stated the NAs reported to her that Resident #21 had cursed them when they went into her room to transfer her to bed. Nurse #7 further stated that she had told the NA's she would speak to	F0677		

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F0677 SS = D	Continued from page 21 Resident #21 about the incident. She indicated she was unaware that NA #4 and NA #5 were not going to provide Resident #21 care prior to them leaving their shift. Nurse #7 explained that one of the NAs on the 11:00 PM to 7:00 AM shift was late for work on 9/29/25 and Resident #21 was not assisted to bed until around 12:30 AM. She stated that the NA's had not asked her to assist them with transferring Resident #21 to bed or providing incontinence care. Nurse #7 indicated she was unaware that Resident #21 had a bowel movement and needed incontinence care. An interview was completed with NA #7 on 10/2/25 at 8:10 AM. NA #7 stated that she was working the 11:00 PM to 7:00 AM shift on 9/29/25. She further stated that there was only 2 NA assigned to the 300 and 400 halls at night, and that NA #6 was approximately an hour late for work on 9/29/25. NA #7 indicated Resident #21 was still up in her electric wheelchair when she came on shift at 11:00 PM. She stated that Resident #21 was very upset and was crying that she was left up in her wheelchair and she needed incontinent care. NA #7 further stated that she and NA #6 did transfer Resident #21 to bed and provide incontinence care at approximately 12:30 AM. She explained that she had not asked Nurse #7 to assist her with transferring Resident #21 to bed because she was busy with new admissions and other work. An interview was conducted with the Director of Nursing on 11/18/25 at 3:15 PM. The DON stated that it was unacceptable that NA #4 and NA #5 had refused to transfer Resident ##21 to bed and provide incontinent care for her when she requested. She further stated that she expected the nursing staff to provide care for residents, regardless of the residents' use of a curse word. The DON explained that it was their job to provide ADL care for residents. An interview was completed with the Administrator on 11/18/25 at 3:55 PM. The Administrator stated that NA #4 and NA #5 were wrong for not providing ADL care for Resident #21. She indicated that she expected the staff to provide care for the residents, regardless of the residents' behavior. The Administrator stated that NA #4 and NA #5 should have provided ADL care for Resident #21 when she requested their assistance.	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684	Resident #6 no longer resides in the facility. UM #1 was educated by the Director of Nursing on 12/8/2025 on verifying accuracy of physician ordered weights with emphasis on obtaining a re-weigh for significant weight changes.	01/08/2026

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F0684 SS = D	Continued from page 22 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff interviews, the Registered Dietician, the Nurse Practitioner and the Physician interviews the facility failed to verify the accuracy of physician ordered weights for a resident (Resident #6) with congestive heart failure. This occurred for 1 of 1 resident (Resident #6) reviewed for quality of care. Based on observations, record review, staff interviews, the Registered Dietician, the Nurse Practitioner and the Physician interviews the facility failed to verify the accuracy of physician ordered weights for a resident (Resident #6) with congestive heart failure. This occurred for 1 of 1 resident reviewed for quality of care. Findings included: Resident #6 was admitted to the facility on 3/31/25 with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and dementia. A care plan dated 4/9/25 revealed Resident #6 was at nutritional risk related to frequent hospitalizations, multiple chronic disease processes, history of weight gain and fluid retention, cognitive impairment, therapeutic diet order with restrictions, prescribed diuretics (high risk of weight fluctuations), significant weight loss, and history of increased nutrient needs with pressure areas. Interventions included in part: weigh per policy. A physicians order dated 4/5/25 for Resident #6 revealed Furosemide Solution 20 milligrams per milliliter (mg/ml) intramuscularly (IM) one time now for fluid overload. A physician’s order dated 4/07/25 for Resident #6 was	F0684	Continued from page 22 The Director of Nursing or Nurse Managers conducted a quality review 30 day lookback of residents identified as having a diagnosis of congestive heart failure to verify the accuracy of weights by 12/15/25. Any residents identified with significant weight changes were re-weighed to ensure accuracy by the Nurse Aide. The physician was notified by the licensed nurses of any significant weight changes identified. The Director of Nursing educated licensed nurses by 12/23/25 on verifying accuracy of physician ordered weights with emphasis on obtaining a re-weigh for significant weight changes to verify accuracy. Newly hired staff will be educated upon hire during orientation. The Director of Nursing or Nurse managers will conduct a quality review of weights to ensure accuracy of weights 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks . The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0684 SS = D	Continued from page 23 to obtain weekly weights for four weeks then monthly weights. A physicians order dated 4/11/25 for Resident #6 revealed Furosemide Solution 20 mgs/ml intramuscularly (IM) one time for excessive fluid. A physicians order dated 4/12/25 for Resident #6 revealed Furosemide 40 milligrams (mg) give one tablet as needed for edema. A physicians order dated 4/17/25 for Resident #6 revealed Furosemide 40 milligrams (mg) one time daily for edema. A physician's order dated 4/24/25 for Resident #6 was to obtain weekly weights for four weeks then monthly weights. A physicians order dated 4/29/25 for Resident #6 revealed Furosemide 40 milligrams (mg) one time daily for congestive heart failure (CHF). A nutritional assessment dated 4/20/25 completed by the Registered Dietician for Resident #6 revealed in part; Resident #6 had a history of weight gain and loss due to edema, recent hospitalization and poor appetite. She received a consistent carbohydrate and No Added Salt (NAS) diet, with regular texture, and thin liquids. Resident #6 eats independently after tray set up. Pressure ulcers noted to (sacrum, heel, coccyx). Pertinent medications included Furosemide (a diuretic used to treat fluid retention) medication. She remained on 1.5 liter fluid restrictions. Weight loss was 15% over 1 month. Nutrition Recommendations: Reorder Med Pass (nutrition supplement) three times a day. Monitor: Weights, labs, skin, and meal intake. A nutritional assessment dated 8/16/25 completed by the Registered Dietician for Resident #6 revealed in part; history of weight fluctuations 160 - 200 lbs. (intermittent edema and diuretics), history of intermittent poor appetite due to illness and hospitalizations. No new recommendations at this time. Monitor and evaluate weights, labs, skin, and meal intake.	F0684		

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F0684 SS = D	Continued from page 24 The Minimum Data Set (MDS) significant change assessment dated 8/25/25 revealed Resident #6 was severely cognitively impaired. She had no rejection of care. She had weight gain and received a therapeutic diet. Resident #6 required staff assistance with activities of daily living (ADLs) and supervision with eating. Review of Resident #6's electronic medical record revealed the following weights recorded using the mechanical lift: 4/08/25: weight 205.0 4/16/25: weight 194.0 4/20/25: weight 174.0 5/08/25: weight 172.0 6/20/25: weight 147.6 7/15/25: weight 146.2 8/03/25: weight 146.0 8/06/25: weight 154.4 9/09/25: weight 152.6 During an interview on 10/01/25 at 2:00 PM Unit Manager #1 stated Resident #6's significant weight changes noted in the medical record should have had a re-weigh done within 24 hours and that was not done. Unit Manager #1 stated the nurse aides obtained the ordered weights and then gave the weights to her and she entered the weights into the residents electronic medical record. Unit Manager #1 stated she did not always check the previous weight to identify any significant weight gain or loss which was an error on her part. She stated the facility policy was that with any weight increase or decrease a reweigh should be done at that time for accuracy and she had not been directing staff to do the reweighs. Unit Manager #1 stated she should have asked for Resident #6 to be reweighed for accuracy to determine if Resident #6 had a 10 to 20 pound weight loss to verify accuracy. A phone interview was conducted on 10/01/25 at 9:20 AM	F0684		

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F0684 SS = D	Continued from page 25 with Nurse Practitioner #1 who stated it was her expectation that residents with significant weight changes get reweighed. She stated that a reweigh was to be done on all weight loss or gain greater than 5% within a month, or greater than 10% in six months, so in order to make the necessary treatment recommendations. During an interview on 10/2/25 at 10:00 AM Nurse Aide #10 stated she received a list each morning of which residents needed weights. She completes the weights and gives the results to Unit Manger #1. Nurse Aide #10 indicated she would not know to reweigh a resident unless a nurse or the Unit Manger instructed her to do so, then she would reweigh the resident. During an interview on 11/19/25 at 1:00 PM the Physician stated some of the weights documented in Resident #6's medical record could not be accurate because it was impossible for her to have a 20 pound loss in 4 days. The Physician stated that staff had not reported any change in condition and there were no concerns with Resident #6. He stated accurate weights should be documented in the medical record in order to make the appropriate treatment decisions. During a phone interview on 11/19/25 at 2:00 PM the Director of Nursing (DON) stated weights were to be reviewed and compared to the previous weight and if any significant increase or decrease then another weight should be obtained at that time. The DON stated the staff were to verify the accuracy of weights and report any changes to the physician if significant changes.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F0686	Resident #86 no longer resides in the facility. The Director of Nursing, Nurse Manager or Wound Nurse conducted a quality review of newly admitted residents within the last 30 days to identify residents admitted with wounds to ensure the initial wound assessment was completed upon admission including wound description with measurements and wound care orders were obtained and documented by 12/15.25. The Market Clinical Lead educated the Director of Nursing on 12/02/25 on completing initial wound assessments upon admission to include wound descriptions with measurements, obtain wound care orders for treatment. The Director of Nursing, Nurse	01/08/2026

