STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2026

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F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with four (4) Complaint Investigations (CI MS #3168614, CI MS #3171421, CI MS #3176192 and CI MS #3204980) at the facility from 9/28/26 through 10/01/26. CI MS #3168614 was investigated for discharge process and CI MS #3176192 for nursing services and treatment and there were no citations related to these complaints. CI MS #3204980 for quality of care and wound care and F656 and F686 were cited. CI MS #3171421 was investigated for accidents/falls and F656 and F689 were cited. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F836, F584, F658, F695, and F880. The facility had a census of 70 and was licensed for 90 beds.	F0000		
F0656 SS = G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F0656		

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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F0656 SS = G	Continued from page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement individualized comprehensive, person-centered care plans to address residents' identified needs for four (4) of 18 sampled residents reviewed for comprehensive care planning. The facility failed to: 1) ensure physician-ordered oxygen therapy was provided in accordance with the resident's care plan (Resident #64); 2) develop a comprehensive care plan addressing hospice services (Resident #5); 3) implement care plan interventions requiring wheelchair leg rests during transportation (Resident #75); and 4) failed to develop and implement a comprehensive, individualized care plan that addressed Resident #33's left elbow wound and subsequent pressure injury in accordance with the resident's assessed needs. The resident's left elbow wound was initially identified as a skin tear on 08/16/2026; however, a	F0656		

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F0656 SS = G	Continued from page 2 corresponding care plan was not initiated until 08/31/2026. The wound subsequently deteriorated and was identified as an unstageable pressure injury on 09/11/2026. The facility failed to ensure the resident's care plan adequately reflected the changing wound status and addressed the resident's assessed needs related to the pressure injury. These failures resulted in the resident's care plan not accurately addressing the resident's wound and changing care needs. Findings include: A review of the facility's policy titled "Care Plan Process," revised 12/2024, revealed "…results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care…The comprehensive care plan is an interdisciplinary communication tool…" Resident #64 A record review of Resident #64's "Care Plan Report" date initiated 6/22/25 revealed an individualized focus addressing oxygen therapy, with an intervention requiring continuous oxygen at two (2) liters per minute (L/min) via nasal cannula. On 09/28/2026 at 11:14 AM, during an observation, the State Agency (SA) observed Resident #64 receiving oxygen via nasal cannula with the oxygen concentrator flow rate set at three (3) L/min. On 09/30/2026 at 9:36 AM, during an interview, Licensed Practical Nurse (LPN) #2, Medication Cart Nurse, stated she entered Resident #64's room during her morning rounds and observed the oxygen concentrator running at three (3) L/min. During a subsequent observation with the SA, LPN #2 confirmed the oxygen concentrator remained set at three (3) L/min. LPN #2 reviewed the physician's order and confirmed the prescribed oxygen flow rate was two (2) L/min via nasal cannula. LPN #2 confirmed Resident #64 was receiving oxygen at three (3) L/min rather than the physician-ordered and care-planned rate of two (2) L/min. A record review of Resident #64's "Face Sheet" revealed the facility admitted the resident on 07/13/2026 with a diagnosis of Chronic Respiratory Failure with Hypoxia. A record review of Resident #64's "Order Summary Report" revealed an active physician's order for	F0656		

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F0656 SS = G	Continued from page 3 continuous oxygen at two (2) liters per minute (L/min) via nasal cannula. A record review of Resident #64's "Significant Change in Status Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/20/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section O documented the resident received oxygen therapy. Resident #5 A record review of Resident #5's "Order Summary Report" revealed an active physician's order dated 05/01/2026 to admit the resident to (Proper Name) hospice services. A record review of Resident #5's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/05/2026, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating the resident was moderately cognitively impaired. Section O documented the resident received hospice care. A record review of Resident #5's "Care Plan Report" revealed the comprehensive care plan did not contain individualized focuses, goals, or interventions addressing the resident's hospice services. On 09/30/2026 at 2:45 PM, during an interview, Licensed Practical Nurse (LPN) #4, Care Plan/MDS Coordinator, stated the comprehensive care plan served as a communication tool for all disciplines to identify and address residents' individualized care needs. On 10/01/2026 at 2:00 PM, during an interview and review of Resident #5's comprehensive care plan, Registered Nurse (RN) #1 confirmed the care plan did not address the resident's hospice services. RN #1 stated comprehensive care plans were reviewed quarterly, annually, when new orders were received, and following significant changes in residents' conditions. RN #1 further stated the resident's Significant Change MDS should have triggered development of a care plan addressing hospice services. A record review of Resident #5's "Face Sheet" revealed the facility admitted the resident on 04/16/2021 with diagnoses including Atherosclerotic Heart Disease of the Native Coronary Artery without Angina Pectoris.	F0656		

