STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345298	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Pender	**311 S Campbell Street , Burgaw, North Carolina, 28425**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/12/2026 to 1/15/2026. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID # 1E073C-H1.	E0000		01/15/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/12/2026 through 1/15/2026. Event ID# 1E073C-H1. The following intakes were investigated 792830, 792829, 792832, 2694412, 792837, and 792831. 4 of the 21 allegations resulted in deficiency.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Nurse Practitioner and staff interviews, the facility failed to obtain and document	F0552	F-Tag 552 Psychotropic Medication Consent 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #98 consented for treatment for psychotropic medications for Amitriptyline , Depakote Sodium Extended, and Seroquel on 01/15/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing (DON)/Designee performed audit on all residents to ensure that all residents have consented for psychotropic medications by 01/31/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON/Designee will educate all Licensed Nurses on obtaining consent for treatment for all residents with psychotropic medications and review with the resident or resident representative in advance of the risks versus benefits of psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) prior to administration of psychotropic medications by 01/31/2026.	02/06/2026

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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F0552 SS = D	Continued from page 1 consent for treatment with psychotropic medications and review with the resident or resident representative in advance of the risks versus benefits of psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) prior to administration of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #98). Findings included: Resident #98 was admitted to the facility on 01/07/26 with diagnoses that included bipolar disorder, dementia and anxiety. Resident #98's physician orders dated 01/07/26 revealed orders for the following psychotropic medications: Amitriptyline (antidepressant/psychotropic medication) 25 milligrams give 2 tablets in the evening for bipolar disorder, Depakote Sodium Extended Release (an anticonvulsant and mood stabilizer used to treat several conditions including bipolar disorder) 500 milligrams give 3 tablets in the evening for dementia, and Seroquel (antipsychotic/psychotropic medication) 300 milligrams give one tablet in the evening for dementia. The Medication Administration Record (MAR) from 01/07/26 through 01/15/26 indicated Resident #98 was administered Seroquel, Depakote, and Amitriptyline as ordered. The Minimum Data Set admission assessment dated 01/12/26 revealed Resident #98 was cognitively intact and Resident #98 received antipsychotic, anticonvulsant, and antidepressant medications during this assessment period. A review of Resident #98's medical record revealed no documentation that Resident #98 or the resident's representative consented to or were informed in advance of the risks versus benefits of receiving Seroquel and Amitriptyline. An interview was conducted with Unit Manager #2 on 01/14/26 at 4:30 PM. Unit Manager #2 stated when a resident was admitted, the admitting nurse was given an "admission packet." She stated within the packet was a checklist of all the areas the admitting nurse needed to address. Unit Manager #2 stated #6 on the checklist was the consent form for psychotropic medications which	F0552	Continued from page 1 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON/Designee will audit all new psychotropic medication orders that are prescribed daily to ensure consents for treatment have been obtained/completed prior to administering psychotropic medication Monday through Friday during Clinical Morning Meetings X 12 weeks. Results from audits will be forwarded to Quality Assurance Committee monthly x 3 for further recommendations, as necessary.	

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F0552 SS = D	Continued from page 2 should be reviewed and signed and was located in the electronic record. At this time, Unit Manager #2 reviewed Resident #98's electronic medical record to see if the consent was reviewed and signed by Resident #98. Unit Manager #2 confirmed there was no documentation to support this consent, or the risks verses benefits were reviewed with Resident #98 and signed. An interview was attempted with Nurse #7 who was the admitting nurse for Resident #98 via phone and a message was left for a return call on 01/15/26 at 11:30 AM. Nurse #7 did not return the call. An interview was conducted with the Nurse Practitioner on 01/14/26 at 4:35 PM. The Nurse Practitioner stated the psychotropic medication consent form should have been completed upon admission for Resident #98. He stated it was important for the nurse to inform the resident of the risks verses benefits of each psychotropic medication to ensure Resident #98 was aware prior to administration of the medication. An interview was conducted with the Director of Nursing (DON) on 01/15/26 at 11:00 AM. The DON reported that the psychotropic consent form should have been done while completing the assessment by the admitting nurse when the resident was admitted on 01/07/26. She stated it was important for the consent to be reviewed and risks versus benefits to be discussed with the resident about each of the psychotropic medications that were ordered and should have been done prior to administration of the medications. .	F0552		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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:	F0684	F684 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #33 allowed dressing and tolerated treatment to left lateral thigh on 01/13/2026. Notified Responsible Representative and Provider of wound care not provided on 1-7-2026. Resident #33 was discharged to Assisted Living Facility on 01/22/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	02/06/2026

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F0684 SS = D	Continued from page 3 Based on observation, record review, and staff, and the Medical Director's interview, the facility failed to follow the physician's order for the care of a surgical wound for 1 of 2 residents reviewed for wound care (Resident #33). Findings included: The hospital discharge summary dated 12/31/25 for Resident #33 revealed; Aquacel (a wound dressing that promotes a moist healing environment) to remain in place to the left surgical wound for seven days and replace with new Aquacel. Resident #33 was admitted to the facility on 12/31/25 with diagnoses including a left femur fracture with surgical repair. A physician's order dated 1/1/26 entered by the Wound Nurse for Resident #33 revealed to cleanse the wound to the left lateral thigh with generic wound cleanser. Apply protective barrier to the peri wound, then apply silicone foam with silver (wound care that uses silver for antimicrobial protection, a foam core to absorb drainage, and a silicone adhesive for secure placement) every seven days and as needed. A care plan dated 1/2/26 revealed Resident #33 had the potential for complications from the surgical wound of the left thigh. The goal of care included the wound would heal without signs of infection. Interventions included to observe for signs of infection (i.e. redness, swelling, temperature increases, increased drainage or odor), report abnormal findings to the physician, and provide wound treatments as ordered The Minimum Data Set (MDS) admission assessment dated 1/5/26 revealed Resident #33 had moderately impaired cognition. He had no behaviors and rejection of care occurred 1-3 days. Resident #33 had a surgical wound and no wound care. Review of the Treatment Administration Record (TAR) dated January 2026 for Resident #33 revealed on 1/7/26 Nurse #6 documented that wound care was not performed with code 5 indicating to see progress notes. Further review of the TAR from 1/1/26 through 1/13/26 revealed no documentation that wound care was provided to the	F0684	Continued from page 3 Director of Nursing (DON)/Designee will complete a 7-day look-back audit on 100% of residents with current wound care orders to ensure all notifications of refusals are documented by 01/31/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON/Designee educated 100% of licensed nurses on following physicians orders and to notify Responsible Representative and Provider of refusal of treatment by 01/31/2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON/Designee will audit wounds Monday - Friday weekly x 12 weeks to ensure treatment orders are followed and responsible representative and provider are notified of refusals. Results from audits will be forwarded to Quality Assurance Committee monthly x 3 for further recommendations, as necessary.	