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F0686 SS = D	Continued from page 26 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and the Wound Care Physician's interview, the facility failed to complete initial wound assessments upon admission to include the wound descriptions with measurements and obtain wound care orders upon admission and when the wound vac (vacuum assisted closure (vac), negative pressure wound therapy that uses suction to aid in wound healing) was not available in the facility for a resident admitted with multiple pressure wounds and osteomyelitis (infection of the bone tissue) requiring intravenous and oral antibiotics. This occurred for 1 of 6 residents (Resident #86) reviewed for wound care. Findings included: Resident #86 was admitted to the facility on 3/15/25 with diagnoses including a Stage IV pressure ulcer of the left ischium (the lower and back portion of the hip bone), Stage IV pressure ulcer on the sacrum, Stage IV pressure ulcer of the right hip, Stage II pressure ulcer on the right buttock, a deep tissue injury of the left heel, osteomyelitis (an infection of the bone tissue) of the vertebra, sacral, coccyx region, and left thigh, and paraplegia (paralysis of the lower extremities). Review of the hospital discharge instructions dated 3/15/25 for Resident #86 revealed to follow up with the wound center. There were no further wound treatment orders listed on the discharge instructions. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Piperacillin Sodium Tazobactam (a broad-spectrum antibiotic used to treat moderate to severe bacterial infections). Use 3.375 grams intravenously every 8 hours for osteomyelitis for 18 days in 100 milliliters 0.9% Sodium Chloride. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Vancomycin (an antibiotic used to treat severe infections) intravenous solution. Use 1 gram intravenously two times a day for	F0686	Continued from page 26 Manager or Wound Care nurse educated licensed nurses completing initial wound assessments upon admission to include wound descriptions with measurements, obtain wound care orders for treatment by 12/23/25. Newly hired staff will be educated upon hire during orientation. The Director of Nursing, Nurse managers or Wound Nurse will conduct a quality review of new admissions to ensure initial wound assessment is completed upon admission 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks . The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0686 SS = D	Continued from page 27 osteomyelitis until 04/03/25. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Sulfamethoxazole-Trimethoprim oral antibiotic tablets 800-160 milligrams. Give 1 tablet by mouth one time a day for osteomyelitis. Review of Resident #86's electronic medical record from 3/15/25 through 3/17/25 revealed no documented admission assessment of the wounds and no documented physician orders for wound care until 3/17/25. A progress note dated 3/17/25 at 9:48 PM documented by Unit Manager #1 revealed in part: Admission assessment, Resident #86 was alert and oriented to person, place, and time. He was noted with multiple opened wounds to his buttocks, left ischium, right buttocks, left posterior upper thigh and buttock fold, sacral wound, right hip wound, and right heel DTI. The Physician (previous Medical Director) was notified 3/17/25. Treatment orders and intravenous orders were clarified with new orders received. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order with a start date of 3/17/25 for Wound Vac application (vacuum assisted closure (vac), negative pressure wound therapy that uses suction to aid in wound healing). Gently irrigate the wound to the left ischium with normal saline and pat dry. Apply skin prep to peri wound and let dry. Window pane peri wound with clear wound vac drape. Apply black foam to the wound bed and cover with vac drape then apply Wound VAC with 125 mm/hg (millimeters of mercury) continuous pressure 3 times a week every day shift on Monday, Wednesday, Friday. Review of Resident #86's Treatment Administration Record (TAR) and Medication Administration Record (MAR) from 3/17/25 through 3/20/25 revealed the wound vac was not applied to Resident #86. The Wound Vac order was discontinued on 3/20/25 by the Wound Care Physician. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to apply saline wet to dry dressings to the left ischium every day until the wound vac is available. This order was not signed as administered on 3/17/25.	F0686		

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F0686 SS = D	Continued from page 28 Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order with a start date of 3/18/25 to cleanse the left ischium with normal saline, apply wet to dry saline moist gauze and cover with foam dressing until the Wound Vac arrives then discontinue. This order was signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open area to right hip with normal saline and apply wet to dry saline gauze and cover with foam dressing as needed. This order was not signed as administered on 3/17/25. The order was changed on 3/18/25 to every day shift and was signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open area to sacrum and apply Calcium Alginate (a wound dressing used for moderate to heavy exuding wounds to create a moist healing environment, absorbs drainage and controls minor bleeding), and cover with foam dressing as needed. This order was changed to every day shift on 3/18/25 and signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open area to upper left thigh/buttock fold with normal saline and apply Calcium Alginate dressing and cover with foam dressing as needed. This was not administered, and the order was changed to every day shift on 3/18/25 and signed as administered on 3/18/25. A physicians order dated 3/18/25 for Resident #86 revealed to mop right heel DTI (deep tissue injury) with sure prep every day shift. This order was signed as administered on 3/18/25. A care plan dated 3/18/25 revealed Resident #86 had a stage IV pressure ulcer on the left hip, a stage IV pressure ulcer on the right hip, a stage IV pressure ulcer on the sacrum, and a stage II pressure ulcer on the right buttock with the risk of further skin breakdown related to decreased activity, frail fragile skin, incontinence, and limited mobility. Interventions included in part; to provide wound care.	F0686		

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F0686 SS = D	Continued from page 29 A progress note dated 3/18/25 at 2:19 PM written by Unit Manager #1 revealed Skin Issue: #1: Sacrum - Stage 4 pressure ulcer with full thickness skin and tissue loss. The wound was present on admission. The length was 4.2 centimeters (cm), width 1.9 cm, and depth 1.1 cm. There was no undermining (separation of the wound edge from the surrounding tissue), and no tunneling (a deep tract or channel that goes into the tissue). Wound #2 on the right gluteus was a stage III pressure ulcer with full thickness skin loss. The wound was present on admission. No signs and symptoms of infection. The length was 4.2 cm, width 3.7 cm, depth 0.1 cm. There was no undermining or tunneling. Wound #3: Rear left trochanter (Hip) pressure ulcer present on admission. Length 4.5 cm, width 5.5 cm, depth 1.4 cm with undermining length 1.7 cm. The left ischium pressure ulcer measured 2.0 x 1.3 x 1.3 cm. The Minimum Data Set (MDS) admission assessment dated 3/22/25 revealed Resident #86 was cognitively intact, with no behaviors and no rejection of care. He had three stage IV pressure ulcers, and one stage II pressure ulcer present on admission. Resident #86 received pressure wound care including intravenous (IV) antibiotics. He required extensive 1-to-2-person assistance with activities of daily living (ADLs). During an interview on 11/18/25 at 2:00 PM Unit Manager #1 stated Resident #86 admitted on Saturday 3/15/25. He admitted with stage IV pressure wounds. She stated the initial skin assessments were to be completed by the assigned nurse within the first 24 hours of admission. Unit Manager #1 stated when she returned to work on 3/17/25 she realized the wound care orders were not entered and she called the Medical Director at that time to get new wound care orders while waiting on the wound vac supplies to arrive. Unit Manager #1 stated the weekend nurse should have completed the initial skin assessments upon Resident #86's admission or at least within 24 hours and obtain new wound care orders while waiting on the wound vac, and that did not occur. Unit Manager #1 received new wound care orders on 3/17/25 when she notified the Physician and the wound treatments were administered beginning the following day on 3/18/25. Unit Manager #1 indicated Medication Aide #1 was assigned to the hall that Resident #86 was admitted to on 3/15/25 but Medication Aide #1 would not be responsible for managing wound care or treatment orders. The responsible day shift and night shift nurses on 3/15/25 and 3/16/25 were agency staff and were no longer employed by the facility. Unit Manger #1 stated she entered Resident #86's wound treatment	F0686		

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F0686 SS = D	Continued from page 30 orders into the residents electronic medical record on 3/17/25, and she conducted the initial wound assessments with measurements on 3/18/25 and that should have been done by the admission nurse on 3/15/25. During a phone interview on 11/18/25 at 7:00 PM Medication Aide #1 stated she would not have been responsible for wound care treatments and did not have any information regarding Resident #86's wound care on 3/15/25 or 3/16/25. During an interview on 11/19/25 at 8:15 AM the wound treatment nurse stated Resident #86 was compliant with wound care. She stated that she began working in the facility around the time Resident #86 was admitted but she did not work full-time, and the floor nurses were responsible for daily wound care. She stated she was not working on the weekend of 3/15/25 when Resident #86 was admitted. During a phone interview on 11/19/25 at 10:00 AM the Wound Care Physician stated her initial evaluation of Resident #86 was done on 3/20/25, then weekly until he discharged from the facility. She stated Resident #86 admitted with four significant pressure wounds. At the time of his admission there was no dedicated wound nurse, and she could not attest to how often the wound care was getting done. The Wound Physician stated she last evaluated Resident #86 on 5/23/25 before he discharged and at the time of discharge the sacrum was more necrotic, and the left hip fascia was exposed with muscle. She stated the worsening of Resident #86's wounds during his stay in the facility was multifactorial, and also due to not offloading, possible missed wound treatments, osteomyelitis, and other comorbidities. The Wound Physician indicated initial wound assessments should have been completed on admission, and the wound vac supplies were usually easily accessible and should have been available. The Wound Physician stated she discontinued the wound vac due to it not being available when she initially evaluated Resident #86. The Wound Physician indicated Resident #86 discharged to the hospital May 2025 unrelated to wound care and did not return to the facility. During a phone interview on 11/19/25 at 1:00 PM the Director of Nursing (DON) stated the weekend nurse on 3/15/25 should have completed the initial wound	F0686		

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F0686 SS = D	Continued from page 31 assessments with measurements which was to be done within the first 24 hours of admission. The DON stated when Resident #86 admitted on 3/15/25 and the wound vac was not available the nurse should have clarified the treatment orders in order to get daily treatments started due to Resident #86's significant wounds. The DON indicated wound treatments should have been initiated sooner than 3/18/25 and that did not occur.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide care in a safe manner when Nurse Aide #8 provided incontinence care to a resident (Resident #39). This resulted in Resident #39 rolling off of the bed onto the floor sustaining a fracture to the first cervical vertebrae (C1) of the cervical spine. This occurred for 1 of 5 residents reviewed for accidents (Resident #39). Resident #39 was admitted to the facility on 12/16/20. Her diagnoses included cerebral vascular accident (CVA), hemiplegia (paralysis or weakness on one side of the body), and dementia. A care plan dated 4/18/25 revealed Resident #39 required assistance with activities of daily living (ADLs) including bed mobility due to having limited mobility related to cerebral vascular accident (CVA) with hemiplegia. The Minimum Data Set (MDS) quarterly assessment dated 8/29/25 revealed Resident #39 was severely cognitively impaired. She had no falls at the time of the assessment. Her weight was 168 pounds. She required extensive two-person assistance with bed mobility, and	F0689	"Past Noncompliance - no plan of correction required"	01/08/2026

