STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345102**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maggie Valley Nursing and Rehabilitation	**75 Fisher Loop , Maggie Valley, North Carolina, 28751**

(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 3/16/26 through 3/19/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F39C2-H1.	E0000		04/01/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/16/26 through 3/19/26. Event ID# 1F39C2-H1. The following intakes were investigated 2636543, 2661625, 2735044, and 2806180. 10 of the 10 complaint allegations did not result in deficiency.	F0000		04/01/2026
F0567 SS = F	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F0567	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversation and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 567 Effective immediately, the facility restored access to all resident trust funds Residents identified in the survey (Residents #74 and #12) were provided: Full access to their trust account balances Immediate cash disbursement for personal needs Any missed cash disbursements or purchases from prior months were reconciled and issued. The Business Office Manager (BOM) verified that resident account balances were accurate and current prior to disbursement. Residents and/or responsible parties were notified verbally that trust funds were accessible without delay and given said fun.	04/15/2026

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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F0567 SS = F	Continued from page 1 exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident, staff and Regional Business Office Manager interviews, the facility failed to provide residents with access to their personal trust accounts for more than two months for 2 of 2 residents reviewed for management of personal funds (Resident #74 and #12). This practice had the potential to affect 66 residents who maintained trust accounts at the facility. The findings included: a. Resident #74 was admitted to the facility on 5/31/23. A review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated 12/23/25 revealed he was cognitively intact. An interview on 3/19/26 at 8:44 AM with Resident #74 revealed he maintained a trust account at the facility and used his money every month to pay for toiletries and other personal items. He stated facility staff had previously gone to the store monthly to purchase his items and debited his account but reported that staff had not gone to the store for him for the past couple of months and he didn't know why. Resident #74 stated his family had provided his toiletries and other personal items during this period. b. Resident #12 was admitted to the facility on 3/18/24. A review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated 12/24/25 revealed she was moderately cognitively impaired. An interview on 3/19/26 at 9:13 AM with Resident #12 revealed she had routinely received $70 in cash from	F0567	Continued from page 1 All residents with trust accounts will be reviewed to ensure by the Business office manager on April 1, 2026. Accounts are active, accessible and available to use without interruption regardless of ownership and banking changes The Petty Cash Box will be replenished in a timely manner to always have funds accessible. The Business office manager is accountable for ensuring resident funds are always accessible. Staff training was completed for Business office staff, by the licensed nursing home administrator. This education was completed on April 1, 2026. Any Business office employee will receive education prior to the start of their shift by the nursing home administrator. New Business office staff will receive education by the administrator during the orientation process. The BOM/Regional BOM will conduct a weekly audit of: Resident trust account accessibility; timeliness of disbursements and availability of petty cash. This audit will be completed weekly x 12 weeks. Audit results will be reviewed during QAPI meeting to assess compliance and determine if further action or resolution is necessary. Date of completion: 4/15/2026	

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F0567 SS = F	Continued from page 2 her trust account at the beginning of every month but had not received any money for over 2 months until 3/17/26 when she received $138 in cash from staff. She reported that she used her money to buy phone minutes for herself and her son. She stated she was still owed $140 and indicated she would have run out of phone minutes the next day if she had not received the money on 3/17/26. On 3/19/26 at 9:26 AM, an interview with the Business Office Manager (BOM) revealed the facility had been purchased by a new company in December 2025 and was in the process of switching bank accounts. She reported the facility had not had a cash box available to give residents money since that time and that no cash was currently available. The BOM indicated Resident #12 had previously received $70 cash at the beginning of each month but had not received any 2026 payments due to the lack of a cash box. She confirmed no residents or responsible parties had received cash for the past two months and that the facility was unable to access resident funds. She revealed she received a call from the Accounts Receivable corporate office on 3/17/26 informing her that $138 in cash was available, and she delivered the money to Resident #12 that same day. The BOM explained that Resident #12 was the only resident to receive cash at the beginning of each month, and reported staff in the Activity Department had previously shopped for residents (including Resident #74), but this was on hold while the trust accounts were inaccessible. On 3/19/26 at 10:27 AM, a phone interview with the Regional Business Office Manager explained that the delay in residents accessing their funds was due to the time needed to transition the facility's financial accounts after the company change. She acknowledged that residents had no access to their funds since January 2026 and was aware that residents should have had access to their funds. She explained there was nothing that could be done until the bank accounts were changed over which should be completed within a week. An interview with the Administrator on 3/19/26 at 2:46 PM confirmed that residents had been unable to access their trust accounts since January 2026. She explained that the unavailability was related to the shift to new bank accounts by the new company. The Administrator noted that residents should have reasonable access to their trust accounts at the facility.	F0567		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F0644	F644	04/15/2026