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F0684 SS = D	Continued from page 4 left femur surgical wound. Review of the progress notes dated 1/7/26 revealed no documentation as to why Nurse #6 did not provide wound care to Resident #33's surgical wound on 1/7/26. Further review of the progress notes from 1/1/26 through 1/13/26 revealed no documentation that wound care was provided to the left femur surgical wound for Resident #33. During an interview on 1/15/26 at 3:00 PM Nurse #6 stated Resident #33 refused wound care for her on 1/7/26 and she reported the refusal that day to the Wound Nurse. Nurse #6 stated she did not provide wound care to Resident #33 at any time since his admission. During an interview on 1/13/26 at 1:30 PM Nurse Aide #3 indicated Resident #33 would refuse care but if you redirect or reapproach him later he would allow you to provide his care. During an interview on 1/13/26 at 10:30 AM the Wound Nurse stated Resident #33 admitted to the facility on 12/31/25 following a femur fracture repair. The Wound Nurse stated wound care had not been completed to Resident #33's surgical wound because he refused on 1/7/26. She stated Resident #33's wound care was not due again until 1/14/26. A wound care observation was conducted on 1/13/26 at 11:00 AM with the Wound Nurse. Resident #33 was lying in bed. He was in no distress and verbalized no pain. The Wound Nurse removed the left hip dressing dated 12/31/25 that was applied at the hospital. The incision site included 14 intact staples with slight redness noted on the edges of one end of the incision. There was no drainage or odor noted. The Wound Nurse cleaned the area with wound cleaner, applied skin prep, and covered with a silicone foam dressing. During a second interview on 1/14/26 at 2:00 PM the Wound Nurse stated she entered an order on 1/1/26 for weekly dressing changes for Resident #33. She reported that the assigned nurse on 1/7/26 (Nurse #6) stated Resident #33 refused care that day and that was why wound care was not done. The Wound Nurse stated she asked Resident #33 one day last week if he would let her change the dressing and he refused but she did not	F0684		

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F0684 SS = D	Continued from page 5 document that refusal. The Wound Nurse stated she was responsible for wound care Monday through Friday when she was in the facility and on the weekends either the charge nurse or the assigned nurse was responsible for wound care. The Wound Nurse stated that wound care should have been provided on 1/7/26 which was day 7 following admission. She stated she should have made efforts to get the wound care done later on 1/7/26 or the following days and she didn't do that and it was done in error. The Wound Nurse stated she should not have waited 13 days following admission to provide wound care to Resident #33's surgical site. During an interview on 1/14/26 at 3:45 PM the Director of Nursing (DON) stated Resident #33's wound care should have been provided according to the physician's order. The DON stated that if Resident #33 refused wound care on 1/7/26 attempts should have been made later that day and the following days and documented in the medical record but that did not occur. The DON stated wound care should have been provided to Resident #33's surgical wound sooner than 13 days after admission. During an interview on 1/14/26 at 4:15 PM the Medical Director stated Resident #33's wound care should have been provided according to the order and wound care should have been done sooner than 13 days after admission to assess for complications including signs of infection. The Medical Director indicated no concerns had been brought to him regarding Resident #33 having any change in condition or any concerns regarding the left femur surgical site.	F0684		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff and Nurse Practitioner interviews, the facility failed to obtain orders to assess and manage a new arterial venous (A/V) fistula (A surgical connection of	F0698	F-Tag 698 Dialysis 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #7's orders were updated and corrected to monitor bruit/thrill on a resident's AV(arterial venous fistula) access on 01/15/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. DON/Designee audited all residents with Dialysis/AV access to ensure all orders and treatments to monitor were in place by 01/28/2026.	02/06/2026