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F0689 SS = D	Continued from page 32 activities of daily living. A fall incident report dated 9/7/25 at 10:10 PM written by Nurse #9 revealed Nurse Aide #8 yelled for help. Nurse #9 entered the room and Resident #39 was lying on the floor on her side and partially on her stomach. A puddle of blood was noted under Resident #39's head. Nurse #9 applied pressure to the area to slow the bleeding. No other injuries were observed other than the laceration to the top of the forehead where the blood was coming from and possible guarding of the right arm. Emergency Medical Services (EMS) was immediately notified. Nurse #9 stayed with Resident #39 until EMS arrived. Resident #39 was unable to give a description of what happened. The Physician, Director of Nursing, and the Responsible Party were notified. Resident #39 was transported to the hospital for evaluation. The hospital summary dated 9/7/25 at 11:52 PM revealed Resident #39 presented to the emergency department after a witnessed fall. According to the report Resident #39 rolled off the bed while being changed. Resident #39 had a history of CVA and dementia at baseline. Computed Tomography (CT) of the cervical spine showed a nondisplaced fracture on the lateral margin of C1 (first cervical vertebrae) with no other abnormalities involving the cervical spine. A cervical collar was placed. The CT also revealed a midline frontal scalp soft tissue laceration with no underlying fracture. Resident #39 was transferred to a tertiary care facility (provides highly specialized medical services) for further evaluation. The hospital summary from the tertiary care facility revealed Resident #39 admitted on 9/8/25 and discharged back to the skilled nursing facility on 9/8/25. Resident #39's diagnoses was C1 fracture of the cervical spine with no surgical interventions needed. A progress note dated 9/8/25 at 3:36 PM written by Unit Manager #1 revealed a call was received from the hospital. Resident #39 was returning back to the facility with a C1-nondisplaced fracture with no neurosurgical involvement. Resident #39 was to wear the cervical collar at all times and follow up in 4 weeks. The facility investigation report dated 9/8/25 revealed on 9/7/25 at approximately 10:30 PM Nurse Aide #8 stated while providing care for Resident #39 she positioned Resident #39 who was severely cognitively	F0689		

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F0689 SS = D	Continued from page 33 impaired on her left side to begin washing her because of a bowel movement. Nurse Aide #8 began to change the sheets while providing care. Nurse Aide #8 had one hand placed on Resident #39 and the other hand was used to make the bed. Resident #39 began to wiggle and fell off the bed on to her left side. Nurse Aide #8 immediately called for help never leaving the residents side. Nurse #9 ran into the room and assisted in providing emergency care. Nurse #9 called for the charge nurse and they both stayed with Resident #39 to provide care until EMS arrived. Resident #39 was observed with blood pooling from her head from a laceration and guarding of her right arm. First Aide was rendered to stop the bleeding. The on-call physician was notified. Resident #39 was transferred to the hospital for evaluation. The hospital report revealed a nondisplaced fracture of C1 (first vertebrae of cervical spine). A written statement dated 9/8/25 made by the Regional Corporate Consultant during the facility's investigation revealed Nurse Aide #8 was called to return to the facility to perform a return demonstration of Resident #39 sliding out of the bed onto the floor. This writer along with the Director of Nursing and the Administrator assisted Nurse Aide #8 to room #203. Nurse Aide #8 stated she went into Resident #39's room to provide incontinence care. Nurse Aide #8 explained that Resident #39 was positioned on her back, and she assisted her to her left side and began to provide incontinence care. Nurse Aide #8 stated during care Resident #39 began to move to the edge of the bed. Bolsters (a long cylindrical pillow used for support, which also acts as a safety barrier) were in place on both sides of the bed. While on her left side Resident #39 rolled off of the bed onto the floor. Nurse Aide #8 was unable to prevent her from sliding off of the bed. Resident #39 landed on her right side. Nurse Aide #8 immediately called for help and staff responded. When questioned if Nurse aide #8 checked the Kardex (a resident care guide that shows essential information including transfer status and bed mobility) prior to providing care Nurse Aide #8 stated she did not. Nurse Aide #8 also stated she knew Resident #39 required two-person assistance for bed mobility because she had cared for her many times prior to the incident. Resident #39's Kardex (a quick reference of a residents care needs) revealed Resident #39 required two-person assistance with bed mobility, transfers and activities of daily living, prior to the fall including the day of the fall on 9/7/25. A written statement from Nurse Aide #8 was obtained by the facility on 9/8/25 during their investigation.	F0689		

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F0689 SS = D	Continued from page 34 Nurse Aide #8'written statement stated: while she was providing incontinence care and changing Resident #39's bed sheet, Resident #39 fell off of the bed. She immediately yelled for the nurse who ran into the room and quickly assessed Resident #39. The nurses stayed with Resident #39 until EMS arrived. Attempts were made on 9/30/25 at 3:39 PM, 10/1/25 at 2:00 PM and 10/1/25 at 7:00 PM to contact Nurse Aide #8. There was no response. A phone interview was conducted on 9/30/25 at 6:30 PM with Nurse #9. She stated she was the assigned nurse on duty on 9/7/25 the night Resident #39 fell. Nurse #9 stated she had just assisted Nurse Aide #8 in the room adjacent to Resident #39 who also required two-person assistance. Once they were done in the other residents room Nurse Aide #8 went one way and Nurse #9 went the other way. Nurse #9 stated not long after she heard Nurse Aide #8 yelling for help, and she ran down to check on her. When she entered the room Resident #39 was lying on her side and partially on her stomach on the side of the bed near the window. Resident #39 had dementia and was yelling out. EMS was immediately notified due to the resident having a lot of blood on her forehead. Nurse #9 stated she did not move Resident #39 and stayed with her and placed support under her head until EMS arrived and transported her to the hospital. Nurse #9 stated she did not know that Nurse Aide #8 was going in to assist Resident #39 and Nurse Aide #8 did not ask her to go in and assist her with changing Resident #39. Nurse #9 stated she would have assisted Nurse Aide #8 and there were other staff on duty that night that would have assisted her, but Nurse Aide #8 did not ask anyone for help. Nurse #9 stated that Nurse Aide #8 reported to her that she thought she could do it herself. Nurse #9 stated Nurse Aide #8 was agency staff but had provided care to Resident #39 in the past and knew Resident #39 required two staff members to assist with care. During an observation on 9/30/25 at 11:30 AM Resident #39 was observed in her room lying in bed with a cervical collar in place. She was oriented to person only and could not engage in dialogue. She was in no distress. During an interview on 10/1/25 at 2:30 PM the Director of Nursing stated Resident #39 sustained a fall with injury on 9/7/25 when Nurse Aide #8 was providing incontinence care and did not have a second person to assist her. Resident #39 rolled off of the bed. She was transported to the hospital. She sustained a cervical fracture and forehead laceration. An investigation was	F0689		

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F0689 SS = D	Continued from page 35 initiated on 9/8/25 and Nurse Aide #8 was suspended pending the investigation. The DON indicated the root cause analysis determined Nurse Aide #8 failed to follow Resident #39's Kardex and care plan that showed Resident #39 required two-person assistance for bed mobility which resulted in the injury. The DON stated a corrective action plan was initiated on 9/8/25, and the decision was made on 9/8/25 to monitor residents requiring two-person assistance during care and to put it into their Quality Assurance (QA) program for ongoing monitoring. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/7/25, at approximately 10:30 PM, Nurse Aide #8 stated was providing care to Resident #39. She positioned her on her left side and Nurse Aide #8 began to change the sheets while providing care. Nurse Aide #8 had one hand placed on Resident #39 and the other hand making the bed when Resident #39 began to wiggle and fell off of the bed onto the left side. Nurse Aide #8 immediately called for help never leaving the resident's side. Nurse #9 ran into the room, quickly assessed the scene and assisted in providing emergency care. Nurse #9 called for the Nurse in Charge to assist. She arrived, as well as two other aides. The two nurses prepped Resident #39 and stayed at the bedside to provide care until the paramedics arrived. Nurse #9's observation revealed Resident #39 to have blood pooling from her head from a laceration, and she had guarding of the right arm. On 9/7/25 at 10:43 PM the on-call Physician was notified by Nurse #9, and an order was received to send Resident #39 to the local hospital for evaluation. Resident #39's Responsible Party was attempted to be notified via phone. A chart review was completed by the Director of Nursing on 9/8/25. The chart indicated a Bed Safety Evaluation was completed on 8/24/25 for Resident #39. The evaluation indicated Resident #39 was able to move her upper and lower extremities independently, however she was unable to turn side to side, move up and down in the bed, or pull herself up from laying to sitting position independently.	F0689		

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F0689 SS = D	Continued from page 36	F0689		

Resident #39’s Kardex at the time of the fall indicated to provide two-person assistance with bed mobility.

Resident #39’s care plan indicated to provide two-person assistance with bed mobility.

Nurse Aide #8 was placed on administrative leave pending the facility investigation.

On 9/8/25 at 6:39 AM the hospital note indicated Resident #39 presented to the emergency department after a witnessed fall. Per the report, Resident #39 was being changed and rolled off the bed. Resident #39 had a nondisplaced fracture through the lateral margin of the cervical spine with no other bony abnormalities involving the cervical spine.

A root cause analysis was conducted on 9/8/25 and based on the findings, the facility found that Nurse Aide #8 failed to properly position Resident #39 prior to providing care and failed to follow the Kardex and care plan which stated to provide two-person assistance with bed mobility.

Resident #39 was evaluated by the facility Medical Director on 9/8/25 with no new orders received.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

The center recognizes all residents that require assistance with bed mobility have the potential to be affected by the noncompliance.

On 9/8/25, the Director of Nursing completed a review of all current resident’s Kardex and Care Plans to ensure accuracy.

On 9/8/25 licensed nurses completed skin assessments on all cognitively impaired residents with no concerns identified.

