STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355050	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Care Center	**1116 9TH AVE , LANGDON, North Dakota, 58249**

(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
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey was started on 09/08/25 and concluded on 09/10/25.	F0000		10/05/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to	F0657	All residents have the potential to be affected by this practice. All care plans will be reviewed. In addition, a new MDS coordinator was put into this position and she was educated on the process of updating care plans.	10/24/2025

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

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

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F0657 SS = D	Continued from page 1 review and revise the comprehensive care plan to reflect the current status for 3 of 14 sampled residents (Resident #3, #11, and #32). Failure to review and revise the care plan as the needs change for the resident limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans, Comprehensive Person-Centered" occurred on 09/10/25. The revised policy, dated March 2025, stated, ". . . Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. . . ." -Observation on the afternoon of 09/08/25 showed facility staff changed Resident #32's brief and left his/her pants down and around the ankles and covered with a blanket. On 09/09/25 at 3:39 p.m., observation showed the resident lying in bed without pants and covered with a blanket. Review of Resident #32's medical record occurred on all days of survey. The current care plan failed to identify no pants while in bed. During an interview on 09/10/25 at 8:41 a.m., an administrative nurse (#1) confirmed the care plan lacked Resident #32's choice of having pants removed while lying in bed. -Review of Resident #3's medical record occurred on all days of survey. A code status form, signed and dated by the resident on 03/22/25, showed do not resuscitate (DNR). A physician's order, dated 05/30/25, and the resident's electronic health record (EHR) identification ribbon identified DNR. The current care plan identified a full code status. During an interview on 09/09/25 at 3:18 p.m., an administrative staff member (#2) confirmed facility staff failed to revise Resident #3's care plan when the code status changed to DNR. - Review of Resident #11's medical record occurred on all days of survey. The physician's orders included Seroquel (an antipsychotic medication) started on 05/09/25. The care plan lacked a problem, goal, or interventions related to the use of an antipsychotic medication. During an interview on 09/10/2025 at 11:55 a.m. an	F0657		

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F0657 SS = D	Continued from page 2 administrative nurse (#1) confirmed staff failed to revise Resident #11's care plan to reflect the use of an antipsychotic medication.	F0657		
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 observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 2 of 3 sampled residents (Residents #3 and #5) observed during medication pass. Failure to disinfect the rubber seal of insulin pens increases the risk of infection to residents and failure to follow manufacturer instructions for eye drop administration may impede the effectiveness of the eye drops. Findings include: Review of the facility policy titled "Insulin Administration" occurred on 09/10/25. This policy, dated May 2025, stated, ". . . Pull off the pen cap. Wipe the rubber seal with an alcohol swab. . . ." Information found at https://www.drugs.com/pro/pataday-once-daily-relief.html, revised 08/14/25, stated, ". . . Pataday (treatment for dry eyes) . . . Package Insert/Prescribing Info [information] . . . if using other ophthalmic products while using this product, wait at least 5 minutes between each product . . ." -Observation on 09/09/25 at 9:14 a.m. showed a nurse (#4) administered Pataday eye drops to both of Resident #5's eyes. At 9:16 a.m. (two minutes later) the nurse administered Xiidra eyedrops (treatment for dry eyes) to both eyes. The nurse (#4) failed to wait at least five minutes between administering two different eye products. During an interview on 09/10/25 at 12:45 p.m., an administrative staff member (#2) agreed the nurse should wait at least five minutes between administration of two eye drops.	F0658	Completion date was 10/24/25	10/24/2025

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F0658 SS = D	Continued from page 3 -Observation on 09/10/25 at 8:09 a.m. showed a nurse (#3) prepared an insulin pen for Resident #3. The nurse failed to wipe the rubber seal with an alcohol swab before applying the needle to the insulin pen. During an interview on the afternoon of 09/10/25, an administrative nurse (#1) confirmed she expected staff to wipe the rubber seal of an insulin pen with an alcohol swab before applying the needle.	F0658		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure 1 of 1 sampled resident (Resident #29) with contractures received the necessary devices. Failure to consistently provide a rolled washcloth to the resident's right hand may result in worsening of the contracture, pain, and further skin breakdown. Findings include: Review of Resident #29's medical record occurred on all days of survey. Diagnosis included hemiplegia and hemiparesis [weakness or paralysis] following cerebral infraction [stroke] affecting the right side. The care plan stated, "I require assist for all ADL's [Activity of Daily Living] . . . Please ensure that a rolled-up	F0688	Resident #29 was identified as being affected by this practice All residents that have contractures have the potential to be affected by this practice. All residents with contractures will be observed to be utilizing the ordered adaptive equipment in place. Education will be provided to nursing staff on 10/8/2025 Audits to ensure devices for contractures being used correctly will be completed weekly for 4 weeks, monthly for 2 months, and then quarterly thereafter until 100% compliance is achieved. Audits will be reviewed by administration or designee & brought to QAPI for review and recommendations. This will be completed by 10/24/25	10/24/2025