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F0698 SS = D	Continued from page 6 an artery to a vein, usually in the arm, to create a long-lasting access point for dialysis needles) that was maturing for 1 of 1 resident reviewed for dialysis (Resident #7). Findings included: A history and physical assessment from the hospital dated 12/08/25 revealed Resident #7 was admitted to the hospital with possible gastrointestinal bleed. The hospital note further indicated Resident #7 had an A/V fistula in place since October 2025 in anticipation for dialysis to the right upper extremity that was positive for bruit and thrill (whooshing sound heard with a stethoscope and a vibrating sensation felt with fingers on the A/V fistula; both signs that an access was working and had good blood flow) but has not matured and a permacath (a catheter inserted into the chest used for dialysis) was placed during this hospitalization. Resident #7 was admitted to the facility on 12/17/25. He was discharged to hospital on 01/01/26 and readmitted on 01/11/26. Diagnoses included end stage renal disease with dependence on renal dialysis. A skilled care note written by Nurse #8 on 12/17/25 revealed Resident #98 had permacath to right upper chest, and dialysis site to right upper extremity was positive for bruit and thrill. On 01/15/26 at 3:53 PM a phone interview was attempted with Nurse #8 who admitted Resident #98 on 12/17/25. Nurse #8 did not return the call. The Minimum Data Set admission assessment dated 12/23/25 revealed Resident #7 was moderately cognitively impaired and was coded as receiving dialysis services. Review of Resident #7's care plan dated 12/17/25 revealed a plan of care was in place for at risk for complications related to requiring dialysis due to end stage renal disease. The goal was that Resident #7 would have immediate interventions should any signs or symptoms or complications from dialysis occur through the next review. Interventions included, in part, do not draw blood or take blood pressure in the arm with	F0698	Continued from page 6 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON/Designee educated all nurses on the Dialysis Policy and identifying AV access on admission and ensure orders are in place on residents with AV access by 01/31/2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON/Designee will audit all residents with dialysis related to AV access to ensure bruit/thrill on a resident with AV access every week x 12 weeks. Results from audits will be forwarded to Quality Assurance Committee monthly x 3 for further recommendations, as necessary.	

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F0698 SS = D	Continued from page 7 fistula (arterial venous fistula), observe for signs or symptoms of infection to access site to include redness, swelling, warmth or drainage/bleeding, palpate for presence of thrill and listen for bruit, and report abnormalities to physician. Physician orders written for Resident #7 revealed an order written on 12/18/25 for dialysis treatments every Tuesday, Thursday and Saturday and to observe dialysis catheter site for any signs of bleeding and infection and to make sure caps (covering port sites) were intact. There were no orders in place to assess the A/V fistula to right arm. A progress note written by the Nurse Practitioner on 12/18/25 revealed Resident #98 had the right chest permacath in place and was on a Tuesday, Thursday, and Saturday dialysis schedule. The progress note indicated under assessment and plan that a right A/V fistula was placed in October 2025 and that it was not yet mature and a permacath was placed during the most recent hospitalization. A skin assessment note written by the Wound Treatment Nurse on 12/18/25 revealed a double lumen permacath to right chest, old dialysis access to right upper arm. The Medication Administration Record (MAR) for December 2025 revealed the catheter (permacath) site was being assessed from 12/18/25 through 12/31/25. The MAR did not include any orders to assess the A/V fistula to right arm. A progress note written on 01/01/26 revealed Resident #98 was sent to the hospital for a low hemoglobin (a lab value to measure oxygen in the blood). Resident #98 was readmitted back to the facility on 01/11/26. Review of the physician orders written on 01/11/26 revealed orders to include dialysis treatments every Tuesday, Thursday and Saturday and to observe dialysis catheter site for any signs of bleeding and infection and to make sure caps (covering port sites) were intact. There were no orders in place to assess the A/V fistula to right arm. A skilled care note written by Nurse #9 on 01/11/26	F0698		

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F0698 SS = D	Continued from page 8 revealed resident with temporary permacath placement as A/V fistula placed in October 2025 was not mature, and receiving dialysis on Tuesday, Thursday, and Saturday. An interview was conducted with Nurse #9 on 01/15/26 at 10:22 AM. Nurse #9 stated she was the nurse who started the admission for Resident #98 on the evening of 01/11/26. Nurse #9 stated usually the Unit Manager put in orders called “batch” orders whenever a resident had an A/V fistula. She added the batch orders included to assess fistula for bruit and thrill, monitor for signs of infection, and do not take blood pressures or do lab draws from the extremity the access site was on. Nurse #9 stated she assessed the A/V fistula site, and it was positive for a bruit and thrill, but she did not put any orders in. Nurse #9 stated that Nurse #8 took over the remainder of the admission process from Nurse #9 when she finished her shift at 7:00 PM. On 01/15/26 at 3:53 PM a phone interview was attempted with Nurse #8 and Nurse #8 did not return the call. A skilled care note written by Nurse #8 on 01/11/26 revealed dialysis site to right arm positive for bruit and thrill; dialysis days Tuesday, Thursday, and Saturday and pick up time was at 10:30 AM. A skin assessment note written by the Wound Treatment Nurse on 01/13/26 revealed double lumen permacath to right chest, dialysis access to right upper arm. The Medication Administration Record (MAR) for January 2026 revealed the catheter site (permacath) was documented as being assessed on 01/12/26, 01/13/26, 01/14/26, and 01/15/26. The MAR did not include any orders to assess the A/V fistula to right arm. An interview was conducted with Resident #98 on 01/12/26 at 9:00 AM. Resident #98 stated he was getting dialysis and pointed to his permacath to his right chest. Resident #98 stated he had a fistula to his right arm, but it was not in use at this time. Resident #98 could not recall why it was not in use or how long he had the A/V fistula. An observation of Resident #98 on 01/12/26 at 9:00 AM revealed an A/V fistula to his right upper arm and a	F0698		