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F0689 SS = D	Continued from page 37 On 9/8/25 the Social Services Director interviewed a sample of alert and oriented residents with no concerns identified. On 9/8/25 the Director of Nursing and designee completed transfer assessments for residents residing in the facility. On 9/8/25, resident care plans and Kardex's were reviewed and updated to reflect resident transfer assessments by licensed nurses and the DON. On 9/8/25 the Director of Nursing and designee conducted an audit of all falls in the last 30 days to ensure no falls with injury were due to improper assistance provided by nursing staff. There were no concerns noted during the audit. On 9/8/25 the Director of Nursing and designee-initiated education to all nursing staff on safe handling of the residents, the location of the Kardex, when to review the Kardex, and the importance of following the Kardex when providing resident care, and the abuse and neglect policy. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 9/8/25, licensed nurses and certified nursing assistants to include agency licensed nurses and agency certified nursing assistants were provided education by the DON and Nurse Educator on resident safe handling, location of the Kardex, when to review the Kardex, and the importance of following the Kardex when providing resident care. All new staff and new agency staff will be educated in the new hire orientation program and before the next scheduled shift. Beginning 9/8/25, education was provided to all facility staff, to include agency staff, by the Nurse Educator on the abuse policy with an emphasis on neglect. Any staff identified as not receiving abuse and neglect education by 9/8/25 will not be allowed to work before receiving education on the facility's abuse policy. All newly hired staff, to include new agency	F0689		

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F0689 SS = D	Continued from page 38 staff, will be educated on the facility's abuse prohibition policy in the new hire orientation program. Post tests were completed beginning on 9/8/25 for validation of understanding of abuse reporting timeframe, the requirements and reporting any allegations or witnessed abuse to the facility Administrator immediately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 9/9/25, the Director of Nursing and designee will review all incidents and accidents through the Risk Management System in the morning clinical meeting 5 times weekly for 12 weeks to ensure the Kardex and care plans were followed with bed mobility and transfers to ensure resident safety. Effective 9/9/25, the Director of Nursing or Nurse Manager will conduct random audits through observations of 5 staff per week for 12 weeks to ensure safe bed mobility and transfers were maintained. An ADHOC Quality Assurance Performance Improvement (QAPI) meeting was conducted on 9/8/25 in collaboration with the Medical Director to discuss the root cause analysis of the deficient practice, to formulate a plan to include monitoring beginning on 9/8/25, and to ensure resident safe handling and residents bed mobility were followed during care as outlined in the patient's care plan. The results of the quality monitoring will be brought to the monthly Quality Assurance meeting to ensure compliance of resident safety for 3 months. The improvement-monitoring schedule will be modified based on the findings of monitoring. The facility's alleged compliance date of the corrective action plan was 9/10/25. The corrective action plan was validated on 10/2/25. The following documentation was reviewed along with staff interviews and observations:	F0689		

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F0689 SS = D	Continued from page 39 Validation included staff interviews regarding the incident and in-service training that was received to ensure understanding and knowledge of the training provided. Staff members interviewed stated they had received training. In-service training included safe handling during resident care, the importance of reviewing the residents Kardex, and the abuse and neglect policy. Inservice logs were verified, and the initial and ongoing audits were verified. An observation of incontinence care was conducted of a resident who required two-person assistance with bed mobility and activities of daily living. There were no concerns identified. The compliance date of 9/10/25 was validated.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, Nurse Practitioner (NP), and Registered Dietitian (RD) interviews, the facility failed to determine the accuracy of a weight when a resident had a significant weight gain of 26.8 pounds in 19 days and failed to	F0692	Resident #6 no longer resides in the facility. UM #1 was educated by the Director of Nursing on 12/8/2025 on verifying accuracy of weights with emphasis on obtaining a re-weigh for significant weight changes and notifying the dietician for nutritional assessment. The Director of Nursing or Nurse Managers conducted a quality review 30 day lookback of residents identified as having a significant weight change to verify the accuracy of weights and communication of the significant weight change to the dietician for a nutritional assessment by 12/15/25. The Director of Nursing educated licensed nurses by 12/23/25 on verifying accuracy of physician ordered weights with emphasis on obtaining a re-weigh for significant weight changes with communication to the dietician for a nutritional assessment. Newly hired staff will be educated upon hire during orientation. The Director of Nursing or Nurse managers will conduct a quality review of weights to ensure accuracy of weights and significant weight changes are communicated to the dietician for a nutritional assessment 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks . The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the	01/08/2026

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F0692 SS = D	Continued from page 40 communicate the significant weight gain to the Registered Dietitian for a nutritional assessment for 1 of 5 residents reviewed for nutrition (Resident #62). Findings included: Resident #62 was admitted to the facility on 04/08/25 with a cumulative diagnosis including right above the knee amputation (AKA), atrial fibrillation (A-fib), hypertension (HTN), congestive heart failure (CHF), and peripheral vascular disease (PVD). A physician order dated 04/28/25 revealed an order to weigh Resident #62 every day shift every 1 month(s) starting on the 28th for 2 day(s), with start date of 04/28/2025. A review of Medication Administration Record (MAR) dated 09/15/25 for Resident #62 revealed: Eliquis (treat Atrial fibrillation), Entresto (treat chronic heart failure), iron, Lasix (treat fluid retention), metformin (treat diabetes), metoprolol (treat high blood pressure), and spironolactone (treat edema and heart failure). Resident #62's Quarterly Minimum Data Set (MDS) assessment dated 07/16/25 revealed Resident #62 had severe cognitive impairments and required extensive assistance with activity for daily living (ADL) and had a weight of 218 pounds. Resident #62's care plan goals dated 07/23/25 revealed the resident exhibits or is at risk for fluid volume excess as evidence by edema (a condition where excess fluid accumulates in the body's tissues, causing swelling) of left lower extremity. Interventions include assessing and monitoring symptoms of edema, shortness of breath, weight gain, and weigh resident per policy and alerting dietitians and physicians to any significant loss or gain. A nursing note dated 09/29/25 at 2:52 PM by Unit Manager #1 for Resident #62 revealed a weight of 247.0 pounds. on 09/28/25 at 3:03 PM for Resident #62, utilizing a mechanical lift. Review of Resident #62's weekly/monthly weights revealed: 04/08/25 hospital weight was 207.2 pounds (lbs.)	F0692	Continued from page 40 Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date (01/08/26)	

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F0692 SS = D	(see below)	F0692		

Continued from page 41
04/28/25 was 209.4 lbs.

04/29/25 was 209.2 lbs.

05/28/25 was 208 lbs.

06/28/25 was 211.6 lbs.

07/28/25 was 218.6 lbs.

08/29/25 was 218 lbs.

09/09/25 was 220.2 lbs.

09/28/25 was 247 lbs. a weight gain of 26.8 lbs. in 19 days

An interview was conducted on 10/01/25 at 2:00 PM with Unit Manager #1. She stated Resident's weight significant change from 09/09/25 - 220.2 lbs. to 09/28/25 - 247 lbs. should have had a re-weight done on 09/28/25 (within 24 hours) and wasn't. She said she entered the 247 lb. weight into their electronic medical record on 09/28/25 but did not review resident's previous weights, which she stated she should have. She stated that when she entered resident's weight of 247 lbs., the electronic medical record flagged the resident's weight gain in red numbers signifying Resident #62's weight gain was significant, and that she should have then asked the nursing aids to do a reweight and didn't.

Further review of Resident #62's medical record on 09/29/25 revealed there were no additional weights.

An interview on 10/01/25 at 9:20 AM with the Nurse Practitioner (NP) revealed it was her expectation that Resident #62's significant weight of 247 lbs. on 09/28/25 should have had a reweight done. She said a reweight was to be done on all weight loss/gain weights greater than 5% within a month, or greater 10% in six months, so she could make the necessary treatment recommendations. The NP added it was her expectation for nursing staff to follow the facility's policy on weights and to follow resident's care plan protocols.

An interview was conducted on 10/01/25 at 2:00 PM with Unit Manager #1. She stated Resident's weight significant change from 09/09/25 - 220.2 lbs. to 09/28/25 - 247 lbs. should have had a re-weight done on 09/28/25 (within 24 hours) and wasn't. She said she entered the 247 lb. weight into their electronic medical record on 09/28/25 but did not review

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F0692 SS = D	Continued from page 42 resident's previous weights, which she stated she should have. She stated that when she entered resident's weight of 247 lbs., their electronic medical record flagged resident's weight gain in red numbers signifying Resident #62's weight gain was significant, and that she should have then asked the nursing aids to do a reweight and didn't. An interview was conducted on 09/30/25 at 3:15 PM with the Registered Dietitian (RD) revealed a reweight should be done the same day on all weight loss/gain weights greater than 5% within a month, or greater 10% in six months, so he would be able to make the necessary dietary changes. The RD was made aware on 09/30/25 by the Surveyor of Resident #62's weight gain. An interview on 09/30/25 at 4:00 PM with the Director of Nursing (DON) and Market Clinical Advisor revealed they confirmed Resident #62's last two documented weights were: 09/09/25-220.2 lbs., and 09/28/25-247 lbs. DON said it was her expectation that with the weight discrepancy between the two weights she would have expected her nursing staff to have done a reweight within 24 hours.	F0692		
F0730 SS = D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a performance review every 12 months for 1 of 1 nursing assistant (Nurse Aide #4) reviewed to ensure in-service education was designed to address the outcome of the performance review. Findings included: Nurse Aide #4's personnel file was reviewed and revealed the date of hire of was 7/30/24. The personnel file for Nurse Aide #4 did not include evidence that a performance review had been completed for Nurse Aide #4.	F0730	NA #4 no longer works at the facility. The Administrator and or Director of Nursing conducted an audit of nurse aides personnel files for completed performance review at least once within 12 months by 01/07/26. Identified discrepancies were completed by the Director of Nursing. On 12/3/2025, The Market Resource Operator educated the Administrator and Director of Nursing on In-Service Training policy to include performance review of every nurse aide at least once every 12 months and regular in-service education to address the outcome of the performance review. The Executive Director or designee will conduct quality improvement monitoring of 1 random employee 3x per week for 4 weeks, 1 random employee 2x per week for 4 weeks, then 1 random employee per week for 4 weeks to ensure performance review was completed once within 12 months and in-service training conducted. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring	01/08/2026