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F0656 SS = G	Continued from page 4 Resident #75 A record review of Resident #75's "Care Plan Report" initiated 6/26/26 revealed a focus addressing the risk of injury during wheelchair transport related to lower-extremity weakness. Interventions required bilateral leg rests to be in place and properly positioned whenever the resident was transported in a wheelchair and verification that the resident's feet were securely positioned on the leg rests before initiating wheelchair transport. On 09/28/2026 at 11:45 AM, during an interview, Certified Nursing Assistant (CNA) #1 stated she worked at the facility from 07/29/2026 through 08/19/2026. CNA #1 stated that on 08/19/2026, she positioned Resident #75 in her wheelchair but could not locate the wheelchair footrests in the resident's room. CNA #1 stated she began transporting the resident down the 300-hall toward the dining room without the footrests attached to the wheelchair. CNA #1 stated that during transport, she noticed the resident's oxygen tank was low and notified a nurse, who instructed her to follow her to the oxygen storage room. CNA #1 stated she continued transporting Resident #75 behind the nurse. CNA #1 stated that as they approached the area near the dining room, Resident #75 placed her foot on the floor and fell from the wheelchair. CNA #1 stated she knew to review residents' care plans to identify their care needs. CNA #1 stated she did not receive an in-service following the incident and was told she was not at fault. On 09/29/2026 at 10:00 AM, during an interview, the Director of Nursing (DON) acknowledged the facility failed to follow Resident #75's comprehensive care plan interventions related to wheelchair transport. The DON stated staff were expected to use comprehensive care plans to identify residents' care needs and provide care according to the identified interventions. On 09/29/2026 at 10:35 AM, during an interview, Licensed Practical Nurse (LPN) #4, MDS Nurse, stated Resident #75 had a comprehensive care plan addressing the risk of injury during wheelchair transport. LPN #4 stated she updated care plans quarterly or when changes in residents' conditions required revisions. LPN #4 stated CNAs were informed of residents' care needs through the comprehensive care plans. On 10/01/2026 at 8:51 AM, during an interview, the	F0656		

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F0656 SS = G	Continued from page 5 Administrator stated the facility made efforts to provide staff with information regarding residents' care needs. The Administrator stated following comprehensive care plans was important to ensure residents received appropriate care and expected staff to implement the identified interventions. A record review of Resident #75's “Face Sheet” revealed the facility admitted the resident on 04/02/2025 with diagnoses including Primary Generalized (Osteo)Arthritis. A record review of Resident #75's “Quarterly Minimum Data Set (MDS),” with an Assessment Reference Date (ARD) of 06/19/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #33 A record review of Resident #33's “Care Plan Report” revealed a care plan addressing a skin tear to the left elbow was initiated on 08/31/2026, fifteen (15) days after the wound was initially identified on 08/16/2026. The care plan was subsequently documented as resolved on 9/14/26. A separate care plan identifying an unstageable pressure ulcer to the left elbow was initiated on 09/23/2026, after the resident's transfer to the hospital on 09/15/2026. The care plan included interventions for administering treatments and medications as ordered and providing a pressure-reducing device to the bed, with an intervention initiation date of 09/14/2026. A record review of Resident #33's “Progress Notes” revealed the left elbow wound was initially identified as a skin tear on 08/16/2026. Treatment orders were initiated to cleanse the wound, apply Xeroform gauze, and cover with a dry border dressing three (3) times weekly and as needed. A record review of Resident #33's wound assessments dated 08/27/2026, 09/03/2026, and 09/10/2026 revealed the left elbow wound continued to be classified as a skin tear despite documented deterioration, including increased wound measurements and the presence of slough and eschar. A record review of Resident #33's wound care Nurse Practitioner's (NP's) assessment dated 09/11/2026 revealed the left elbow wound was identified as an unstageable pressure injury.	F0656		

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F0656 SS = G	Continued from page 6 On 10/01/2026 at 3:05 PM, during an interview and record review, Registered Nurse (RN) #4 stated the facility considered care plans to be working documents that were expected to be updated as residents' needs changed. RN #4 explained that new orders were printed each weekday morning for care plan updates; however, care plan revisions were delayed, and the care plans were not current. RN #4 reviewed Resident #33's care plans and confirmed the left elbow wound was initially identified as a skin tear on 08/16/2026, but the care plan was not initiated until 08/31/2026. RN #4 stated the skin tear care plan was resolved or revised on 09/14/2026 when the wound was reclassified as an unstageable pressure injury. Upon reviewing the resident's skin assessments and corresponding wound photographs dated 08/27/2026, 09/03/2026, and 09/10/2026, RN #4 stated the left elbow wound was a pressure ulcer and should have been identified and addressed in the resident's care plan as a pressure injury. On 10/01/2026 at 3:25 PM, during an interview, the Administrator stated she expected staff to develop and implement comprehensive care plans for residents and follow the identified interventions. A record review of Resident #33's “Face Sheet” revealed the resident was admitted to the facility on 07/30/2026 with diagnoses including quadriplegia and cervical spine fusion.	F0656		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686		

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F0686 SS = G	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide necessary treatment and services to prevent the avoidable deterioration of a facility-acquired pressure injury for one (1) of two (2) residents reviewed for pressure injuries. The facility failed to accurately identify and reassess a deteriorating left elbow wound as a pressure injury, ensure timely provider evaluation in response to documented wound deterioration, and implement the wound care Nurse Practitioner's (NP's) recommendation for daily dressing changes. The resident's left elbow wound, initially documented as a skin tear, deteriorated to an unstageable pressure injury with extensive slough and eschar. Following transfer to the hospital for left arm and abdominal swelling, the resident underwent surgical debridement of the left elbow wound, bone biopsy, and wound vacuum placement. Resident #33. Findings include: A record review of the facility's policy titled "Prevention and Treatment of Skin Issues," reviewed 05/2026, revealed "… It is the policy to identify and assess residents whose clinical conditions place them at increased risk for impaired skin integrity and pressure ulcers. The facility shall implement appropriate preventative interventions and provide evidence-based treatment modalities for wound care in accordance with current industry standards and best practice … Prevention of Pressure Ulcers … C. Monitoring of Skin Integrity Skin integrity shall be routinely monitored during daily care by nursing staff. Any changes in skin condition shall be promptly reported, documented, and addressed in accordance with facility protocols … F. Additional Preventative Measures The following interventions may be implemented based on identified risk factors and individual resident needs: Pressure-reducing, relieving, or redistributing mattresses for resident beds … All findings, changes, or concerns shall be documented in the resident's clinical record … Notify the Physician/NP (Nurse Practitioner), Family and Supervisor/Designee if the skin issue has not shown progress in 2-4 weeks and/or is deteriorating …Resident Choice To support the resident's right to make informed decisions regarding care and treatment-including the right to refuse treatment-the facility shall discuss with the resident and/or legal representative … These discussions and decisions shall be documented in the resident's clinical record"	F0686		