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F0698 SS = D	Continued from page 9 permacath to his right chest. An interview was conducted with Unit Manager #2 on 01/15/26 at 9:30 AM. Unit Manager #2 stated she did not realize the A/V fistula to Resident #98's right arm was maturing. She knew that it existed, but she thought it was not functioning and that was why he had the permacath because that had been what he had been dialyzing through since admission. She reviewed the history and physical from the hospital at this time from 12/17/25 and confirmed he had a new A/V fistula inserted in October 2025 and that the access site was positive for bruit and thrill, but the access was not mature yet. She stated she did not assess Resident #98's site for bruit and thrill, or check for any redness, swelling or warmth and there should have been orders in place to assess the access site upon initial admission and readmission. Unit Manager #2 stated the admitting nurses should have initiated orders for the A/V fistula which would have included: no blood pressures or lab draws in the right arm, assess for signs and symptoms of infection such as bleeding, redness, swelling, and check for bruit and thrill. An interview was conducted with the Wound Treatment Nurse on 01/15/26 at 2:00 PM. The Wound Treatment Nurse stated she completed a skin assessment on Resident #98 on 12/18/25 and on 01/13/26 and saw that he had an A/V fistula. She stated she thought it was an old access site that was not in use and that was why Resident #98 had the permacath. The Wound Treatment Nurse stated she did not assess the A/V fistula site. The Wound Treatment Nurse stated she would not have put orders in the electronic record for the A/V fistula and that the admitting nurse would have initiated those orders. The Wound Treatment Nurse stated she was responsible for any dressing treatments to the permacath site or an A/V fistula site. A follow up interview was conducted with Unit Manager #2 on 01/15/26 at 11:00 AM. Unit Manager #2 stated the admitting nurses should have implemented batch orders for the A/V fistula access site and that it was not the sole responsibility of the Unit Manager. Unit Manager #2 stated she was primarily responsible for verifying orders. An interview with the Nurse Practitioner on 01/15/26 at 11:07 AM revealed he was aware Resident #98 had the A/V fistula to the right arm and mentioned it in his	F0698		

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F0698 SS = D	Continued from page 10 admitting progress note that it was maturing. He stated he would have expected the nursing staff to initiate batch orders for the A/V fistula since it was maturing and not old. He stated it was important to assess the bruit and thrill to make sure the access was not clotted (no blood flow), to check for signs and symptoms of infection, and to make sure no blood draws or blood pressures were being done from that arm. An interview was conducted with the Director of Nursing (DON) on 01/15/26 at 11:17 AM. The DON stated the admitting nurses should have initiated the batch orders for the A/V fistula access site for Resident #98 on 12/17/25 and on 01/11/26. She stated the Unit Managers verified the orders by double checking all admission orders to be sure all orders were put in place. The DON stated the orders to assess the A/V fistula site were not entered on both admissions and should have been.	F0698		
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	F0756	F-Tag 756 Drug Regimen Review 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Res #72 provider was notified on 01/15 /2026 of midodrine administration and irregularity receive blood pressure medications response. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All current residents that receive blood pressure medications will be reviewed with a 30 day look back to validate accuracy of Pharmacist with oversight of DON conducted facility wide audit of all blood pressure medications to ensure compliance with CMS requirements by 02/02/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed nurses will be reeducated so that all blood pressure medications will be administered as ordered by 01/31/2026. Re-education with Pharmacist Consultant by Licensed Nursing Home Administrator and Director of Nursing on CMS F-tag 756 requirements with emphasis on identifying and reporting all irregularities on Medication Regimen Reviews (MRR). 4. Indicate how the facility plans to monitor its	02/06/2026

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F0756 SS = D	Continued from page 11 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and the Consultant Pharmacist's interviews, the Consultant Pharmacist failed to identify and report a medication irregularity during 2 consecutive monthly medication regimen reviews (MRR) (November and December 2025) for 1 of 6 residents reviewed for unnecessary medications (Resident #72). Findings included: Resident # 72 was admitted to the facility on 11/5/25 with diagnosis which included orthostatic hypotension (a sudden drop in blood pressure upon changing positions). A review of Resident #72's physician orders revealed an order dated 11/6/25 to give midodrine 2.5 milligrams (mg) twice per day for hypotension (low blood pressure). The order indicated to hold the medication for a systolic blood pressure (SBP) reading over 120 millimeters per mercury (mm/Hg) or diastolic blood pressure over 80 mm/Hg. A review of Resident #72's medication administration record (MAR) for November 2025 revealed an entry which indicated to administer the medication midodrine 2.5 mg. Hold the medication if SBP is over 120 mm/Hg or diastolic blood pressure is over 80 mm /Hg. The MAR revealed the following: 11/9/25 6:00 PM the blood pressure was recorded as 124/53 mm/Hg and the midodrine was signed off by Nurse #1 as administered. 11/10/25 6:00 PM the blood pressure was recorded as	F0756	Continued from page 11 performance to make sure that solutions are sustained. DON/Designee will review consultant pharmacist new admission reviews Monday-Friday x 12 weeks and monthly for completeness and accuracy including pharmacist follow-up reviews monthly x 3. Findings from the audits will be reviewed in Quality Assurance Committee Meeting Monthly X 3 for further recommendations, as necessary.	

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F0756 SS = D	Continued from page 12 124/68 mm/Hg and the midodrine was signed off by Nurse #4 as administered. 11/15/25 9:00 AM the blood pressure was recorded as 129/54 mm/Hg and the midodrine was signed off by Nurse #5 as administered. 11/17/25 6:00 PM the blood pressure was recorded as 129/56 mm/Hg and the midodrine was signed off by Nurse #3 as administered. The Consultant Pharmacist's MRR dated 11/18/25 documented that Resident #72's medication regimen contained no new irregularities." The medication regimen review did not address that Resident #72's medication midodrine was documented as administered outside the ordered parameters. A review of Resident #72's medication administration record (MAR) for December 2025 revealed an entry which indicated to administer the medication midodrine 2.5 mg. Hold the medication if SBP is over 120 mm/Hg or a diastolic blood pressure is over 80 mm /Hg. The MAR revealed the following: 12/4/25 9:00 AM the blood pressure was recorded as 122/67 and the midodrine was signed off by Nurse #2 as administered. 12/9/25 at 6:00 PM the blood pressure was recorded as 121/66 and the midodrine was signed off by Nurse #2 as administered. 12/11/25 at 6:00 PM the blood pressure was recorded as 132/60 and the midodrine was signed off by Nurse #1 as administered. 12/14/25 at 6:00 PM the blood pressure was recorded as 121/60 and the midodrine was signed off by Nurse #2 as administered. 12/17/25 at 6:00 PM the blood pressure was recorded as 121/67 and the midodrine was signed off by Nurse #2 as administered. The Consultant Pharmacist's medication regimen review dated 12/18/25 documented that Resident #72's medication regimen contained no new irregularities." The medication regimen review did not address that Resident #72's medication midodrine was documented as	F0756		