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F0730 SS = D	Continued from page 43 An interview was conducted on 11/19/25 at 9:00 AM with the Administrator who stated the Director of Nursing (DON) was responsible for conducting the annual performance review for all Nurse Aides and she was aware the DON had not conducted the annual performance reviews. An interview was conducted on 11/19/25 at 9:05 AM with Nurse Aide #4. During the interview, Nurse Aide #4 stated her annual performance evaluation was due in 7/30/25 and she had not received a performance evaluation in the last year by the Director of Nursing (DON) and should have. A phone interview was conducted on 11/19/25 at 10:25 AM with the Director of Nursing (DON). During the interview, the DON stated since being hired at the facility in March 2025, she had not conducted a performance review for the facility's Nurse Aide staff. The DON did not provide a reason as to why she had not conducted an annual performance review for Nurse Aides.	F0730	Continued from page 43 findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Date of Compliance 01/08/26	
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F0755	Resident #3 was not affected related to the missing medication. On 11/7/25, the Director of Nursing implemented effective safeguards and systems to prevent drug diversion of discontinued medications. This includes verifying physicians' orders to the residents medication administration record, two nurses pulling discontinued medications and declining count sheets from the medication cart and any remaining doses are returned back to the pharmacy and 2 nurses accurately counting the controlled medication card and declining count at shift change. The Director of Nursing completed a quality review of current residents prescribed controlled medications. Identified residents prescribed controlled medications were reconciled to the declining inventory count sheet to ensure the controlled medication cards and declining count sheets match and the medications ordered were available and on the medication carts on 11/06/25. No discrepancies noted. On 11/05/25, the Director of Nursing, nurse managers or licensed nurses removed discontinued controlled medications from the medication carts. The Social Services Director interviewed alert and oriented residents on 11/06/25 to ensure residents are receiving medication when scheduled or when they ask for it and if they are experiencing an increase in pain. No issues were noted. The Director of Nursing and or Nurse Manager assessed non-interviewable residents for signs and symptoms of pain to ensure pain is managed appropriately. No concerns identified.	01/08/2026

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F0755 SS = E	Continued from page 44 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff interviews, the Consultant Pharmacist, and the Medical Director interviews the facility failed to have effective safeguards and systems in place to prevent drug diversion of discontinued narcotic pain medication (Hydrocodone-Acetaminophen oral tablet 5-325 milligrams) which resulted in a total of 20 missing tablets. This occurred for 1 of 1 resident (Resident #3) reviewed for misappropriation of medications. Findings included: Resident #3 was re-admitted to the facility on 7/14/25 with diagnoses including a stage IV and stage II pressure wounds. A hospital physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for up to 5 days. A second hard copy physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 mgs. Give 1 tablet by mouth every 6 hours as needed for pain for 14 days (56 tablets). This order was not entered into the electronic medical record. A packing slip and proof of delivery from the dispensing pharmacy dated 7/14/25 revealed the hospital physician's order was filled with a delivery of 11 tablets of Hydrocodone-Acetaminophen oral tablets 5-325 mgs for Resident #3 was received in the facility on 7/15/25. The delivery was signed as received by Nurse #7. A packing slip and proof of delivery from the dispensing pharmacy dated 7/15/25 revealed the facility's physician's order was filled with a delivery	F0755	Continued from page 44 The Regional Nurse Consultant provided reeducation to the Director of Nursing in regards to procedures and processes related to controlled medications, 2 nurses/ medication aides counting controlled medications prior to leaving shift with oncoming nurse/ medication aide, controlled medication reconciliation on 11/06/25-01/07/26. The NPE began re-education to licensed nurses and med aides to include agency staff on counting the medication cart when signing off (release of medication cart keys) and when signing on (accepting medication cart keys) on 11/06/25 - 012/23/25 . New Licensed nurses and medication aides will be educated on counting the medication cart when signing off (release of medication cart keys) and when signing on (accepting medication cart keys) during new hire orientation. The Director of Nursing or Nurse Managers educated all licensed nurses and medication aides on medication administration to include verifying MD orders before administering medications 11/06/25 - 12/23/25. Newly hired licensed nursing staff to include agency staff will receive this education in the new hire orientation program. The Director of Nursing or Nurse Manager will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks ensure all controlled medications are accounted for and narcotic counts are correct with nurses counting and documenting total cards and total count sheets. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Date of Compliance 01/08/26	

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F0755 SS = E	Continued from page 45 of Hydrocodone-Acetaminophen oral tablets 5-325 mg and a total of 54 tablets for Resident #3 was received in the facility on 7/15/25. The delivery was signed as received by Nurse #7 and Nurse #5. The declining count sheet for the 11 tablets of Hydrocodone-Acetaminophen 5-325 mgs ordered on 7/14/25 by the hospital physician and the Medication Administration Record (MAR) dated July 2025 included corresponding information indicating that the medication was signed by nursing staff as administered to Resident #3 from 7/15/25 through 7/19/25 with zero tablets remaining. The MAR had a stop date of 7/19/25. The declining count sheet for the 7/14/25 order for the 54 tablets of Hydrocodone-Acetaminophen 5-325 mgs ordered by the facility's physician and Resident #3's MAR were reviewed. The July and August 2025 MARs revealed the hard copy order from the facility physician's dated 7/14/25 was not entered on Resident #3's MAR. The declining count sheet and the MAR revealed the following information related to this Hydrocodone-Acetaminophen order: - 7/19/25 at 2:00 PM: On the declining count sheet one tablet was signed as administered by Nurse #9 with 53 pills noted as remaining. This was documented on the MAR on the 5-day under the order given by the hospital physician on 7/14/25. - 7/19/25 at 8:00 PM: On the declining count sheet one tablet was signed as administered by Nurse #7 with 52 pills noted as remaining. There was no documentation on the MAR corresponding to the declining count sheet. - 8/8/25 with no time documented: On the declining count sheet one tablet was signed out by a nurse whose name was not legible with 51 pills noted as remaining. There was no documentation on the MAR corresponding to the declining count sheet. A new physician's order dated 9/17/25 for Resident #3 revealed Hydrocodone-Acetaminophen 5-325 mgs 1 tablet by mouth every 6 hours as needed for pain for 14 days. This order was on the MAR with a stop date of 10/1/25. The 9/17/25 as needed order for	F0755		

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F0755 SS = E	Continued from page 46 Hydrocodone-Acetaminophen was signed out as administered on the declining count sheet from the 7/14/25 order for the 54 tablets delivered by the pharmacy on 7/15/25. The declining count sheet and the September MAR revealed the following information: - 9/18/25 at 8:50 AM one tablet was signed as administered by Nurse #9 and documented on the September MAR. There were 50 pills remaining. - 9/18/25 at 4:20 PM one tablet was signed as administered by Nurse #9 and documented on the September MAR. There were 49 pills remaining. - 9/24/25 at 7:00 AM one tablet was signed as administered by Nurse #10 and was not documented on the September MAR. There were 48 pills remaining. - 9/27/25 at 7:00 AM one tablet was signed as administered by Nurse #10 and was not documented on the September MAR. There were 47 pills remaining on the 54-count card. The Minimum Data Set (MDS) quarterly assessment dated 10/16/25 revealed Resident #3 was cognitively intact. He received scheduled and as needed opioid medications with occasional pain. An investigation report completed by the Administrator dated 11/5/25 revealed an order for Hydrocodone-Acetaminophen 5-325 mgs was given by the hospital. Eleven tablets were delivered to the facility on 7/14/25 and signed in by Nurse #7 and Nurse #5. Nurse Practitioner #1 placed an additional order on 7/14/25 and 54 tablets were delivered on 7/15/25 and signed in by Nurse #9. The 11 Hydrocodone-Acetaminophen 5-325 mgs were completed on 7/19/25. The descending count for the 2nd card of 54 tablets was 49 on 9/18/25. On 11/5/25 Nurse #10 discovered the count on the narcotic sheet had been changed to 27 noting 20 missing tablets and reported this to the Director of Nursing (DON). The DON then directed Nurse #10 to check the medication cart to ensure the pills were missing. Nurse #10 confirmed the pills were missing. Nurse #10 was directed to count the medication versus the count sheet to ensure there were no other discrepancies, and none were found. On 11/5/25 Resident #3's discontinued Hydrocodone-Acetaminophen was removed from the	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345409**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/21/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	**310 E Wardell Drive , Pembroke, North Carolina, 28372**

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F0755 SS = E	Continued from page 47 medication cart. On 11/5/25 the DON directed all nursing staff to complete an audit of all narcotics versus count sheets with no issues found. On 11/5/25 the DON contacted the local police to report the missing narcotics who stated he would notify the detective for further investigation. On 11/6/25 the State Agency and the Pharmacy was notified. On 11/6/25 while conducting nursing interviews Nurse #10 confirmed that when she last counted on 10/27/25 the count was correct at 47 of the 54 doses remaining on the medication card. Other staff interviewed stated they could not recall the count number. Interviews were conducted with both the agency night shift nurse on 10/27/25 and the agency day shift nurse on 10/28/25. One nurse stated the count was correct and the other nurse stated he could not remember. The facility substantiated the allegation of misappropriation of residents property. During an interview on 11/17/25 at 1:30 PM Resident #3 was lying in bed. He was alert and oriented to person, place, and time. Resident #3 was in no distress and stated he received Hydrocodone as scheduled and there had not been any time that his pain medication was not available to him. Resident #3 stated the Hydrocodone relieved his pain and he had no concerns with his medications. During an interview on 11/18/25 at 10:00 AM Nurse #10 stated she was an agency nurse and knew for certain the count was right when she last counted the Hydrocodone doses on 10/27/25, which was the last time she worked before 11/5/25. She stated on 11/5/25 she and Nurse #7 were counting the controlled medications during shift change and the medication declining count sheet from the original 54 doses had been tampered with and it looked as if someone had marked through the amount remaining of 48 pills on 9/24/25 and put 28, then marked through the amount remaining of 47 pills on 9/27/25 and put 27. The 27 remaining pills were removed from the cart on 11/5/25 and returned to pharmacy. Nurse #10 stated she did not know who removed the missing pills. Nurse #10 stated the Hydrocodone-Acetaminophen 5-325 mgs written 7/14/25 should have ended after 14 days and the medication card with the remaining tablets returned to pharmacy but that did not occur. Nurse #10 stated when she reported that the count was accurate as of 10/27/25 that was during shift count and the card was still on the medication cart. Nurse #10 indicated she did not verify that an active order was in place on 10/27/25.	F0755		