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F0686 SS = G	Continued from page 8 A record review of Resident #33's “Face Sheet” revealed the resident was admitted on 07/30/2026 with diagnoses including quadriplegia and cervical spine fusion. A record review of the resident's “Braden Scales,” dated 07/31/2026, 08/07/2026, 08/14/2026, 08/21/2026, and 09/14/2026, revealed the resident was identified as being at high risk for pressure ulcer development on each assessment. A record review of Resident #33's “Admission Minimum Data Set (MDS),” with an Assessment Reference Date (ARD) of 08/06/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. Section M revealed one (1) Stage 2 pressure ulcer. A record review of the resident's “Discharge MDS,” with an ARD of 09/15/2026, revealed one (1) Stage 3 pressure ulcer and one (1) unstageable pressure ulcer. A record review of Resident #33's “Progress Notes” revealed the left elbow wound was initially documented as a skin tear on 08/16/2026. Treatment orders were initiated to cleanse the wound, apply Xeroform gauze, and cover with a dry border dressing three (3) times weekly and as needed. A record review of Resident #33's “Progress Notes” revealed the following progression of the left elbow wound: On 08/27/2026, the wound was documented as a skin tear measuring 1.78 centimeters (cm) in length, 1.54 cm in width, and 0.10 cm in depth, with 10% slough and moderate serosanguineous drainage. On 09/03/2026, the wound remained classified as a skin tear and measured 2.15 cm in length, 2.21 cm in width, and 0.10 cm in depth, with 60% slough and moderate serosanguineous drainage. On 09/10/2026, the wound remained classified as a skin tear and measured 2.36 cm in length, 1.97 cm in width, and 0.1 cm in depth, with 20% slough, 40% eschar, and moderate serosanguineous drainage. The assessments documented an increase in wound dimensions and the development of additional nonviable tissue while the wound continued to be classified as a skin tear. A record review of Resident #33's “Assessment”	F0686		

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F0686 SS = G	Continued from page 9 completed by the wound care NP, with a date of service of 09/11/2026, revealed the left elbow wound was identified as an unstageable pressure ulcer measuring 3.5 cm in length, 2.8 cm in width, and 0.1 cm in depth, with 76–100% slough and moderate exudate. The wound care NP recommended daily dressing changes and as needed. A record review of Resident #33's "Order Summary Report" revealed that following the wound care NP's assessment on 09/11/2026, the facility's treatment orders continued to identify the left elbow wound as a skin tear and directed dressing changes three (3) times weekly, rather than daily as recommended by the wound care NP. The treatment order dated 09/14/2026 continued to specify dressing changes on Monday, Wednesday, and Friday. A record review of Resident #33's "Treatment Administration Record (TAR)" for September 2026 revealed treatments for the left elbow wound were not documented as completed on 09/01/2026, 09/08/2026, 09/10/2026, and 09/14/2026. A record review of Resident #33's "View Progress Note" dated 09/11/2026 revealed the resident's family expressed concerns regarding a possible infection of the left elbow wound. The nursing assessment documented swelling, odor, moderate serosanguineous drainage, and slough in the left elbow wound. The NP was notified, and the resident received orders for antibiotics. A record review of Resident #33's "Notice of Transfer/Discharge Notice" dated 09/15/2026 revealed the resident was transferred to the hospital for increased swelling of the abdomen and left upper extremity. A record review of Resident #33's hospital "Plastic Surgery Consultation" dated 09/15/2026 revealed "Reason for Consult: Left elbow wound…The wound is thought to be due to pressure injury sustained at the patient's nursing home…X-ray and MRI (Magnetic Resonance Imaging) showed subtle subcortical irregularity in the olecranon concerning for early osteomyelitis…He is on vanc, Zosyn, and doxycycline…left elbow with 3 cm by 4 cm open wound on the proximal forearm overlying the ulna/distal olecranon with exposed tendon…" A record review of Resident #33's hospital "Orthopedic Consult Note" dated 09/16/2026 revealed the left elbow wound appeared to be full thickness with exposed bone.	F0686		