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F0644 SS = D	Continued from page 3 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation after a new serious mental illness disorder was identified for residents previously determined to have a Level I PASRR status for 2 of 4 residents reviewed for PASRR (Residents #8 and #88). The findings included: 1. A PASRR Determination Notification letter dated 05/06/13 revealed Resident #8 had a Level I PASRR with no expiration date that indicated “no further PASRR screening is required unless a significant change occurs with the individual’s status which suggests a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions.” Resident #8 admitted to the facility on 04/26/25 with diagnoses that included major depressive disorder and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated 05/02/25 revealed Resident #8 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Her active diagnoses included anxiety disorder and she received antidepressant medication during the MDS assessment look-back period.	F0644	Continued from page 3 The facility discharge planner submitted Level II Pre-Admission screening and resident review (PASRR) referrals for Residents #8 and #88 immediately upon identification of the deficiency. Care planning will be updated in accordance with PASRR determinations. The facility discharge planner completed an audit of current residents with mental health diagnoses, psychotropic medication use, or significant changes in condition to verify PASRR compliance. No additional unmet PASRR referrals were identified, or appropriate referrals were submitted as indicated. This was completed on April 6, 2026. During the morning clinical meeting team, discharge planner will review new admission for any mental diagnosis and any new diagnosis added. The facility administrator provided education to discharge planner director and the discharge planner assistant on 04/06/2026 regarding ensure that residents mental health diagnosis require a level II PASRR screening. Any member of the discharge planning team not receiving education will be educated prior to the start of their shift by the facility administrator or designee. New discharge planning members will receive orientation during the orientation process from the facility administrator The director of discharge planning will conduct audits to ensure all residents with mental health diagnosis have Level II PASRR screens 5x/week x 2weeks, then 3x/week x 2weeks, then weekly x4 weeks, and then monthly x 1 The administrator is responsible for reporting the audit results and they will be reviewed during QAPI meeting to assess compliance and determine if further action or resolution is necessary. Date of completion: 4/15/2026	

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F0644 SS = D	Continued from page 4 A Nurse Practitioner (NP) progress note dated 11/19/25 revealed in part, Resident #8 was seen to evaluate nighttime hallucinations after nursing staff reported that Resident #8 was screaming and terrified throughout the night. The NP added Seroquel (antipsychotic) 50 milligrams (mg) every night at bedtime. A psychiatric progress note dated 02/27/26 revealed in part, Resident #8 was seen for a follow-up after her dose of Seroquel was increased to 100 mg on 02/19/26. The psychiatric provider noted that Resident #8 reported decreased hallucinations and mood disturbance since the medication change with the plan to continue the current dose of Seroquel 100 mg every night at bedtime. A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #8 had a Level I PASRR effective 05/16/13 with no expiration date. There were no PASRR reevaluation requests submitted on or after 11/19/25. During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations, however, she was not always notified when a resident was diagnosed with a new mental illness. The SW stated she did not submit a request for a Level II PASRR evaluation following the new diagnoses of nighttime hallucinations for Resident #8 and it was an oversight. During an interview on 03/19/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #8's was just overlooked. 2. Resident #88 admitted to the facility on 09/19/24. A PASRR Determination Notification letter dated 09/19/24 revealed Resident #88 had a Level I PASRR with no expiration date that indicated "no further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or if present, suggests a change in treatment needs for those conditions." A psychiatric progress note dated 02/06/25 revealed in part, on 01/30/25 Resident #88 was started on prazosin	F0644		