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F0688 SS = D	Continued from page 4 washcloth to [sic] placed to her right hand while at night and when she is in bed during the day. . . " Observation occurred on all days of survey and showed Resident #29's right hand contracted in a gripped position. On the afternoon of 09/09/25 and 09/10/25, observation showed Resident #29 in bed without a rolled-up wash cloth in her right hand. During an interview on the afternoon of 09/10/2025, a CNA (#5) stated staff are able to open Resident #29's right hand, but it hurts her. When asked about the rolled-up wash cloth, the CNA stated "forgot to put it in." The CNA (#5) returned to Resident #29's room, opened the resident's right hand, and the resident grimaced in pain. The CNA (#5) placed a rolled-up washcloth into Resident #29's right hand and noticed a small open area on her palm. During an interview on the afternoon of 09/10/25, an administrative nurse (#1) stated she expected staff to place the rolled-up wash cloth in Resident #29's hand whenever they assisted her to bed.	F0688		
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 observation, record review, and staff interview, the facility failed to properly utilize assistive devices for 1 of 4 sampled residents (Resident #16) reviewed for falls. Failure to properly use a bed and chair alarm placed the resident at risk for falls. Findings include: Review of Resident #16's medical record occurred on all days of survey. Diagnosis included dementia and anxiety. The current care plan stated, ". . . I am at	F0689	Staff were directed to check the alarms when leaving a resident to make sure that they were in place and working. We are doing audits after the education was provided initially and at a separate meeting. If the audits show that the issue still persists then we will add them to task list for the aides. If that is not showing improvement then we would have the nurses check off on the MAR/TAR	10/24/2025

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F0689 SS = D	Continued from page 5 risk for falls . . . Silent fall alarms on chair and bed. . . ." A Quarterly Minimum Data Set (MDS) dated 07/21/25 identified a bed and chair alarm used daily. A "Fall Risk Evaluation," completed 08/23/24 identified a Fall Risk Score of 18 (High Risk of falls). Observations on all days of survey showed Resident #16's chair and bed alarm unplugged and not functioning. During an interview on 09/10/2025 at 8:44 a.m., an administrative nurse (#1) confirmed Resident #16's bed and chair alarm were unplugged, was not aware if the resident was able to unplug the alarms, and expected staff to ensure the alarms are functional.	F0689		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of professional reference, and resident and staff interview, the facility failed to develop and provide an effective pain management regimen to meet resident needs for 2 of 14 sampled residents (Resident #4 and #5) reviewed for pain management. Failure to develop, implement, and provide an effective pain management plan resulted in unresolved pain and discomfort and decreased quality of life. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 625-626, stated, ". . . pain is a physical and emotional experience . . . Pain interferes with functional abilities and quality of life. Severe and persistent pain affects all body systems, causing potentially serious health problems while increasing the risk of complications and delays in healing. . . . Pain management is the alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the client. . . ." Page 631 stated, ". . the nurse must act to promote optimal and	F0697	Resident #4 and 5 were identified as being affected by this practice. Staff was educated to use prn dose prior to cares for #4 and for resident #5 pain medication was changed to different drug class in hopes that it would relieve her of her pain. All residents who experience pain with treatments and cares have the potential to be affected by this practice. Policy was reviewed, no update was needed. For residents who have pain that is not controlled, nursing will contact provider and ask for recommendations to assist with pain management. Education was provided at the nurses meeting to promote guidelines for proper use of pain medication. Audits to determine if pain is under control will be completed weekly for 4 weeks, monthly for 2 months, and then quarterly thereafter until 100% compliance is achieved. Audits will be reviewed by administration or designee & brought to QAPI for review and recommendations. This will be completed by 10/24/25.	10/24/2025