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F0686 SS = G	Continued from page 10 A record review of Resident #33's hospital "Operation Note" dated 09/28/2026 revealed the preoperative diagnosis was an open wound of the left elbow with suspected Stage IV pressure injury. The resident underwent sharp and blunt excisional debridement of skin and subcutaneous tissue measuring 3.5 cm by 4.5 cm, bone biopsy of the left olecranon, and wound vacuum placement. On 09/29/2026 at 9:35 AM, during a telephone interview, Resident #33's family member stated she observed wounds to the resident's buttocks and left elbow during a visit before his transfer to the hospital. She stated the resident's left arm was swollen and that he reported experiencing swelling and receiving pain medication. The family member expressed concerns regarding the residents' limited mobility and repositioning needs. On 09/29/2026 at 2:55 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated Resident #33 continued to complain of left arm pain despite receiving pain medication from the night-shift nurse on the day of his hospital transfer. LPN #3 stated she notified the NP of the resident's condition, and the resident was transferred to the hospital for evaluation. On 09/30/2026 at 4:00 PM, during an interview, the Director of Nursing (DON) stated Resident #33 refused repositioning at times; however, the facility did not obtain a refusal-of-treatment form. The DON confirmed the resident had one (1) wound upon admission and subsequently developed additional wounds, including the left elbow wound. The DON stated that, due to the resident's quadriplegia and limited mobility, he would have benefited from a low air loss mattress. On 09/30/2026 at 4:30 PM, during an interview, the Physician stated he had been informed that Resident #33 refused repositioning and that it would be difficult to determine whether the wounds were unavoidable. The Physician stated he expected staff to implement preventive interventions to reduce the risk of skin breakdown and prevent deterioration of existing wounds. On 10/01/2026 at 2:20 PM, during an interview, the Assistant Director of Nursing (ADON) stated she completed her first assessment of Resident #33's left elbow wound on 08/27/2026. The ADON stated she believed she had reclassified the wound as a pressure injury; however, upon reviewing the assessments dated 08/27/2026, 09/03/2026, and 09/10/2026, she confirmed the wound remained	F0686		

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F0686 SS = G	Continued from page 11 documented as a skin tear despite deterioration and the presence of slough and eschar. The ADON acknowledged the wound had increased in size and deteriorated. She confirmed the wound care NP completed the first specialist assessment of the left elbow wound on 09/11/2026. The ADON further confirmed the wound care NP recommended daily dressing changes; however, the facility did not update the treatment orders, which remained three (3) times weekly. On 10/01/2026 at 3:05 PM, during an interview and record review, Registered Nurse (RN) #4 reviewed Resident #33's skin assessments and wound photographs dated 08/27/2026, 09/03/2026, and 09/10/2026. Following the review, RN #4 stated the left elbow wound was a pressure ulcer and should have been identified and addressed in the resident's care plan as a pressure ulcer. On 10/01/2026 at 3:00 PM, during an interview, the DON stated she had not personally assessed Resident #33's wounds but was aware the left elbow wound had deteriorated. The DON stated she was unable to locate documentation that the left elbow wound had been evaluated by a NP or physician before the wound care NP's assessment on 09/11/2026. The DON further stated she was unaware that the wound care NP's recommendation for daily dressing changes had not been reflected in the facility's treatment orders. The DON stated she expected staff to accurately assess and document wounds, report changes in skin condition, and notify the NP or physician of identified skin concerns. On 10/01/2026 at 3:30 PM, during an interview, the Administrator stated she expected staff to follow the facility's policies and procedures regarding wound care and pressure ulcer prevention.	F0686		
F0836 SS = E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with	F0836		

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F0836 SS = E	Continued from page 12 accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to comply with state nursing facility staffing requirements by failing to designate a licensed nurse to serve as the Charge Nurse responsible for supervision of the total nursing activities in the facility, separate from the medication/treatment nurse assignment, from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM, for two (2) of three (3) shifts reviewed for charge nurse supervision. Findings include: A record review of the facility's policy titled "Nursing Services-Staffing" dated 02/2026 revealed "…The facility will comply with established staffing requirements by the individual state governing agencies. Each facility will designate a nurse who holds an active license…as a Charge Nurse…" A record review of the facility's daily staffing records for 09/29/2026 and 09/30/2026 revealed the facility did not designate a Charge Nurse separate from the medication/treatment nurse from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM. On 09/30/2026 at 1:45 PM, during an interview, the Assistant Director of Nursing (ADON) stated she works Monday through Friday from 8:00 AM until 4:30 PM. The ADON stated she serves as the	F0836		

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F0836 SS = E	Continued from page 13 Charge Nurse when she is on duty. The ADON noted that when she is not on duty a cart nurse is assigned to work as the charge nurse as well as maintain the medication cart. On 10/01/2026 at 8:07 AM, during an interview, Certified Nursing Assistant (CNA) #2 stated she works 7:00 AM until 7:00 PM. The CNA reported that the cart nurse is the charge nurse. The CNA stated that in the event she needed supervisory assistance she would go to the cart nurse for help. On 10/01/2026 at 8:36 AM, during an interview, the Director of Nursing (DON) stated that the presence of a designated Charge Nurse would lend better care to the residents. The DON affirmed that the facility is actively looking to hire someone to fill the role of Charge Nurse for the uncovered hours. On 10/01/2026 at 1:17 PM, during an interview, the Administrator stated she was informed the facility was not in compliance with state staffing requirements because a Charge Nurse separate from the medication/treatment nurse was not designated from 7:00 AM to 8:00 AM and 4:30 PM to 11:00 PM. The Administrator stated the importance of having a designated Charge Nurse was to provide an additional supervisory resource.	F0836		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584		

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F0584 SS = D	Continued from page 14 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents' rights to a safe, clean, comfortable, and homelike environment were maintained by failing to: 1) ensure a resident's over-the-bed light was accessible for independent use despite requests for repair; and 2) ensure blood-soiled bed linens were changed timely after staff became aware of the soiled linens, for two (2) of 18 sampled residents. Residents #67 and #77. Findings include: A record review of the facility's policy titled "Resident Rights Policy" review date 05/2026 revealed "Every resident in this facility has the right to: … 8. Receive a prompt response to all requests and inquires …" A record review of the facility's policy titled "Infection Control," revision date 04/2026 revealed "…The facility shall maintain a comprehensive Infection Prevention and Control Program designed to provide a safe, sanitary and comfortable environment in which residents reside with minimal risk for the development and transmission of infections and communicable diseases…"	F0584		