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F0756 SS = D	Continued from page 13 administered outside the ordered parameters. 12/19/25 at 6:00 PM the blood pressure was recorded as 122/61 and the midodrine was signed off by Nurse #1 as administered. 12/20/25 at 6:00 PM the blood pressure was recorded as 124/62 and the midodrine was signed off by Medication Aide #2 as administered. 12/23/25 at 9:00 AM the blood pressure was recorded as 128/61 and the midodrine was signed off as administered by Nurse #2 as administered. 12/23/25 at 6:00 PM the blood pressure was recorded as 131/72 and the midodrine was signed off by Nurse #2 as administered. 12/24/25 at 9:00 AM the blood pressure was recorded as 139/74 and the midodrine was signed off by Nurse #2 as administered. 12/24/25 at 6:00 PM the blood pressure was recorded as 124/69 and the midodrine was signed off by Nurse #2 as administered. 12/26/25 at 6:00 PM the blood pressure was recorded as 134/68 and the midodrine was signed off by Nurse #1 as administered. 1/9/26 at 9:00 AM the blood pressure was recorded as 126/66 and the midodrine was signed off by Medication Aide #1 as administered. 1/9/26 at 6:00 PM the blood pressure was recorded as 127/70 and the midodrine was signed off by Medication Aide #1 as administered. During a phone interview on 1/15/26 at 11:20 AM the Consultant Pharmacist who was the pharmacist for the facility during November 2025 through January 2026 stated when he conducted his monthly reviews he reviewed the current MAR and the prior month's MAR for any irregularities including any medication administered outside of the parameters ordered. The Consultant Pharmacist stated a blood pressure medication should be documented as held when the blood pressure reading at the time of administration was outside the ordered parameter. The Consultant Pharmacist stated that he should have addressed Resident #72's documentation of the medication midodrine being administered outside the ordered	F0756		

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F0756 SS = D	Continued from page 14 parameter on his medication regimen reviews completed in November 2025 and December 2025. He stated that it was human error that he missed the medication administered outside the parameters when he reviewed Resident #72's MARs. An interview was conducted with the Director of Nursing (DON) on 1/15/26 at 3:15 PM. The DON stated that the Consultant Pharmacist completed a monthly review of each residents' medications. The DON stated that as part of the medication regimen review, the Consultant Pharmacist should have addressed that Resident #72's hypotension medication (midodrine) was documented as administered outside the designated parameter on the November and December 2025 MARs.	F0756		
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. §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, manufacturer's instructions, and staff interviews, the facility failed to record an opened date on multi-dose insulin pen injectors and an	F0761	F761 Label/Store Drugs and Biologicals 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. All Lantus, Lispro, Tresiba, Humalog that was not labeled and dated upon opening were discarded and replaced by Unit Manager on 01/14/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing/Designee audited all residents receiving insulin to ensure all packages had an open date and expiration dates there were no irregularities on 01/30/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director or Nursing or designee will educate all licensed nurses on the policy and procedures on the importance of correct Labeling and Medication Storage by dating all Insulin upon opening and including date of expiration by 1-31-2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/Designee will perform random	02/06/2026

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F0761 SS = E	Continued from page 15 insulin vial for 3 of 4 medication carts that were reviewed for medication storage (100 and 400 hall medication carts). Findings included: a) An observation of the 400-hall medication cart on 01/14/26 at 8:20 AM with Medication Aide #3 revealed the follow medications: Humalog prefilled insulin pen was opened with no opened date Lantus prefilled insulin pen was opened with no opened date. The manufacturer's instructions for both the Humalog and Lantus insulin pens read to discard after 28 days once opened. An interview with Medication Aide #3 on 01/14/26 at 8:12 AM revealed nurses and medications aides were responsible for checking the medication carts to make sure there were no expired medications. Medication Aide #3 stated that as a Medication Aide she cannot administer insulin and she did not check the dates on them. An interview with Unit Manager #2 on 01/14/26 at 8:12 AM stated the nurses should be checking the medication carts to make sure there were no expired medications and all insulin pens were dated once opened. The Lantus Insulin Pen and the Humalog Insulin pen were received on 01/12/26 as was indicated on the pharmacy labels adhered on the insulin pens. She stated they had been used and should have been dated once opened in order to determine how long the pens were good for according to the manufacturer's instructions. how did she know they were received on 1/12? b) An observation of the 100 - hall long term care medication cart on 01/14/26 at 8:40 AM with Nurse #10 revealed the following medications: Tresiba prefilled insulin pen was opened with no opened date. The manufacturer's instructions for Tresiba read to discard after 56 days once opened.	F0761	Continued from page 15 audits on each medication cart with Insulin 3 days a week x 12 weeks to ensure there are no concerns. The audit tool will be reviewed by the Director of Nursing and/or designee and discussed in the monthly Quality Assurance Performance Improvement meeting x 3 months.	