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F0697 SS = G	Continued from page 6 appropriate pain control. . . " and page 645 stated, ". . . A preventive approach to pain management involves the provision of measures to treat the pain before it occurs or before it becomes severe . . . " - Review of Resident #4's medical record occurred on all days of survey. The record identified on hospice services for a terminal illness. The care plan stated, "I am at risk for pain. My pain will be well controlled . . . Give medications as ordered . . . " The physician's orders included the following: * Baclofen (muscle relaxant) tablet 20 milligrams (mg) four times a day, start date 12/15/23. * Morphine Sulfate (opioid for severe pain) Oral Concentrate 0.3 milliliters (ml) every 4 hours, start date 07/30/25. * Morphine Sulfate Oral Concentrate 0.3 ml every 1 hour as needed (PRN), start date 07/30/25. Observation on 09/09/25 at 10:16 a.m. showed Resident #4 in bed, contractures to both legs, and two certified nurse aides (CNAs) (#9 and #10) provided morning cares. When the CNAs rolled the resident from side to side and moved/spread his legs, the resident repeatedly stated, "It's bad. It's bad. Oh, it's bad" and "Oh that hurts really bad. It hurts really bad though." The CNAs asked the resident multiple times to relax. The resident stated, "I'm trying to relax." When asked if the resident received any pain medication prior to the start of cares, the CNA (#9) stated, "He gets morphine round [sic] the clock. He gets it in 45 minutes." Observation on 09/10/25 at 10:42 a.m. showed Resident #4 in bed and a CNA (#6) provided morning cares. When the CNA moved the resident's legs to apply a clean brief, the resident stated, "Ouch. Hurts really bad." Review of Resident #4's medication and treatment administration records (MAR/TARs) for September 1-9, 2025, identified scheduled morphine administered every four hours and the PRN morphine administered only once on 09/03/25 at 10:00 a.m. The nursing staff failed to effectively utilize the PRN morphine to promote optimal pain control before providing cares to Resident #4. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included diabetic neuropathy [nerve pain] and a left foot ulcer. The care plan stated, ". . . I have chronic pain r/t [related	F0697		

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F0697 SS = G	Continued from page 7 to] osteoarthritis and Diabetic neuropathy . . . Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results . . . Notify MD [medical doctor]/NP [nurse practitioner] of an increase of pain levels. . . ." The physician's orders included the following: * Left diabetic foot ulcer dressing changes twice a day in the morning and at bedtime. * Gabapentin tablet 600 mg three times a day for diabetic neuropathy, start date 04/25/25 * Oxycodone-Acetaminophen tablet 10-325 mg every 4 hours as needed for pain, start date 06/12/25. Review of the quarterly Minimum Data Set (MDS), dated 08/16/25, identified intact cognition and a pain rating of 8 out of 10 (10 being the worst pain) and pain almost constantly which frequently affected sleep and day-to-day activities. Observation of 09/09/25 at 1:41 p.m. showed a nurse (#4) completed Resident #5's dressing change to the left foot. The resident displayed facial grimacing, muscle tension, under-the-breath vocal sounds, and moved her head back and forth throughout the entire dressing change procedure. During an interview on the afternoon of 09/09/25, Resident #5 stated, "I've been on the same pain med [medication (the resident referred to oxycodone)] since 2014. I keep asking for a different family [drug class] to see if that helps," and "I wish it was like when I was in the hospital. They would give me morphine with dressing changes." Review of Resident #5's MAR/TARs for September 1-9, 2025 related to morning dressing changes identified the following: * 09/02/25, no PRN oxycodone administered. * 09/03/25, the PRN oxycodone administered 1 hour and 37 minutes after the dressing change. * 09/04/25, the PRN oxycodone administered at 6:57 a.m., the same time the dressing change signed out. * 09/08/25, the PRN oxycodone administered 3 hours and 37 minutes before the dressing change. The facility failed to implement measures to prevent	F0697		

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F0697 SS = G	Continued from page 8 and/or treat Resident #5's pain before it occurred to promote optimal pain control before dressing changes. The medical record lacked evidence the facility notified Resident #5's provider related to increased pain with dressing changes or consider scheduled pain medications. During an interview on 09/10/25 at 3:51 p.m., an administrative nurse (#1) stated, "We could do more [to help control Resident #4 and #5's pain].	F0697		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs	F0801	No residents were identified in this tag. All residents have the potential to be affected by this tag. Dietary manager completed the required college course on September 3nd 2025 and is registered and scheduled to sit for the national exam. Once certified, the Dietary Manager will complete continuing education to maintain their certification. October 24th 2025.	10/24/2025

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F0801 SS = F	Continued from page 9 (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on review of a facility job description and staff interview, the facility failed to ensure 1 of 1 dietary manager (#11) obtained the proper qualifications to serve as the dietary manager. Failure to ensure staff	F0801		