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F0584 SS = D	Continued from page 15 Resident #67 A record review of Resident #67's "Face Sheet" revealed the facility admitted the resident initially on 07/21/2016 and re-entry on 01/16/2021 with diagnoses including Essential (Primary) Hypertension and Acute Kidney Failure, Unspecified. A record review of Resident #67's "Comprehensive Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/08/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated cognitively intact. Section GG0170 revealed that Resident required partial/moderate assistance with sit to stand and chair/bed-to-chair transfers. On 09/28/2026 at 12:12 PM, during an observation and interview, Resident #67 was observed sitting on the side of his bed eating lunch. Resident #67 stated he had repeatedly reported to staff that his over-the-bed light needed a pull cord and a replacement light. The resident stated the pull cord had been missing for approximately nine (9) months, preventing him from independently turning the light on and off. The State Agency (SA) observed the resident's over-the-bed light did not have a pull cord, while his roommate's light had a pull cord. On 09/28/2026 at 2:54 PM, during an interview, Certified Nurse Aide (CNA) #5 confirmed Resident #67's over-the-bed light did not have a pull cord. On 09/29/2026 at 1:40 PM, during an interview and observation, Resident #67 was sleeping in bed with head covered. The SA observed the over-the-bed light did not have a pull cord. Resident reported that he has told Maintenance and the other staff he needs a string to turn on his light. He explained he is unable to reach the light switch to turn it on or off and has to ask staff to turn on light each time he eats. On 09/29/2026 at 2:10 PM, during an interview, CNA #3 stated that Resident #67 asked to have the light above his bed turned on when he ate yesterday and today. She confirmed there was no cord for him to pull to turn the light on. Today is only her second day working with Resident #67, but he can stand and transfer to his wheelchair and takes himself to the bathroom but is not able to stand for long periods of time. Resident asks for assistance when needed. On 09/29/2026 at 2:45 PM, during an interview, the Maintenance Director stated he had been aware that	F0584		

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F0584 SS = D	Continued from page 16 Resident #67's over-the-bed light had been missing the pull cord for approximately two (2) months. The Maintenance Director stated the light could only be operated using the switch located on the light fixture. He stated he contacted the supply store on 09/24/2026 regarding a replacement pull cord and was informed the item was on order; however, he could not provide documentation verifying the order. The Maintenance Director stated maintenance concerns were reported verbally by staff, and the facility did not maintain a log of maintenance requests or repairs. He stated he reported to work at 6:00 AM five (5) days per week to communicate with night- and day-shift staff regarding maintenance concerns. On 09/29/2026 at 3:25 PM, during an interview, CNA #4 stated that Resident #67 mostly sleeps all the time. She reported that he doesn't like the lights on unless he is eating his meals. She confirmed that there has not been a cord or string attached to his over the bed light since she has been working at the facility for two (2) months. Resident #77 A record review of Resident #77's “Face Sheet” revealed the facility admitted the resident initially on 03/19/2026 and re-entry on 07/02/2026 with diagnoses including Chronic Kidney Disease, Stage 3a, Obstructive and Reflux Uropathy, Unspecified, and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection as The Cause of Diseases Classified Elsewhere added 9/10/2026. A record review of Resident #77's “Discharge Minimum Data Set (MDS)” with an Assessment Reference Date (ARD) of 08/30/2026 revealed Section C1000 revealed resident is independent for cognitive skills for daily decision making. On 09/29/2026 at 2:00 PM, during an interview, Licensed Practical Nurse (LPN)#5 stated that Resident #77's PICC (peripherally inserted central catheter) line is being assessed via the PICC line nurse currently due to the site had been bleeding. On 09/29/2026 at 3:23 PM, during an observation of catheter care provided to Resident #77 by Certified Nurse Aide (CNA) #3, with assistance from CNA #6, the State Agency (SA) observed bright red blood on the fitted sheet on the right side of the resident's bed and on the outer tape of the resident's peripherally inserted central catheter (PICC) line dressing.	F0584		

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F0584 SS = D	Continued from page 17 On 09/29/2026 at 3:55 PM, during an interview and observation with LPN #2, she explained resident #77 had been in and out of the hospital since being admitted. She reported that resident was currently on contact isolation related to MRSA in urine. Blood remained on the fitted sheets. LPN reported the PICC line was assessed today and the line was out two (2) centimeters, and a new dressing was put in place today. She confirmed the blood on the sheet and on the PICC line outer tape. On 09/30/2026 at 7:40 AM, during an observation and interview, Resident #77 was observed lying in bed with dried blood remaining on the fitted sheet. The resident's PICC line dressing had a scant amount of dried blood at the insertion site and dried blood on the outer tape. Registered Nurse (RN) #2 stated the PICC line had been bleeding since Monday and had been assessed the previous day. Resident #77 confirmed the blood had remained on the fitted sheet and outer tape since the previous day. The resident stated he did not like lying in blood, especially after experiencing multiple infections. RN #2 removed the blood-soiled outer tape. On 09/30/2026 at 8:45 AM, during an observation with RN #2, the SA observed RN #2 remove the intravenous antibiotic tubing and flush the PICC line. Blood remained on the resident's fitted sheet. On 09/30/2026 at 11:05 AM, during an observation and interview, Resident #77 stated staff had not changed his bed linens. He reported that his PICC line finally had not been bleeding any more. He explained he knows that the staff is busy and may not have had a chance to change his bed. On 09/30/2026 at 1:30 PM, during an observation and interview of Resident #77, he reported that he is not feeling good and will be going out to the hospital. Blood continued to be on the sheet, resident reported that he guesses the sheet will get changed when he goes to the hospital. On 10/01/2026 at 2:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated Resident #77 remained on Contact Precautions following his return from the hospital. LPN #5 stated staff were expected to change bed linens when they became soiled or blood was observed. LPN #5 stated she changed Resident #77's bed linens while the resident was at the hospital. On 10/01/2026 at 3:00 PM, during an interview with the Director of Nursing (DON), she confirmed any	F0584		