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F0761 SS = E	Continued from page 16 Lispro Insulin vial was opened with no opened date. Insulin Glargine prefilled insulin pen was opened with no opened date. The manufacturer's instructions for the Lispro insulin vial and the Insulin Glargine prefilled insulin pen read to discard after 28 days once opened. An interview with Nurse #10 on 01/14/26 at 8:45 AM revealed all nurses were responsible for checking their medication carts to make sure there were no expired medications and that all the insulin pens and vials were dated when opened. Nurse #10 stated the Tresiba insulin pen, the Lispro vial of insulin and the Insulin Glargine should have had a date on it when it was opened so nursing staff would when it should be used by. Nurse #10 stated she should have checked the insulins at the start of the shift to be sure they were all dated. Nurse #10 stated she would discard the insulin pens and vial. c) An observation of the 100 - hall skilled care medication cart on 01/14/26 at 9:11 AM with Medication Aide #1 revealed the following medications: Lantus prefilled insulin pen was opened with no opened date. The manufacturer's instructions for Lantus prefilled insulin pen read to discard after 28 days once opened. An interview was conducted with the Medication Aide #1 on 01/14/26 at 9:11 AM revealed all nurses and medication aides were responsible for checking the medication carts to make sure there were no expired medications. Medication Aide #1 stated that as a Medication Aide she cannot administer insulin and she did not check for opened dates on the insulin pens. An interview with Unit Manager #1 on 01/14/26 at 9:11 AM stated she should have checked the medication carts to be sure all the insulin pens were dated once opened. Unit Manager #1 stated she was overseeing Medication	F0761		

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F0761 SS = E	Continued from page 17 Aide #1 since she cannot administer insulin and Unit Manager #1 should have checked the medication cart at the start of the shift. Unit Manager #1 stated all nurses and medications aides should be checking their carts at the start of their shift to check for expired medications, and to be sure all insulin was dated once opened. An interview was conducted with the Director of Nursing (DON) on 01/15/26 at 11:10 AM. The DON reported her expectation was that once an insulin pen or vial was opened the nurses should be putting am opened date on them. She stated insulins pens and vials have a manufacturer's instruction to discard after so many days once opened and without having the initial opened date recorded on the vial or the pen, nurses would not be able to determine if the medication was still good for use.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to label and date opened packages of	F0812	F0812 Food Procurement, Store/Prepare/Serve-Sanitary Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Foods identified as not being stored properly on 1-12-26 during the Initial Tour were immediately discarded by the Dietary Manager on 1-12-26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. A 100% audit of proper food storage will be completed on 1-30-26 by the Dietary Manager to ensure proper food storage per policy. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 100% facility staff education on the food storage policy will be completed by the Dietary Manager or designee by 1-30-26. Indicate how the facility plans to monitor its	02/06/2026

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F0812 SS = E	Continued from page 18 food in 2 of 2 freezers (the front freezer and the outside freezer), label and date opened packages of food in 1 of 1 dry goods storage room, and discard expired foods stored for use in 2 of 2 nourishment room refrigerators (100 and 400 hall nourishment rooms). This deficient practice had the potential to affect the food served to the residents. The findings included: An initial tour of the kitchen was conducted on 1/12/26 at 9:25 AM in the presence of the Dietary Manager. a). At 9:35 AM on 1/12/26 an opened plastic bag containing bread sticks and an opened plastic bag containing biscuits were observed in the kitchen front freezer without an opened date or expiration date. At 9:40 AM on 1/12/26 an opened plastic bag of garlic bread without an opened date or expiration date was observed in the large freestanding freezer located outside the kitchen. b). At 9:45 AM on 1/12/26 an opened package of hamburger buns and an opened loaf of bread that were not in the original packaging were observed in the dry goods storage room without an opened date or expiration date. An interview was completed with the Dietary Manager on 1/12/26 at 9:55 AM. The Dietary Manager stated that all opened foods stored in the freezer and the dry goods storage room should be labeled and include the date the item was opened and the expiration date. c). An observation of the 400-hall nourishment room was conducted on 1/12/26 at 10:05 AM in the presence of the Dietary Manager. There was an opened container of a nectar consistency nutritional supplement with no opened date or expiration date. The label on the nutritional supplement indicated that the manufacturer recommended that the product be consumed within 4 days after it was opened. A disposable food container with a resident name, no date received and no expiration date was observed in the 400-hall nutrition room. An observation of the 100-hall nourishment room was conducted on 1/12/26 at 10:10 AM in the presence of the Dietary Manager. There was a disposable food container with a resident name on it dated 1/1/26. An interview was completed with the Dietary Manager on 1/12/26 at 11:05 AM. The Dietary Manager stated there was not supposed to be any expired food in the	F0812	Continued from page 18 performance to make sure that solutions are sustained. A weekly audit will be completed weekly Monday through Friday for 12 weeks by the Dietary Manager or designee to ensure proper food storage per policy. Results of the audits will be reviewed by the QAPI Committee for 3 months.	

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F0812 SS = E	Continued from page 19 nutrition rooms. She indicated that the staff were not paying close attention to the dates. The Dietary Manager stated that food brought in by outside sources was to be labeled, dated and discarded after three days. The Dietary Manager indicated that the nursing staff were responsible for labeling food brought in from outside with the resident name and date it was brought in. The dietary staff were responsible for monitoring the expiration dates and discarding expired food and supplements. An interview was completed with the Administrator on 1/13/26 at 8:40 AM. The Administrator stated that he expected the kitchen staff to check for expired food in the kitchen and nutrition rooms and to discard them. He further stated he expected the staff to label and date food stored in the kitchen and nutrition rooms.	F0812		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F0842	F-Tag 842 Resident Medical Records - Identifiable Information 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Provider was notified on 01/15/2026 of Resident #72 Midodrine 2.5mg for accuracy and documentation. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing (DON)/Designee audited Residents on Blood pressure medication ordered to follow Parameters to ensure no other guests were affected by 02/02/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. DON/Designee will re-educate all Clinical Nursing Staff on the Medication Administration policy and following physician orders related to blood pressure medications by 02/02/2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON/Designee will audit all residents receiving blood pressure medications weekly x 12 weeks to ensure accuracy of blood pressure medication administration and following physician orders with blood pressure medications. Findings from the audits will be reviewed	02/06/2026

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F0842 SS = D	Continued from page 20 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F0842	Continued from page 20 in Quality Assusurance Committee Meeting Monthly X 3 for further recommendations, as necessary.	