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F0801 SS = F	Continued from page 10 have the qualifications to carry out the functions of a manager in the dietary department has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: Review of the facility job description titled "Dietary Manager" occurred on 09/10/25. This undated job description stated, ". . . Minimum requirements include one of the following . . . Certification as a dietary manager . . . Certification as a food service manager . . . Has similar national certification for food service management and safety from a national certifying body . . . Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, but no later than October 1, 2023 . . ." During an interview on 09/08/25 at 3:00 p.m., the dietary manager (#11) confirmed she had not completed the certified dietary manager course. The facility failed to ensure the dietary manager (#11) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food services management and safety from a national certifying body.	F0801		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812	1. No specific residents were identified in this tag. 2. All residents have the potential to be affected by this tag. 3. All Dietary Staff had general education on glove usage on September 26th, 2025. Staff will be reeducated on safe handling when delivering food to residents. 4. Audits will be conducted weekly x4 weeks, monthly x 2 months, and quarterly thereafter until 100% compliance. 5. October 24th 2025	10/24/2025

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F0812 SS = E	Continued from page 11 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and review of facility policy, the facility failed to serve food in accordance with professional standards for food safety in 1 of 2 dining rooms (north dining room). Failure to ensure no bare-hand contact with ready-to-eat food has the potential to result in a food borne illness. Findings include: Review of the facility policy titled "Kitchen and Service Kitchen Safe Practice Guidelines" occurred on 09/10/25. This policy, dated 07/14/25, stated, ". . . When handling clean dishes care will be taken to minimize hand contact with food surfaces. . . . plates [will be touched] on the outside rim . . ." Review of the facility policy titled "Serving Meals" occurred on 09/10/25. This policy, dated 07/13/25, stated, ". . . Staff will serve meal without touching prepared food. . . ." Review of the facility policy titled "Dietary Infection Control and Glove Usage" occurred on 09/10/25. This policy, dated 07/14/25, stated, ". . . Change Gloves after . . . touching hair or face with gloved hands. . . ." -Observations of food service showed the following: *On 09/09/25 at 7:45 a.m., a dietary staff member (#13) placed a plate with a breakfast sandwich on it in the microwave, touching the top of the plate with her bare right thumb. The staff member then removed the heated sandwich/plate from the microwave, placed grapes on the plate, touching them with her bare hand, and touched the top of the plate with her bare right thumb as she handed the plate to another staff member. *On 09/09/25 at 12:17 p.m., two dietary staff members	F0812		

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F0812 SS = E	Continued from page 12 (#13 and #14) touched the top of dished and/or reheated plates with their bare thumbs. The dietary staff member (#13) also touched her face and face mask with her bare hand as she dished and passed plates.	F0812		
F0868 SS = F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by:	F0868	1) 1) No residents were affected 2) 2) No residents were identified to be affected 3) 3) Policy was reviewed and Medical Director and Executive Director were educated on 9-30-2025. Medical director will be notified 2 days prior to each meeting. 4) 4) Audits will be done quarterly for 1 year or until 100% compliance has been reached. Administrator or designee will review the audits and bring them to the QAPI committee. 5) 5) 10-24-25 5)	10/24/2025

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F0868 SS = F	Continued from page 13 Based on review of the facility Quality Assurance and Performance Improvement (QAPI) program, review of the facility policy, and staff interview, the facility failed to ensure the Medical Director (physician) actively participated on the Quality Assurance (QA) committee for 3 of 4 quarters (July-September 2024, October-December 2024, and April-June 2025). Failure to ensure the medical director participates in the facility's QA activities deprived the committee of the physician's unique contribution for analyzing and correcting problems with identified resident care areas. Findings include: Review of the facility policy titled "Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership" occurred on 09/10/25. This policy, revised January 2025, stated, ". . . The following individuals serve on the committee . . . Medical director . . . The committee meets at least quarterly (or more often as necessary). Committee members are reminded of meeting day, time and location via e-mail at least two business days prior to the meeting. . . ." Review of the QA committee attendance records from July 2024 to June 2025 showed the medical director attended one meeting, in January 2025. During an interview on 09/10/25 at 10:00 a.m., an administrative staff member (#11) reviewed the QA committee meeting minutes and indicated the medical director attended the January 2025 meeting "via telephone," but was unable to attend the October 2024 and May 2025 meetings. She added, "He did not attend, but read the notes on rounds." She failed to address the 3rd quarter of 2024.	F0868		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	1) Resident #4 and 5 were identified as being affected by this practice. 2) All residents have the potential to be affected by this practice. Education will be provided to nurses and CMAs in regards to placing a barrier or disinfection the table before placing medications on table and to sanitize equipment after leaving room and before placing in cart or designated area. Education will be provided to all nursing staff on how and when to use gloves and dispose of gloves correctly during peri cares, applying barrier cream and touching other items.	10/24/2025

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F0880 SS = E	Continued from page 14 §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	Continued from page 14 Education will also be provided to all nursing staff on how to use the sprayer and cleaning graduate container after emptying catheter bags. Education will be provided to all nursing staff on how to properly change dressings and who is responsible for this task. 3) Audits on glove use, sanitizing work area and equipment, use of sprayer and dressing changes will be completed weekly for 4 weeks, monthly for 2 months, and then quarterly thereafter until 100% compliance is achieved. 4) Audits will be reviewed by administration or designee & brought to QAPI for review and recommendations. 5) This will be completed by 10/24/25.	