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F0584 SS = D	Continued from page 18 resident with soiled linen or bloody linen should have the linens changed. All residents should feel they are in a safe, sanitary, and comfortable home-like environment and have all residents' rights to be honored. The DON confirmed Resident #77 was on Contact Precautions related to MRSA in the urine. On 10/01/2026 at 3:30 PM. during an interview with the Administrator, she reported that she expects all staff to follow Contact Precaution guidelines, honor residents' rights including a safe, sanitary, and comfortable homelike environment ensuring resident rooms have proper working equipment. She reported resident #67 could have been moved to another room until his light was properly working.	F0584		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide services in accordance with professional standards of practice by failing to obtain physician-ordered laboratory testing within the prescribed timeframe when a resident's hemoglobin A1C laboratory test was not obtained in September 2026 as ordered, for one (1) of five (5) residents reviewed for unnecessary medications. Resident #12. Findings include: A record review of the facility's policy titled "Physician Orders," revised 09/2025, revealed, "It is the policy of this facility that all physician orders shall be…carried out in a professional manner…" A record review of Resident #12's "Face Sheet" revealed the facility admitted the resident on 12/09/2022 with diagnoses including Type 2 Diabetes Mellitus with Unspecified Complications. A record review of Resident #12's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/05/2026, revealed a Brief Interview for Mental Status (BIMS) score of 9,	F0658		

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F0658 SS = D	Continued from page 19 indicating the resident was moderately cognitively impaired. A record review of Resident #12's “Order Details,” dated 05/16/2024, revealed an order to “Obtain A1C Every 4 Months (Jan, May, Sept).” A record review of Resident #12's medical record revealed no documentation that the physician-ordered hemoglobin A1C laboratory test was obtained in September 2026. On 10/01/2026 at 11:07 AM, during an interview, the Director of Nursing (DON) stated Resident #12 did not receive the hemoglobin A1C laboratory test in September 2026 because the resident's insulin therapy had been discontinued. The DON stated the physician's order should have been changed to require laboratory testing every six (6) months. The DON confirmed the facility was required to follow physician orders and that Resident #12 should have received the laboratory testing as ordered. On 10/01/2026 at 1:26 PM, during an interview, the Administrator stated she was aware the facility had not obtained Resident #12's laboratory testing within the physician-ordered timeframe. The Administrator stated that following physician orders was important to ensure residents received the care prescribed by their physicians. The Administrator stated she expected staff to follow physician orders as written.	F0658		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure an assistive device necessary to prevent an avoidable accident was utilized when a Certified Nursing Assistant (CNA) transported a resident in a wheelchair without the required bilateral footrests,	F0689		

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F0689 SS = D	Continued from page 20 resulting in the resident's foot contacting the floor and the resident falling from the wheelchair, for one (1) of four (4) residents reviewed for accidents. Resident #75. Findings include: A record review of the facility's policy titled "Fall Risk Screening," revised 03/2026, revealed "…2. Interventions to improve strength, balance and mobility…should be implemented to reduce fall risk…" A record review of Resident #75's "Face Sheet" revealed the facility admitted the resident on 04/02/2025 with diagnoses including Primary Generalized (Osteo)Arthritis. A record review of Resident #75's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 06/19/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A record review of Resident #75's "Care Plan Report" initiated 6/26/26 revealed a focus for risk of injury during wheelchair transport related to lower-extremity weakness, with interventions requiring bilateral leg rests to be in place and properly positioned whenever the resident was transported in a wheelchair and verification that the resident's feet were securely positioned on the leg rests before initiating wheelchair transport. A record review of the "Witnessed Fall" report, dated 08/19/2026, revealed Resident #75 stated, "I dropped my feet." A record review of Resident #75's "Portable Medical Diagnostics" bilateral knee X-ray reports revealed incomplete examinations with oblique lucencies identified in the distal femurs. The radiologist indicated that "distal femur fractures can be evaluated with diagnostic imaging." A record review of Resident #75's "Order Summary," dated 08/19/2026, revealed an order to "transfer to er (emergency room) for further evaluation." A record review of Resident #75's "Discharge MDS," with an ARD of 08/19/2026, revealed the resident was discharged to a short-term general hospital. A record review of the facility's investigation revealed Resident #75 was assessed following the incident and witnesses were interviewed.	F0689		