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F0644 SS = D	Continued from page 5 (medication used to treat high blood pressure and Post-Traumatic Stress Disorder (PTSD) related nightmares) one (1) milligram (mg) every night at bedtime and sertraline (antidepressant) 50 mg daily due to Resident #88's complaints of nightmares and PTSD symptoms. It was noted Resident #88 had diagnoses of PTSD and depression with the plan to continue the current doses of prazosin and sertraline. The annual Minimum Data Set (MDS) assessment dated 09/23/25 revealed Resident #88 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. His active diagnoses included depression (other than bipolar) and PTSD. He received antidepressant medication during the MDS assessment look-back period. A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #88 had a Level I PASRR effective 09/19/24 with no expiration date. There were no PASRR reevaluation requests submitted on or after 01/30/25. During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations, however, she was not always notified when a resident was diagnosed with a new mental illness. The SW stated she did not submit a request for a Level II PASRR evaluation following the new diagnoses of depression and PTSD for Resident #88 and it was an oversight. During an interview on 03/19/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #88's was just overlooked.	F0644		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F0645	F645 The facility submitted a Level II Pre-Admission screening and resident review (PASRR)referral for Resident #27 upon identification of noncompliance. Care planning will reflect PASRR recommendations once received All admissions from the prior 3 months were reviewed to ensure appropriate PASRR screening and referral at	04/15/2026

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F0645 SS = D	Continued from page 6 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely	F0645	Continued from page 6 admission. This was completed by the social services department on April 6, 2026. Any identified needs for Level II review were addressed During the morning clinical meeting team, discharge planner will review new admission for any mental diagnosis and any new diagnosis added. The facility administrator provided education to discharge planning director and the discharge planning assistant on 04/06/2026 regarding ensure that residents mental health diagnosis require a level II PASRR screening. Any member of the discharge planning team not receiving education will be educated prior to the start of their shift by the facility administrator or designee. New discharge planning members will receive orientation during the orientation process from the facility administrator The director of discharge planning will conduct audits to ensure all residents with mental health diagnosis have Level II PASRR screens 5x/week x 2weeks, then 3x/week x 2weeks, then weekly x4 weeks, and then monthly x 1 The administrator is responsible for reporting the audit results and they will be reviewed during QAPI meeting to assess compliance and determine if further action or resolution is necessary Date of compliance: 4/15/2026	

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F0645 SS = D	Continued from page 7 to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with a serious mental health disorder for 1 of 4 residents reviewed for PASRR (Resident #27). Findings included: A PASRR Determination Notification letter dated 12/05/25 revealed Resident #27 had a Level I PASRR with no expiration date. Resident #27 was admitted to the facility on 12/07/25 with diagnoses that included non-Alzheimer's dementia, anxiety disorder, major depressive disorder, and bipolar disorder. A physician's progress note dated 12/12/25 revealed Resident #27 had a diagnoses of dementia and anxiety with depression that was managed with escitalopram (antidepressant) 10 milligrams (mg) daily, buspirone (antianxiety) 15 mg three times daily, and divalproex sodium (anticonvulsant) 125 mg every morning and 250 mg nightly. The admission Minimum Data Set (MDS) assessment dated 12/13/25 revealed Resident #27 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #27's active psychiatric/mood disorder diagnoses included anxiety disorder, depression (other than bipolar) and bipolar disorder. She received antianxiety, antidepressant and anticonvulsant medications during the MDS assessment period.	F0645		

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F0645 SS = D	Continued from page 8 A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Regional Social Worker/Discharge Planning Consultant on 03/17/26 at 4:01 PM revealed Resident #27 had a Level I PASRR effective 12/05/25 with no expiration date. There were no PASRR requests submitted on or after 12/05/25. During interviews on 03/17/26 at 3:30 PM and 4:01 PM, the Regional Social Worker/Discharge Planning Consultant explained when a resident was admitted with mental health disorders, it should trigger the SW to submit a request for a Level II PASRR evaluation providing the mental health diagnoses were not included on the previous PASRR screening. The Regional Social Worker/Discharge Planning Consultant stated when she reviewed Resident #27's previous PASRR screening, she did not see where Resident #27's mental health diagnoses were included. She confirmed a request for a Level II PASRR evaluation was not submitted and should have been. During an interview on 03/17/26 at 4:10 PM, the Social Worker (SW) revealed she was responsible for submitting requests for Level II PASRR evaluations. She explained she didn't always know when provider notes were scanned into a resident's medical record so she could review but normally, when she realized a resident was admitted with a Level I PASRR and had mental health disorders, she submitted a request for a Level II PASRR evaluation. The SW verified Resident #27 had diagnoses of mental health disorders and a Level I PASRR upon admission. She stated she should have submitted a request for Level II PASRR evaluation but didn't and it was an oversight. During an interview on 03/10/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations per the regulatory guidelines. The Administrator explained the SW was in the process of reviewing and auditing residents' PASRR and felt Resident #27's was just overlooked.	F0645		
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	F0880	F880 The staff development coordinator (SDC) immediately re educated Nursing Assistants #1, #2, and #3 on proper transmission based precautions and PPE use specific to resident isolation status. Reinforcement occurred at the time of observation	04/15/2026