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F0842 SS = D	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate documentation on the Medication Administration Record (MAR) the administration of a medication for 1 of 6 residents reviewed for medications (Resident #72). Findings included: A review of Resident #72's physician orders revealed an order dated 11/6/25 to give midodrine 2.5 milligrams (mg) twice per day for hypotension (low blood pressure). The order indicated to hold the medication for a systolic blood pressure (SBP) reading over 120 millimeters per mercury (mm/Hg) or diastolic blood pressure over 80 mm/Hg. A review of Resident #72's medication administration record (MAR) for November 2025 revealed an entry which indicated to administer the medication midodrine 2.5 mg. Hold the medication if the SBP is over 120 mm/Hg or diastolic blood pressure is over 80 mm/Hg. The MAR revealed the following: 11/9/25 6:00 PM the blood pressure was recorded as 124/53 mm/Hg and the midodrine was signed off by Nurse #1 as administered. 11/15/25 9:00 AM the blood pressure was recorded as 129/54 mm/Hg and the midodrine was signed off by Nurse #5 as administered. A review of Resident #72's medication administration record (MAR) for December 2025 revealed an entry which indicated to administer the medication midodrine 2.5 mg. Hold the medication if SBP is over 120 mm/Hg or a diastolic blood pressure is over 80 mm /Hg. The MAR revealed the following: 12/11/25 at 6:00 PM the blood pressure was recorded as 132/60 and the midodrine was signed off by Nurse #1 as administered. 12/19/25 at 6:00 PM the blood pressure was recorded as 122/61 and the midodrine was signed off by Nurse #1 as administered.	F0842		

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F0842 SS = D	Continued from page 22 12/20/25 at 6:00 PM the blood pressure was recorded as 124/62 and the midodrine was signed off by Medication Aide #1 as administered. 12/26/25 at 6:00 PM the blood pressure was recorded as 134/68 and the midodrine was signed off by Nurse #1 as administered. A review of Resident #72's MAR for January 2026 revealed an entry which indicated to administer the medication midodrine 2.5 mg. Hold the medication if SBP is over 120 mm/Hg or a diastolic blood pressure is over 80 mm /Hg. The MAR revealed the following: 1/9/26 at 9:00 AM the blood pressure was recorded as 126/66 mm/Hg and midodrine was signed off by Medication Aide #1 as administered. 1/9/26 at 6:00 PM the blood pressure was recorded as 127/70 mm/Hg and midodrine was signed off by Medication Aide #1 as administered. An interview was conducted with Nurse #5 on 1/15/26 at 9:25 AM. Nurse #5 was assigned to Resident #72 on 11/15/25 from 7:00 AM to 3:00 PM shift. Nurse #5 stated that midodrine was prescribed to raise the blood pressure. Nurse #5 indicated that on the electronic MAR when there was a check mark and initials it indicated that the medication was administered. Nurse # 5 stated she documented incorrectly that she administered Resident #72's midodrine on 11/15/25 and that she did not administer the medication. An interview was conducted with Nurse #1 on 1/15/26 at 9:40 AM. Nurse #1 stated that midodrine was used to raise the blood pressure in a resident with hypotension or low blood pressure. Nurse #1 was assigned to Resident #72 on 11/9/25 at 6;00 PM, 11/26/25 at 9:00 AM, 11/27/25 at 9:00 AM and 6:00 PM, 11/28/25 at 9:00 AM, and 12/11/25 at 6:00 PM, and 12/19/25 at 6:00 PM. Nurse #1 stated that initials and a check mark on the electronic MAR indicated that the medication was administered. Nurse #1 stated that if Resident #72's blood pressure was outside the parameter, he held the medication and he documented in error that he administered it. Nurse #1stated he understood that it was important to document correctly. An interview was conducted with Medication Aide #1 on	F0842		

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F0842 SS = D	Continued from page 23 1/15/26 at 10:10 AM. Medication Aide #1 stated that midodrine was administered for low blood pressure. Medication Aide #1 stated that she was aware that Resident #72 had parameters to hold the medication midodrine. Medication Aide #1 stated that she documented in error that she administered the medication midodrine to Resident #72 on 1/9/26 at 9:00 AM and 6:00 PM. During an interview with the Director of Nursing (DON) on 1/15/26 at 3:15 PM she stated that she expected that medications be administered and documented accurately. The DON stated that when a medication was held, it was to be documented as held with the indication why. The DON indicated that Resident #72's medication midodrine was not documented accurately and that accurate documentation was important for evaluation of the resident's medical condition.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F0880	483.80 Infection control F-Tag 880 Tuberculosis Control Plan/ Enhanced Barrier Precautions 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #24 TB skin test was administered by using the two-step procedure and following facility policies and procedures on 1/16/2026 and 01/29/2026. Nurse aide #1 and Nurse Aide #2 were re-educated on EBP (Enhanced Barrier Precautions) policy and procedures on 01/14/2026 with return demonstration of proper PPE use. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing/Designee will audit all residents to ensure screened for TB on admission using the two-step procedure and following facility policies and procedures by 02/02/2026. Director of Nursing/Designee performed audit on all residents requiring EBP to ensure that staff were following proper precautions by 02/02/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	02/06/2026

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F0880 SS = D	Continued from page 24 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 and Nurse Practitioner interviews, the facility failed to 1.) implement the infection control policy and procedures for Enhanced Barrier Precautions (EBP) when providing direct care activities to a	F0880	Continued from page 24 Director of Nursing/Designee will Re-educate all Clinical Nursing staff on Tuberculosis Control Plan policy using the two-step procedure by 02/02/2026. Director of Nursing/Designee will Re-educate all Clinical Nursing staff on EBP(Enhanced Barrier Precautions) policy and procedures by 02/02/2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing/Designee will audit all new admissions to ensure Tuberculosis Control Plan on admission will be followed by facility policies and procedures X 12 weeks. Director of Nursing/Designee will audit 5 random residents on EBP per week while receiving care to ensure proper use of PPE by staff per week x 12 weeks to ensure proper PPE is being followed. Audits will be forwarded to Quality Assurance Committee monthly x 3 for further recommendations, as necessary.	