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F0689 SS = D	Continued from page 21 On 09/28/2026 at 11:45 AM, during an interview, Certified Nursing Assistant (CNA) #1 stated she worked at the facility from 07/29/2026 through 08/19/2026. CNA #1 stated that on 08/19/2026, she positioned Resident #75 in her wheelchair but could not locate the wheelchair footrests in the resident's room. CNA #1 stated she began transporting the resident down the 300-hall toward the dining room without the footrests attached to the wheelchair. CNA #1 stated that during transport, she noticed the resident's oxygen tank was low and notified a nurse, who instructed her to follow her to the oxygen storage room. CNA #1 stated she continued transporting Resident #75 behind the nurse. CNA #1 stated that as they approached the area near the dining room, Resident #75 placed her foot on the floor and fell from the wheelchair. CNA #1 stated she knew to review residents' care plans to identify their care needs. CNA #1 stated she did not receive an in-service following the incident and was told she was not at fault. On 09/28/2026 at 1:42 PM, during an interview, the Certified Occupational Therapist Assistant (COTA) stated Resident #75 was receiving physical therapy before the fall on 08/19/2026. The COTA stated the resident had chronic extension of the lower extremities and experienced pain with minimal bending. The COTA stated Resident #75 lacked sufficient lower-extremity strength to maintain her legs in an elevated position independently and required wheelchair footrests. The COTA confirmed the resident's wheelchair was equipped with footrests. On 09/28/2026 at 2:03 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated that on 08/19/2026, CNA #1 was transporting Resident #75 in her wheelchair along the 300-hall. LPN #3 stated another staff member, whom she could not recall, asked her to obtain oxygen for the resident. LPN #3 stated that as CNA #1 and Resident #75 approached the area between the nursing station and dining room, the resident fell from the wheelchair. LPN #3 stated she could not recall whether the resident's wheelchair had footrests attached. On 09/29/2026 at 10:00 AM, during an interview, the Director of Nursing (DON) stated she was not employed at the facility at the time of the incident. The DON stated Resident #75 was transferred to the hospital following the incident and had not returned to the facility. The DON stated the resident had wheelchair footrests but was known to resist placing her feet on them.	F0689		

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F0689 SS = D	Continued from page 22 On 10/01/2026 at 8:51 AM, during an interview, the Administrator acknowledged the facility had not taken every reasonable measure to prevent the accident involving Resident #75. The Administrator stated the facility made efforts to provide staff with information regarding residents' care needs and emphasized the importance of providing quality care.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure oxygen therapy was provided in accordance with the physician's order when a resident receiving continuous oxygen was observed receiving oxygen at three (3) liters per minute (L/min) instead of the physician-ordered flow rate of two (2) L/min on two (2) separate survey days, for one (1) of one (1) resident reviewed for respiratory care. Resident #64. Findings include: A record review of the facility's policy titled “Oxygen-Administration, Concentrator, Storage, Assemblage,” revised 01/2024, revealed "Purpose: to provide adequate tissue oxygenation by providing supplemental oxygen…Procedure: 1. Obtain appropriate physician’s order…9. Turn the unit on to the desired flow rate…12. Check oxygen flowmeter for the correct liter flow…” A record review of Resident #64's “Face Sheet” revealed the facility admitted the resident on 07/13/2026 with diagnoses including Chronic Respiratory Failure with Hypoxia. A record review of Resident #64's “Order Summary Report” revealed an active physician's order for continuous oxygen at two (2) L/min via nasal cannula.	F0695		

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F0695 SS = D	Continued from page 23 A record review of Resident #64's "Significant Change in Status Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/20/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section O documented the resident received oxygen therapy. On 09/28/2026 at 11:14 AM, during an observation, the State Agency (SA) observed Resident #64 receiving oxygen via nasal cannula with the oxygen concentrator flow rate set at three (3) L/min. On 09/30/2026 at 9:02 AM, during an observation and interview, the SA observed Resident #64 receiving oxygen via nasal cannula with the oxygen concentrator flow rate set at three (3) L/min. Resident #64 stated a nurse entered the room approximately 30 minutes earlier after the lights flickered and checked the resident's oxygen concentrator. On 09/30/2026 at 9:36 AM, during an interview, Licensed Practical Nurse (LPN) #2, Medication Cart Nurse, stated she entered Resident #64's room during her morning rounds and checked on the resident. LPN #2 stated the resident's oxygen concentrator was running at three (3) L/min when she checked it earlier that morning. During a subsequent observation with the SA, LPN #2 observed the oxygen concentrator remained set at three (3) L/min. LPN #2 reviewed the physician's order and confirmed the prescribed oxygen flow rate was two (2) L/min via nasal cannula. LPN #2 confirmed Resident #64 was receiving oxygen at three (3) L/min rather than the physician-ordered rate of two (2) L/min. On 10/01/2026 at 3:32 PM, during an interview, the Administrator stated her expectation was for staff to follow physician orders and ensure residents' oxygen concentrators were set at the prescribed flow rates.	F0695		
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.	F0880		

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F0880 SS = D	Continued from page 24 §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. §483.80(a)(4) A system for recording incidents	F0880		

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F0880 SS = D	Continued from page 25 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, interviews, record review, and facility policy review, the facility failed to implement established Contact Precaution procedures to reduce the risk of transmission of infectious organisms when designated containers for the disposal of used personal protective equipment (PPE) and potentially contaminated linens were not available in a resident's room, and staff discarded used PPE in regular trash rather than the designated disposal containers required by the facility's procedures, for two (2) of four (4) days of survey. Resident #77. Findings include: A record review of the facility's policy titled "Infection Control," revised 04/2026, revealed "…The facility shall maintain a comprehensive Infection Prevention and Control Program designed to provide a safe, sanitary and comfortable environment in which residents reside with minimal risk for the development and transmission of infections and communicable diseases…" A record review of the facility's policy titled "Isolation Precautions and Duration for Specific Infections," reviewed 06/2026, revealed "The facility shall implement and maintain infection prevention and control practices consistent with current guidance issued by the Centers for Disease Control and Prevention (CDC), applicable state health department regulations and federal requirements …" A record review of the "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)," updated September 2024, revealed "…Contact Precautions are intended to prevent transmission of infectious agents…which are spread by direct or indirect	F0880		