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F0880 SS = E	Continued from page 15 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 observation, record review, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 14 sampled residents (Residents #4 and #5) observed during personal cares. Failure to practice infection control standards during medication administration and resident cares has the potential to spread infection throughout the facility. Findings include: Review of the Centers for Disease Control (CDC) Frequently Asked Questions (FAQS) about Enhanced Barrier Precautions in Nursing Homes at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, dated 06/28/24, stated, "1 . . . Enhanced Barrier Precautions [EBP] involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). . . . 9 . . . Adherence to other recommended infection prevention practices including performing hand hygiene, cleaning and disinfection of environmental surfaces . . . proper handling of indwelling medical devices, and care of wounds is also critical. . . ." Review of the CDC Clinical Safety: Hand Hygiene for Healthcare Workers at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated 02/27/24, stated, ". . . Know when to clean your hands . . . after touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. . . . Know when to wear (and change) gloves. Gloves are not a substitute for hand hygiene. .	F0880		

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F0880 SS = E	Continued from page 16 . . When to change gloves and clean hands . . . If gloves become soiled with blood or body fluids after a task. If moving from work on a soiled body site to a clean body site on the same patient or if clinical indication for hand hygiene occurs. . . ." - Review of Resident #5's medical record occurred on all days of survey and identified EBP related to an open left foot wound. Observation on 09/09/25 at 8:49 a.m. showed a nurse (#4) prepared Resident #5's oral medications, insulin pens, and eye drops for administration. The nurse (#4) applied personal protective equipment (PPE) outside the resident's room, entered the room, and placed the medications onto the resident's overbed table without placing a barrier or disinfecting the table. After administration, the nurse (#4) removed the PPE, carried the insulin pens and the container that held one of the eye drop bottles out of the room, and without sanitizing the pens and the eye drop bottle/container, placed them back into the medication cart. - Review of Resident #4's medical record occurred on all days of survey and identified EBP for multiple open wounds, an indwelling catheter, and MDROs. Observation of Resident #4's cares showed the following: * 09/09/25 at 10:16 a.m., two certified nurse aides (CNAs) (#9 and #10) provided perineal cares. The CNA (#10) failed to remove the soiled gloves prior to opening the resident's nightstand to remove and apply a skin barrier cream. With the same gloves, the CNA (#9) repeatedly reached into her pocket to answer calls from a walkie talkie and placed it back into her pocket. The CNA (#9) failed to sanitize the walkie talkie prior to exiting the room. * The afternoon on 09/09/25, a CNA (#10) emptied the catheter bag into a container. The CNA poured the urine into the toilet, obtained water from the bathroom sink, and poured the water into the toilet. When asked if she ever uses the sprayer located beside the toilet, the CNA stated never and "I don't think it works." Observation on 09/10/25 at 12:03 p.m. showed a CNA (#11) emptied the urine from the catheter bag into a container, poured the urine into the toilet, and utilized the sprayer to rinse out the container. * 09/10/25 at 10:56 a.m., a CNA (#6) assisted with positioning Resident #4 while two nurses (#7 and #8) performed multiple dressing changes. Throughout the	F0880		

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F0880 SS = E	Continued from page 17 observation, the CNA (#6) removed soiled dressings from the resident's ankle, shin, toe, and foot. When the CNA (#6) removed the soiled dressing from the foot, the CNA stated, "It smells," folded the dressing in half, and handed it to the nurse. The CNA failed to remove the soiled gloves, perform hand hygiene, and apply clean gloves before adjusting the resident's clothing and bedding. After the observation, when asked if CNAs typically remove Resident #4's dressings, a nurse (#7) stated, "She [CNA #6] normally does not do that [remove dressings]. I didn't say anything as she already touched them." During an interview on the afternoon of 09/10/25, an administrative staff member (#2) stated she expected staff to place medications on a clean surface, sanitize items after use and before placing them back into the medication cart, change gloves and perform hand hygiene between clean and dirty tasks, and nurses to remove dressings from resident wounds.	F0880		