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F0880 SS = D	Continued from page 25 resident (Resident #4) with a tracheostomy (a surgical opening into the trachea that provides an airway for breathing.), a gastrostomy tube (a feeding tube placed through the abdominal wall into the stomach and used to provide essential nutrition) and a Stage IV pressure ulcer on the sacrum. This occurred with 2 of 10 staff members (Nurse Aide #1 and Nurse Aide #2) observed for infection control practices 2.) implement the infection control policy for Tuberculosis control by not completing Tuberculosis skin testing following admission for 1 of 5 residents reviewed for infection control practices (Resident #24). Findings included: 1.) The Infection Control Policy dated 2/28/25 revealed “Enhanced Barrier Precautions” referred to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. During an observation on 1/14/26 at 10:00 AM Resident #4 was observed lying in bed. An “Enhanced Barrier Precaution” sign was observed on the door of Resident #4’s room. A PPE (personal protective equipment) supply bag with supplies including gloves and gowns were hanging on the door of Resident #4’s room. Nurse Aide #1 and Nurse Aide #2 were observed completing incontinence care. Nurse Aide #1 and Nurse Aide #2 were wearing gloves but did not don a gown prior to providing direct care to Resident #4. During an interview on 1/14/26 at 10:00 AM Nurse Aide #1 stated she did not know that she had to wear PPE when providing care including incontinence care to Resident #4. She stated she gets confused on what PPE was to be used for residents on enhanced barrier precautions. Nurse Aide #1 stated she had received infection control training on enhanced barrier precautions. During an interview on 1/14/26 at 10:00 AM Nurse Aide #2 stated she did not know she had to wear PPE when providing care to Resident #4, and stated she was not clear on why residents needed enhanced barrier precautions. Nurse Aide #2 stated she had received infection control training on enhanced barrier precautions.	F0880		

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F0880 SS = D	Continued from page 26 During an interview on 1/15/26 at 2:00 PM the Infection Control Preventionist Nurse stated staff had received infection control training on enhanced barrier precautions. She stated staff were required to complete monthly infection control in-services through an online platform. She stated Nurse Aide #1 and Nurse Aide #2 should have worn gowns along with gloves when providing direct care to Resident #4. During an interview on 1/15/26 at 2:05 PM the Director of Nursing (DON) stated staff received infection control training and should be following the infection control guidelines and wearing PPE when providing direct care to residents on enhanced barrier precautions. 2.) The facility policy titled “Tuberculosis Control Plan” dated 2/28/25 revealed in part; to minimize employee and resident exposure to, and subsequent infection with tuberculosis the facility will enforce the recommendations of the Centers for Disease Control and Prevention (CDC) regarding prevention of transmission of tuberculosis among employees and residents. All first time residents will be screened for tuberculosis on admission. Screening will consist of a Tuberculin Skin Test (Mantoux) using 5 units of Purified Protein Derivative (PPD) injected intradermally. Skin testing will employ the two step procedure. (If the reaction from the first test is less than 10 millimeters (mm), a second test will be given approximately 1-3 weeks after the first test was read.) A positive second test is indicative of a boosted reaction and not a new infection. If the second test remains negative, the person is classified as uninfected. Resident #24 was admitted to the facility on 5/12/25. Review of Resident #24’s electronic medical record on 1/14/26 revealed Step 1 of the two-step tuberculosis skin test was administered to Resident #24 on 5/23/25. The test was negative, and measured 0.1 mm. Further review revealed Step 2 was not administered to Resident #24 within 1-3 weeks following the first skin test. Step 2 was administered on 9/11/25 to Resident #24. During an interview on 1/15/26 at 2:00 PM the Infection Control Preventionist Nurse stated the tuberculin skin test was administered to residents on admission and	F0880		

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F0880 SS = D	Continued from page 27 Step 2 was to be administered within 1 to 3 weeks after Step 1. She stated Resident #24's Medication Administration Record (MAR) dated June 2025 revealed Resident #24 refused the Step 2 skin test on 6/6/25. The Infection Control Nurse stated that although Resident #24 refused the skin test on 6/6/25 staff should have offered the test again, but it looked as though that was not done. She stated she did not know why Step 2 was not offered again until 9/11/25. During an interview on 1/15/26 at 3:30 PM Resident #24 who was cognitively intact stated she did not recall refusing the skin test or why she would have refused Step 2 of the tuberculin skin test. Resident #24 stated maybe she felt bad on 6/6/25 the day it was offered to her, but she could not recall. She stated she would have agreed to complete Step 2 of the skin test if it was offered to her. During an interview on 1/15/26 at 3:45 PM the Nurse Practitioner stated Resident #24 was at baseline and had no respiratory symptoms, unexplained fever, or weight loss. The Nurse Practitioner indicated the recommended guidelines regarding Two step Tuberculin skin testing should be followed. During an interview on 1/15/26 at 4:00 PM the Director of Nursing (DON) stated Step 1 of the tuberculin skin test was offered on admission then Step 2 was to be given within 1-3 weeks after Step 1. The DON stated if Resident #24 refused Step 2 on 6/6/25 she should have been offered again within the required timeframe and that did not occur.	F0880		