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F0880 SS = D	Continued from page 26 contact with the patient or the patient's environment... Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission … Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination …" A record review of the facility's "In-service Training," dated 03/05/2026, revealed education addressing Enhanced Barrier Precautions and Contact or Droplet Precautions. The training instructed staff to remove PPE and place it in biohazard bags before exiting the room. The attendance record contained 26 staff signatures. A record review of Resident #77's "Face Sheet" revealed the facility initially admitted the resident on 03/19/2026, with re-entry on 07/02/2026, and diagnoses including Chronic Kidney Disease, Stage 3a; Obstructive and Reflux Uropathy, Unspecified; and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection as The Cause of Diseases Classified Elsewhere, added 09/10/2026. A record review of Resident #77's "Order Summary Report" revealed an active order dated 09/28/2026 for "Contact Precautions R/T (related to) MRSA Every Shift," with an end date of 10/13/2026. On 09/28/2026 at 10:57 AM, during an observation and interview, the State Agency (SA) observed Contact Isolation signage posted on Resident #77's door and Registered Nurse (RN) #1 applying personal protective equipment (PPE) before entering the resident's room. RN #1 stated Resident #77 was on Contact Precautions related to wounds, including a sacral wound. RN #1 stated staff were expected to wear PPE when entering the room and providing care. RN #1 stated the resident had a Peripherally Inserted Central Catheter (PICC) line for intravenous antibiotics, and she was assessing the PICC line. On 09/28/2026 at 11:05 AM, during an observation and interview, the SA observed Resident #77 had an indwelling urinary catheter and a PICC line dressing with a moderate amount of blood beneath the dressing. No designated biohazard waste containers	F0880		

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F0880 SS = D	Continued from page 27 or contaminated linen receptacles were observed in the resident's room or bathroom. Discarded PPE was observed in a regular trash container in the bathroom. Resident #77 stated he had experienced repeated hospitalizations related to urinary tract infections and other infections. On 09/29/2026 at 9:05 AM, during an observation, the SA observed Contact Isolation signage remained posted on Resident #77's door, with PPE available at the entrance, hanging on the door. No designated biohazard waste containers were observed in the resident's room or bathroom. On 09/29/2026 at 10:25 AM, during an interview, Certified Nurse Aide (CNA) #3 stated she had worked at the facility for two (2) days and was completing required in-service education, including infection control. CNA #3 confirmed designated biohazard disposal containers were not available in Resident #77's room on 09/28/2026. CNA #3 stated she provided care to the resident and discarded used PPE in regular trash containers. CNA #3 stated she placed used linens in clear bags with other linens. CNA #3 stated she had not been instructed to place designated disposal containers in the resident's room. On 09/29/2026 at 2:20 PM, during an interview, CNA #4 stated Resident #77 was on Contact Precautions related to Methicillin Resistant Staphylococcus Aureus (MRSA) in his urine. CNA #4 stated designated cardboard biohazard containers were expected to remain in the resident's room. CNA #4 confirmed the containers were not present until after lunch on 09/29/2026. On 09/29/2026 at 3:00 PM, during an observation, the SA observed two (2) cardboard biohazard containers with red biohazard bags had been placed in Resident #77's room. On 09/29/2026 at 3:10 PM, during an interview, CNA #5 stated she assisted with Resident #77's care on 09/28/2026 and did not observe designated biohazard containers in the resident's room or bathroom. CNA #5 stated used PPE was discarded in regular trash containers and used linens were placed in clear bags with other linens in the collection bins. On 09/29/2026 at 3:55 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed Resident #77 was on Contact Precautions related to MRSA in his urine. LPN #2 stated staff were expected to wear PPE when entering the resident's room and discard used PPE in designated biohazard	F0880		

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F0880 SS = D	Continued from page 28 containers located in the bathroom. LPN #2 confirmed the designated biohazard containers were not available on 09/28/2026 or during the morning of 09/29/2026. On 09/30/2026 at 7:40 AM, during an interview, RN #2 stated Resident #77 had been on Contact Precautions for more than one (1) month. RN #2 confirmed designated disposal containers had not been available in the resident's room during the preceding survey observations. RN #2 stated she obtained a bag outside the room to dispose of used PPE but did not place a designated container in the resident's room. RN #2 stated the Infection Preventionist was responsible for ensuring designated disposal containers were available. On 10/01/2026 at 2:00 PM, during an interview, LPN #5 stated Resident #77 had been on Contact Precautions for approximately two (2) months. LPN #5 stated designated biohazard containers were expected to be maintained in the resident's bathroom and replaced as needed. LPN #5 stated any staff member could replace the containers and that staff were expected to replace missing containers promptly. LPN #5 stated she was responsible for ensuring staff received infection control and PPE education, including laundry and housekeeping staff. LPN #5 stated she had been unable to monitor completion of all online training. On 10/01/2026 at 3:00 PM, during an interview, the Director of Nursing (DON) stated residents on Contact Precautions were expected to have designated disposal biohazard containers for potentially contaminated linens and biohazardous waste available in their rooms. The DON stated staff were expected to follow Contact Precaution procedures to prevent transmission of infectious organisms and confirmed nursing staff could obtain and place the required containers in residents' rooms. On 10/01/2026 at 3:30 PM, during an interview, the Administrator stated she expected staff to follow CDC Contact Precaution guidelines, ensure resident rooms were equipped with the supplies required to implement Contact Precautions, and promptly report missing infection control supplies.	F0880		