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F0755 SS = E	Continued from page 48 During an interview on 11/18/25 at 10:45 AM the Director of Nursing (DON) stated the medication discrepancy was reported to her by Nurse #10 when she and the oncoming nurse were doing the end of shift count on the morning of 11/5/25. Nurse #10 stated there was an issue with the declining count. The count of 47 had been marked out and changed to 27. Audits were done of the controlled medications immediately on all carts and the police were notified and the State Agency was notified. The DON stated the medication rooms were also audited to see if the medications had been misplaced. During the investigation she interviewed all nurses who had worked since 10/27/25, which was when Nurse #10 confirmed there were 47 pills at that time and the count was correct. All nurses were interviewed who had worked the medication cart, but no other nurse could remember how many pills were on the cart. The DON stated they were unable to determine who took the medications. When asked why the Hydrocodone–Acetaminophen order dated 7/14/25 from the facility's physician was not entered into Resident #3's electronic medical record the DON stated in July 2025 they discovered that the orders that the Nurse Practitioner entered weren't showing up in the electronic medical record and since that time the Nurse Practitioner no longer entered orders, the orders are given to the nurse. The Nurse Practitioner told the DON she could not remember which nurse she gave the order to. There was no order entered for the Hydrocodone – Acetaminophen 54 count. The DON stated the process failed when the order was not entered into Resident #3's medical record, and the nurses not accurately verifying the order associated with the medication card, as well as accurately counting the controlled medications at the end of each shift. The Hydrocodone-Acetaminophen order should have been entered into the electronic medical record, then after the 14-day period ended any doses remaining on the medication card should have been returned to pharmacy for destruction. The medication card should have been taken off the cart at that time, and the process failed with removing the card from the medication cart. The DON stated a night shift nurse (Nurse #5), and the Unit Managers were responsible for removing any discontinued medication cards from the medication cart. During an interview on 11/18/25 at 1:30 PM Unit Manger #2 stated before 11/5/25 there was no process in place to pull medications from the medication cart. She stated since the incident was found she was now required to check the medication carts for discontinued medications. Unit Manger #2 stated she had received	F0755		

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F0755 SS = E	Continued from page 49 in-service training during the facility investigations. During a phone interview on 11/18/25 at 2:15 PM the current Consultant Pharmacist #1 stated she began as the facility's Consultant Pharmacist in October 2025 and had not been to the facility since October. She stated she was told about the drug diversion. She stated the pharmacist is not here daily to remove medication cards and it should be done by the facility. She stated she did periodically conduct controlled card audits and will notify the nurse and DON if any concerns. Consultant Pharmacist #1 stated she selected one controlled medication card to audit per visit. During the audit she looks at the controlled medication book, looks at the medication cards, looks for expiration dates, and expired, or shortened order dates. She did not review Resident #3 during the October audit. During a phone interview on 11/18/25 at 2:30 PM with Consultant Pharmacist #2 who was the consultant during July through September 2025. She stated she did random audits on the controlled medications and randomly selected 4 or 5 cards for auditing. She stated she looked at documentation, final counts, and verified that the card and order match. Consultant Pharmacist #2 stated a note was sent to the DON regarding Resident #3's Hydrocodone-Acetaminophen remaining on the medication cart on the August report. During a phone interview on 11/18/25 at 6:00 PM Nurse #5 stated she was a night nurse and did check the controlled medications at times, but she did not work every night. Nurse #5 stated the Unit Managers were responsible for checking the medication carts daily. During an interview on 11/18/25 at 4:13 PM Unit Manager #1 stated she started auditing medication carts last week. She stated all nurses were tasked with removing medications from the cart if an order was discontinued. Unit Manager #1 stated the nurse should have pulled the medication and the medication card, signed with a second nurse and returned the card to pharmacy who picks up several times a day and that was not done. During an interview on 11/19/25 at 1:00 PM the Medical Director stated he was made aware of the missing Hydrocodone-Acetaminophen for Resident #3. He stated Resident #3's pain was controlled with his pain medications and no further concerns had been reported to him regarding Resident #3. During an interview on 11/19/25 the Administrator indicated a full investigation was conducted regarding	F0755		

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F0755 SS = E	Continued from page 50 the missing Hydrocodone tablets. They were unable to determine who took the missing medications. The decision was made on 11/5/25 to monitor controlled medications and put it in their Quality Assurance (QA) program.	F0755		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F0756	The discontinued controlled medication (Hydrocodone-Acetaminophen 5-325 milligrams) for Resident #3 was removed from the medication cart by the licensed nurse on 11/05/25. The Director of Nursing conducted an audit of the last 30 days pharmacy recommendations to ensure recommendations have been reviewed and addressed by 12/15/25. The Market Clinical Lead educated the Director of Nursing on 12/08/25 on reviewing and addressing the pharmacy recommendations. The Director of Nursing educated the nurse managers on reviewing and addressing the pharmacy recommendations on 12/23/25. The Administrator or Director of Nursing will conduct quality improvement monitoring 1x per week 12 weeks to ensure pharmacy recommendations are reviewed and addressed as indicated. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Date of Compliance 01/08/26	01/08/2026

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F0756 SS = D	Continued from page 51 This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and the Consultant Pharmacist's interview the facility failed to act on the Pharmacist's recommendation to remove a residents (Resident #3) discontinued narcotic pain medication (Hydrocodone- Acetaminophen 5-325 milligrams) from the medication cart. This resulted in 20 missing tablets. This occurred for 1 of 6 residents (Resident #3) reviewed for medication administration. Findings included: Resident #3 was re-admitted to the facility on 7/14/25 with diagnoses including a stage IV pressure wound and osteomyelitis (infection of the bone). A hospital physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for up to 5 days beginning 7/14/25. This order was administered to Resident #3 from 7/15/25 through 7/19/25 and completed. A second hard copy physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain for 14 days (56 tablets). A packing slip and proof of delivery from the dispensing pharmacy dated 7/15/25 revealed the facility physician's order was filled with a delivery of Hydrocodone-Acetaminophen oral tablets 5-325 mg and a total of 54 tablets for Resident #3 was received in the facility on 7/15/25. The delivery was signed as received by Nurse #7 and Nurse #5. The declining count sheet for the 54 tablets of Hydrocodone-Acetaminophen 5-325 mgs for Resident #3 was signed out by nursing staff as needed during the month of July 2025 and signed as administered one time in August 2025. Review of the Consultant Pharmacist's Controlled Substance Random Audit form dated 8/14/25 conducted by Consultant Pharmacist #2 revealed Resident #3 was selected for a random medication audit. The Pharmacist noted that Resident #3's Hydrocodone-Acetaminophen	F0756		

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F0756 SS = D	Continued from page 52 5-325 mg order had been discontinued in July 2025 and to pull the medication card from the cart and return to pharmacy. An investigation report completed by the Administrator dated 11/5/25 revealed in part; On 11/5/25 Nurse #10 discovered the count on the narcotic sheet noting 20 missing tablets of Hydrocodone-Acetaminophen and reported this to the Director of Nursing (DON). During a phone interview on 11/18/25 at 2:30 PM the Consultant Pharmacist (#2) who was the consultant during July through September 2025 stated she did random audits on the controlled medications and randomly selected 4 or 5 cards for auditing at each visit. She stated she looked at documentation, final counts, and verified that the card and the order matched. The Consultant Pharmacist stated a note was sent to the Director of Nursing (DON) regarding Resident #3's Hydrocodone – Acetaminophen 5-325 mgs that remained on the medication cart on the August 2025 pharmacy report. The Consultant Pharmacist stated the note read to pull the Hydrocodone – Acetaminophen 5-325 mg for Resident #3 from the medication cart and return to the Pharmacy for disposal because the order was discontinued on 7/29/25 after 14 days. She stated she typically did not go back and review the previous months recommendations that were sent to the Director of Nursing (DON) and just expected the recommendations would be followed. During an interview on 11/18/25 at 10:45 AM the Director of Nursing (DON) indicated she was responsible for acting on the monthly pharmacy reports. She stated she received the Consultant Pharmacist's medication audit reports each month and would complete the necessary recommendations when she received the report. The DON indicated that the Pharmacist's note to pull Resident #3's discontinued medication from the medication cart on the 8/14/25 review was missed in error. The DON stated had the Hydrocodone-Acetaminophen been removed after the order was discontinued or at least removed after the Consultant Pharmacists recommendations the missing medications would not have occurred.	F0756		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	Resident #86 no longer resides in the facility. An audit was completed by the Director of Nursing or Nurse Manager by 12/08/25 on residents currently	01/08/2026

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F0760 SS = D	Continued from page 53 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, the Pharmacy District Director, and the Wound Physician interviews, the facility failed to administer two intravenous (IV) antibiotics (Piperacillin Sodium Tazobactam - a broad-spectrum antibiotic used to treat moderate to severe bacterial infections and Vancomycin - an antibiotic used to treat severe infections) prescribed for the treatment of osteomyelitis (infection of the bone) following admission for a resident (Resident #86). This resulted in 4 missed doses of the Piperacillin and 4 missed doses of the Vancomycin. This occurred for 1 of 6 residents reviewed for medication administration. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Piperacillin Sodium Tazobactam. Use 3.375 grams intravenously every 8 hours for osteomyelitis for 18 days. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Vancomycin intravenous solution. Use 1 gram intravenously two times a day for osteomyelitis until 04/03/25. Resident #86 was admitted to the facility on 3/15/25 with diagnoses including a Stage IV pressure ulcer of the left ischium (the lower and back portion of the hip bone), Stage IV pressure ulcer on the sacrum, Stage IV pressure ulcer of the right hip, Stage II pressure ulcer on the right buttock, a deep tissue injury of the left heel, osteomyelitis of the vertebra, sacral, coccyx region, and left thigh, and paraplegia (paralysis of the lower extremities). Review of the Medication Administration Record (MAR) dated March 2025 for Resident #86 revealed the first dose of Piperacillin Sodium scheduled for every 8 hours was not administered until 3/17/25 at midnight, the second dose was administered at 8:00 AM on 3/17/25, the third dose was administered at 8:00 PM on 3/17/25. Review of the Medication Administration Record (MAR) dated March 2025 for Resident #86 revealed the first dose of Vancomycin to be administered two times a day	F0760	Continued from page 53 receiving IV antibiotics to ensure the physician order was transcribed to MAR and medication administered as indicated. The Director of Nursing or Nurse Manager conducted an audit of current residents admitted to the facility in the last 30 days to ensure admission orders were transcribed and populated on the MAR by 12/12/25. The Director of Nursing or Nurse Manager educated Licensed Nurses on transcribing and verifying admission orders and physicians orders to ensure orders are entered correctly and populated in the medical record to ensure medications are administered as indicated by 12/23/25. Newly hired licensed nurses, including agency staff will be educated in orientation. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3 random resident orders 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure medications are transcribed and populated in the medical record and medication administered as indicated per physician orders. The Director of Nursing or Nurse Managers will conduct quality monitoring of newly admitted residents to ensure discharge orders are transcribed and populated in the medical record and medication is administered as indicated per physician's orders 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. Compliance Date 01/08/26	