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F0880 SS = D	Continued from page 9 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or 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.	F0880	Continued from page 9 The SDC audited current residents on transmission based precautions to ensure PPE supplies, signage, and staff compliance were in place. No additional concerns were identified. Education to current staff on infection control was completed, emphasizing standard and transmission based precautions, including PPE selection, donning, and doffing. This was completed by the SDC on April 6. 2026 Any staff member including agency staff will receive education prior to the start of their shift by the SDC or designee. Any new staff member will receive education during the orientation process by the SDC. The SDC or designee will perform random PPE audits 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. Audit results will be reviewed during QAPI meeting to assess compliance and determine if further action or resolution is necessary. Date of completion : 4/15/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345102	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maggie Valley Nursing and Rehabilitation	75 Fisher Loop , Maggie Valley, North Carolina, 28751

(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
F0880 SS = D	Continued from page 10 §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 reviews, and staff interviews, the facility failed to implement their infection control policies and procedures when Nursing Assistants (NA) #1, NA #2, and NA #3 did not wear required personal protective equipment (PPE) before entering Resident #79's room who was on special droplet contact precautions. This deficient practice was observed for 3 of 6 staff observed for infection control practices (NA #1, NA #2, and NA #3). Findings included: The facility policy effective 10/24/24 titled "Covid-19" read in part that containment/management of a newly identified patient case required the implementation of special droplet contact precautions. Review of Resident #79's Covid-19 test results dated 3/14/26 revealed he had tested positive. Per facility policy he had been placed in special droplet contact precautions isolation and the signage was placed outside his door. The facility special droplet contact precautions signage dated 11/22 instructed staff to perform hand hygiene before entering room, and to wear gown, N95, eye protection (face shield or goggles), and gloves upon entry. An observation on 3/16/26 at 12:52 PM revealed NA #1	F0880		

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F0880 SS = D	Continued from page 11 and NA #2 entered Resident #79's room wearing surgical masks. The special droplet contact precautions signage was posted outside Resident #79's door. A plastic stackable storage drawer set which held gowns, gloves, N95 masks, and eye protection was observed in the hall outside his door. NA #1 and NA #2 did not perform hand hygiene, and no gown, gloves, eye protection, or N95 mask were observed. NA #1 and NA #2 were observed to physically assist Resident #79 to a sitting position on the side of the bed and set up his lunch tray. They washed their hands with soap and water before exiting the room wearing the surgical masks. An interview on 3/16/26 at 12:54 PM with NA #1 and NA #2 revealed they should have worn gowns, gloves, eye protection, and an N95 mask but they did not and could not explain why. An observation 3/17/26 at 8:55 AM revealed NA #3 inside Resident #79's room wearing a gown, gloves, eye protection, and a surgical mask. No N95 mask was observed. NA #3 was observed to physically reposition Resident #79 in his bed, removed her PPE, and washed her hands with soap and water before exiting the room. An interview on 3/18/26 at 9:29 AM with NA #3 revealed she had been in a hurry to get into Resident #79's room and did not put on an N95 mask. An interview on 3/19/26 at 1:37 PM with the Director of Nursing (DON) stated NA #1 and NA #2 told her they had not read the special droplet contact precaution signage at Resident #79's door and should have. She also stated that NA #3 received education about special droplet contact precautions on 3/16/26 but still had not followed protocol. The DON reported NA #3 stated she put on the wrong mask outside the room. An interview on 3/19/26 at 12:04 PM with the Administrator revealed the staff should have followed the posted special droplet contact precaution signage posted at the resident's door, and she could not explain why they did not.	F0880		