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F0760 SS = D	Continued from page 54 for osteomyelitis was not administered until 3/17/25 at 8:00 PM. Review of Resident #86's progress notes on 3/15/25 and 3/16/25 revealed no documentation as to why the antibiotics were not administered. A progress note was entered by the Social Worker on 3/15/25 at 1:34 PM indicating Resident #86 was in the facility at that time. Review of Resident #86's Vancomycin trough level (the lowest concentration of Vancomycin in the blood, measured just before the next dose is administered. Monitoring the trough level helps to ensure the drug is effective while minimizing the risk of toxicity) that was ordered on 3/17/25 then weekly showed Resident #86 was in therapeutic range. During a phone interview on 11/18/25 at 10:30 AM Unit Manager #1 stated Resident #86 admitted on Saturday 3/15/25 with stage IV pressure wounds and orders for IV antibiotics. Unit Manager #1 indicated the nurses could enter physician orders, but she was responsible for reviewing that the admission orders were entered. She realized the antibiotic orders had not been entered into Resident #86's electronic medical record upon admission on 3/15/25. Unit Manager #1 stated she at times entered orders from home and she was the one that entered the antibiotic orders for Resident #86 and that was why the antibiotic orders did not populate on the MAR to be administered until 3/17/25. She stated the admitting nurse should have sent the antibiotic orders to the pharmacy and entered the antibiotic orders on 3/15/25 the day of admission, but that did not occur. Unit Manager #1 indicated Medication Aide #1 was assigned to the hall that Resident #86 was admitted to on 3/15/25 and 3/16/25. The responsible day shift nurse (Nurse # 12) and night shift nurse (Nurse #11) on 3/15/25 and 3/16/25 were agency staff and were no longer employed by the facility. During a phone interview on 11/18/25 at 7:00 PM Medication Aide #1 stated the nurse in charge would have handled IV medications, but she did not recall what medications Resident #86 received. During a phone interview on 11/21/25 at 11:30 AM the	F0760		

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F0760 SS = D	Continued from page 55 Pharmacy District Director stated they provided 24-hour services 7 days a week to the facility. If IV medications were ordered over the weekend the medications would be delivered over the weekend. She stated Resident #86's Vancomycin order was not received in the pharmacy until 3/16/25 at 9:32 PM and it was delivered to the facility Monday 3/17/25. The Piperacillin order was received in the pharmacy on 3/16/25 at 3:31 AM and delivered to the facility on 3/16/25. During a phone interview on 11/21/25 at 12:30 PM the Wound Physician stated missing doses of Vancomycin and Piperacillin in the treatment of osteomyelitis was significant and could delay wound healing. The Wound Physician stated she could not say the missed doses caused any worsening of the infection regarding Resident #86 but missed doses could lead to subtherapeutic levels causing the antibiotic to be less effective. During a phone interview on 11/21/25 at 1:00 PM the Director of Nursing (DON) stated the orders for Resident #86's IV antibiotics should have been entered into the electronic medical and sent to Pharmacy on 3/15/25 the day of admission. The DON indicated that the IV antibiotics should have been administered to Resident #86 sooner.	F0760		
F0761 SS = E	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.	F0761	F761-Label/Store Drugs 1. The medication cart on 400 was locked on 10/02/25 by the Unit Manager. The licensed nurse removed the 11 loose pills in the bottom of the drawer from 200 hall medication cart drawers on 10/01/25. The unopened expired bottle Vitamin B6 50 mg tablet medications was removed from the 200 hall medication storage room by the Unit Manager on 10/01/25. The medication was removed from the 300 hall cart on 10/02/25 by Unit Manager that included an opened unlabeled and undated foil pack of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution. The manufacturer recommended that the vials be used within two weeks of the foil package being opened. 2. A quality review was completed by the Director of Nursing and/or Designee on all medication storage areas to ensure all medications stored are not expired, and all opened medications have been dated and labeled opening and have not passed the manufacturers recommendation. This was completed on 10/1/2025. No other issues were identified.	01/08/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive , Pembroke, North Carolina, 28372

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F0761 SS = E	Continued from page 56 §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, record review, and staff interviews, the facility failed to 1) secure an unattended medication cart that was facing the hallway for 13 minutes during which time 3 staff members and a resident propelling himself in a wheelchair passed the unattended opened medication cart for 1 of 1 medication carts observed (400 hall medication cart), and 2) remove loose and unsecured pills (200 hall cart), label inhalation breathing medication vials with an open date and store the vials according to manufacturer guidelines (300 hall cart) for 2 of 4 medication carts and failed to discard expired over the counter (OTC) stock medication from 1 of 2 medication storage rooms (200 hall medication room) that were reviewed for medication storage. Findings included: 1) A continuous observation of the 400-hall medication cart on 10/02/25 from 10:10 AM to 10:23 AM revealed the medication cart was noted to be unlocked as evidenced by the lock base not being pushed in flush with the drawer and was unattended and facing the hallway. Three staff members were noted to walk past the medication cart during this observation and one resident who was self-propelling in a wheelchair was noted to pass by the unlocked medication cart. An interview was conducted with Unit Manager #2 on 10/02/25 at 10:23 AM. The Unit Manager exited a resident's room and approached the 400-hall medication cart. At this time, she locked her medication cart. Unit Manager #2 stated she did not realize she left the medication cart unlocked until she came out of the residents' room. She stated she forgot to lock it before she walked away from it. An interview was conducted with Director of Nursing (DON) on 11/18/25 at 10:43 AM. The DON stated she would expect all the nursing staff to keep their medication carts locked if they were out of direct line of site and all medication carts should be secured for resident safety.	F0761	Continued from page 56 3. The Regional Clinical Lead educated the Director of Nursing on 12/08/25 to ensure medication carts are locked when unattended, medication carts are free from loose pills, clean and organized, expired medications are discarded from medication carts and medication storage rooms, medications are labeled and dated when opened and medications are discarded after manufacturers recommended storage time has expired. The Director of Nursing or Nurse Managers educated licensed nurses and medication aides, including agency staff by 12/23/25 to ensure medication carts are locked when unattended, medication carts are free from loose pills, clean and organized, expired medications are discarded from medication carts and medication storage rooms, medications are labeled and dated when opened and medications are discarded after manufacturers recommended storage time has expired. Newly hired nurses and medication aides will be educated upon hire in orientation.The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 5x per week for 4 weeks, 3x per week for 4 weeks, 1x per week for 4 weeks, to ensure medication carts are secured when unattended, medication carts are free from loose pills,medications are dated and labeled upon opening and expired medications are removed from the medication carts and medication storage rooms. 4. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education 5. Date of completion: 1/8/2026	

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F0761 SS = E	Continued from page 57 2. An observation of the 200-hall medication cart was conducted with Nurse #8 on 10/1/25 at 10:10 AM. The observation revealed 11 loose pills of various shapes, colors, and sizes in the bottom of the medication drawers. An interview was completed with Nurse #8 on 10/1/25 at 10:15 AM. Nurse #8 stated the nurses and medication aides (MA) were responsible for cleaning and checking the med carts every shift. She indicated there was not supposed to be any loose pills in the med cart drawers. An interview was completed with the Director of Nursing (DON) on 11/18/25 at 2:52 PM. The DON stated the nurses and medication aides were all responsible for keeping the med carts clean and orderly. She indicated there should not be any loose pills in the med cart drawers. She stated she expected med carts to be clean and free from loose pills. 3. An observation of the 200-hall medication storage room was completed with Unit Manager #1 and Nurse #8 on 10/1/25 at 10:17 AM. A bottle of the over the counter (OTC) stock Vitamin B6 50 milligrams (mg) tablets was available for use with an expiration date of 8/25. An interview was completed with Unit Manager #1 on 10/1/25 at 10:25 AM. Unit Manager #1 stated there should not be any expired medications on the shelf available for use in the medication storage rooms. An interview was completed with the DON on 10/2/25 at 10:30 AM. The DON stated there should not be any expired medications available for use in the medication storage rooms. 4. An observation of the 300-hall med cart was conducted on 10/2/25 at 10:13 AM with the Wound/Treatment Nurse. The observation revealed 20 vials of ipratropium bromide inhalation solution in an open foil package with no label or date opened. The manufacturer's instructions included discarding the medication 2 weeks after opening. An interview was completed with the Wound/Treatment Nurse on 10/2/25 at 10:25 AM. The Wound/Treatment Nurse stated she was unaware the vials expired 2 weeks after opening and it should have had an opened date. An interview was completed with the DON on 10/2/25 at 10:30 AM. The DON stated she was not aware that the vials expired 2 weeks after opening. She indicated all medications should have a label and an opened date.	F0761		

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F0761 SS = E F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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.	F0761 F0880	F880 Infection Control 1) Resident #68 was identified as requiring Isolation Precautions related to COVID 19. On 10/1/2025 when the deficient practice was identified, the Director of Nursing re-educated NA #9 on proper Isolation Precautions to include appropriate PPE and disinfectant of equipment for COVID 19. Resident #28, Resident #9 and Resident #10 was identified as requiring Enhanced Barrier Precautions. The Director of Nursing or Nurse Manager educated NA #1, NA #9 and NA #10 on donning appropriate PPE during high contact care on 10/01/25. 2) The Director of Nursing or Nurse Managers completed a quality review through observation on current residents as indicated as requiring Isolation Precautions to include Contact Precautions, Droplet Precaution and or Enhanced Barrier Precautions to ensure Licensed Nurses, Medication Aides and Nurse aides, including agency staff are wearing appropriate PPE when entering a residents room as indicated per the Isolation Precaution and disinfecting equipment by 01/07/26. The Director of Nursing or Nurse Manager educated staff, including agency staff on Isolation Precautions by 01/07/26. 3) The Market Clinical Lead educated the Director of Nursing on proper PPE and disinfecting equipment as required per Droplet Precautions, Isolation Precautions and Enhanced Barrier Precautions during residents care activity initially on 10/01/25 through 01/07/26. The DON and or Nurse Managers re-educated current licensed nurses, certified nurse aides, therapy on the Enhanced Barrier Precautions policy to include proper PPE required during high-contact resident care activity by 01/07/26. The Director of Nursing or Nurse Manager educated licensed nurses, nurse aides, medication aides, including agency staff, non-direct care staff, including contract personnel on Isolation Precautions policy, proper PPE required to include disinfecting equipment by 12/23/25. The DON or Nurse Manager educated licensed nurses, nurse aide, therapy staff, and non-direct care staff on Donning / Doffing with verbal and or return demonstration of understanding by 12/23/25. Newly hired staff will be educated on Isolation Precautions policy during orientation. The DON and or Unit Manager will conduct Quality Improvement Monitoring through observation 5x per week for 4 weeks, then 3x per week for 4 weeks, then 1x per week for 4 weeks ensure staff don appropriate PPE and	01/08/2026

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F0880 SS = E	Continued from page 59 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 1.) implement the infection control policy and procedures for special contact and droplet precautions for a resident (Resident #68) who was positive for COVID 19. Nurse Aide # 9 was observed walking into Resident# 68's room without wearing gloves or a gown and moved the mechanical lift that was used to transfer Resident # 68 from her bed. Nurse Aide #9 rolled the mechanical lift into the hallway without cleaning it, placed it against the wall, and left the lift unattended. Nurse Aide # 9 went back into Resident #68's room without donning gloves and a gown and moved the bedside table, picked up Resident #68's water cup and handed it to the resident. 2.) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to a resident with an indwelling urinary catheter (Resident #28). Nurse Aide #9 and Nurse Aide #10 were observed in Resident #28's room wearing gloves and no gown while bathing and repositioning Resident #28. 3.) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident (Resident #10) with a gastrostomy (enteral tube feeding site), and a resident (Resident	F0880	Continued from page 59 disinfect equipment after each patient uses. 4) The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education Compliance Date- 01/08/26	

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F0880 SS = E	Continued from page 60 #8) with a pressure ulcer when a Nurse Aide (Nurse Aide #1) was providing resident care without wearing the appropriate personal protective equipment (PPE), and failed to properly dispose of soiled linens that were observed on the floor of Resident #10's room. This occurred for 3 of 6 staff members (Nurse Aide #9, Nurse Aide #10, and Nurse Aide #1) who were observed for infection control practices. Findings included: 1.) The facility's Infection Control Policy revised 2/24/25 for Special Contact and Droplet Precautions revealed in part: Special Contact and Droplet precautions were used to prevent the transmission of infectious organisms that can be spread via pathogens that spread through the air or by direct person to person respiratory transmission. An example of a disease requiring special contact and droplet precautions is SARS-CoV (COVID 19). The process included in part; to wear personal protective equipment (PPE) including mask, gown, and gloves prior to entering the room of residents that required special contact and droplet precautions. During an observation on 9/30/25 at 11:20 AM Resident #68 was observed lying in her bed. A sign was observed on Resident #68's door that read: special droplet and contact precautions. A supply cart was located across the hall with gloves, gown, and masks on the cart. At approximately 11:25 AM Nurse Aide # 9 was observed going into Resident #68's room without donning gloves or a gown, she was wearing a mask and moved the mechanical lift into the hallway and placed it against the wall and walked away. Nurse Aide #9 was observed using alcohol-based hand rub (ABHR) for hand hygiene after walking away from the mechanical lift. Nurse Aide #9 then returned and entered Resident #68's room again without donning gloves or a gown and was observed moving the bedside table closer to the resident then handing Resident #68 her water cup. Nurse Aide #9 then left the room and applied ABHR. At approximately 11:30 AM on 9/30/25 Unit Manager #1 instructed Nurse Aide #9 to move the mechanical lift from the hallway into the dirty utility room and clean it. Nurse Aide #9 complied. Observations revealed the mechanical lift had not been used for other residents during the time it was left in the hallway by Nurse Aide #9.	F0880		

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F0880 SS = E	Continued from page 61 During an interview on 9/30/25 at 11:30 AM Unit Manager #1 stated Resident #68 was on special contact and droplet precautions due to testing positive for COVID 19. She stated Nurse Aide #9 should have applied gloves and a gown before going into a residents room who was COVID positive. Unit Manager #1 stated dirty equipment was stored in the dirty utility room and Nurse Aide #9 should not have left the lift sitting in the hallway without it being cleaned. During an interview on 9/30/25 at 11:55 AM Nurse Aide # 9 stated she forgot to put on gloves and a gown when she went into Resident #68's room. She indicated she gets confused at times on the difference between special droplet and contact precautions and enhanced barrier precautions. Nurse Aide #9 stated she should have put on gloves and a gown before entering Resident #68's room, and should have cleaned the mechanical lift before leaving it in the hallway. Nurse Aide #9 stated the mechanical lift should have been cleaned and taken to the storage room on the hall where they keep the equipment. She stated she had received infection control training on special contact and droplet precautions. During an interview on 9/30/25 at 12:10 PM the Director of Nursing (DON) stated staff were expected to wear the appropriate PPE when going into resident rooms and Nurse Aide #9 should have put on gloves and a gown along with her mask before going into Resident #68's room. The DON stated the mechanical lift should have been taken to the storage room and cleaned instead of being left dirty on the hallway especially after coming from a room of a COVID positive resident. During an interview on 10/2/25 at 1:00 PM the Infection Control Preventionist Nurse stated Resident #68 tested positive for COVID on 9/21/25 and was on special droplet precautions at the time of the observations. 2.) The facility's Infection Control Policy revised 12/16/24 revealed in part: Enhanced Barrier Precautions (EBP) were designed to reduce the transmission of multidrug resistant organisms (MDRO) and employed targeted personal protective equipment (PPE) to include gown and glove use during high contact resident care activities. EBP was indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a MDRO.	F0880		

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F0880 SS = E	Continued from page 62	F0880		

During an observation on 9/30/25 at 11:45 AM Nurse Aide #9 was observed along with Nurse Aide #10 providing a bed bath and repositioning Resident #28. Resident #28 had a urinary catheter in place. Nurse Aide #9 and Nurse Aide #10 were both wearing gloves but no gown while providing direct care.

During an interview on 9/30/25 at 11:55 AM Nurse Aide # 9 stated she forgot to put on a gown when she went into Resident #28's room to give his bath. She indicated she knew Resident #28 was on enhanced barrier precautions due to having a urinary catheter. Nurse Aide #9 stated she should have put on a gown before providing care to Resident #28. She stated she had received infection control training on enhanced barrier precautions.

During an interview on 9/30/25 at 12:00 PM Nurse Aide # 10 indicated she knew Resident #28 was on enhanced barrier precautions due to having a urinary catheter. Nurse Aide #10 stated she should have put on a gown before providing care to Resident #28. She stated she had received infection control training on enhanced barrier precautions.

During an interview on 9/30/25 at 12:10 PM the Director of Nursing (DON) stated all staff have had infection control training including recent infection control training since the COVID outbreak that started on 9/8/25. She stated staff were expected to wear the appropriate PPE when going into resident rooms to provide care.

During an interview on 10/2/25 at 1:00 PM the Infection Control Preventionist Nurse stated she was new to the role of the Infection Control Nurse but stated all staff had received training on special droplet precautions and enhanced barrier precautions. She stated staff had received recent infection control training due to the COVID outbreak that started on 9/8/25. She stated there were adequate supplies of PPE and staff were expected to wear the appropriate PPE when providing care to residents.

3). The facility policy dated 12/16/24 titled, "Enhanced Barrier Precautions" an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms. It employs targeted

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F0880 SS = E	Continued from page 63 personal protective equipment (PPE) used during high contact resident activities to include, in part, dressing, bathing, providing hygiene, changing linens or briefs. High contact residents included, in part, wound care; any skin opening requiring a dressing, and enteral feeding tubes. a. An observation of resident care was conducted with Nurse Aide (NA) #1 on 10/01/25 at 10:00 AM. A sign was posted on the front of the door to indicate Resident #10 was on Enhanced Barrier Precautions and to apply PPE to include gloves and gowns before providing contact care. The PPE was noted to be in the hallway in an enclosed cart to include gloves and gowns. Upon entering Resident #10's room, NA #1 was noted to be wearing gloves only while providing a bath for Resident #10 who had a gastrostomy (tube feeding) site. An interview was conducted with NA #1 on 10/01/25 at 10:00 AM. NA #1 stated, when asked why she did not apply a gown during resident contact care, she just came in the room and got started on incontinent care and to give Resident #10 a bath. NA #1 added, she should have put a gown on since Resident #10 had a tube feeding site. b. An observation on 10/01/25 at 10:00 AM of Resident #10's room revealed NA #1 had placed all the soiled linens on the floor to include bathing towels, bed sheets and the resident's hospital gown. An interview was conducted with NA #1 on 10/01/25 at 10:00 AM. NA #1 stated she should not have put the soiled linens on the floor and instead should have put them in a plastic bag. NA #1 stated she was trained to follow the EBP precautions and to place soiled linens in a trash bag and not on the floor. NA #1 stated she had come in the room and got started with care and did not bring an extra plastic bag to put the soiled linens in. c. An observation of resident care was conducted with NA #1 on 10/01/25 at 11:00 AM. A sign was posted on the front of the door to indicate the Resident #8 was on Enhanced Barrier Precautions and to apply PPE to include gloves and gowns before providing contact care. The PPE was noted to be in the hallway in an enclosed cart to include gloves and gowns. Upon entering Resident #8's room, NA #1 was noted to be wearing gloves only while providing incontinent care for Resident #8 who had pressure ulcers to his right heel. An interview was conducted with NA #1 on 10/01/25 at	F0880		

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F0880 SS = E	Continued from page 64 11:00 AM. NA #1 stated she knew she was supposed to wear a gown according to the EBP sign hanging on Resident #8's door due to his pressure ulcers. NA #1 stated she was rushing to get the resident to dialysis and forgot to apply a gown. An interview was conducted with the Staff Development Coordinator (SDC) on 10/02/25 at 3:30 PM. The SDC stated training was provided to NA #1 upon hire regarding following the EBP signs and to not put dirty / soiled linens on the floor. The SDC stated she would provide additional training to all her staff regarding infection control. An interview with the Director of Nursing (DON) on 10/02/25 at 3:30 PM revealed she would have expected the staff member to apply the appropriate PPE to include a gown whenever she was providing care to a resident with a tube feed and to a resident with an open wound. She stated the Enhanced Barrier Precaution policy was in place to protect other residents and staff members from infection and that more education needed to be given to the staff.	F0880		