STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenoir Health and Rehabilitation Center	**322 Nuway Circle , Lenoir, North Carolina, 28645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/16/25 through 11/20/25. Additional information was collected offsite on 11/21/25 and the survey team returned onsite on 11/22/25 to gather additional information. Additional information was again gathered offsite through 11/24/25, therefore the exit date was change to 11/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DB616-H1.	E0000		12/11/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 11/16/25 to conduct a recertification and complaint investigation survey and exited on 11/20/25. The survey team returned to the facility on 11/22/25 to obtain additional information and exited on 11/24/25. Therefore, the exit date was changed to 11/24/25. Event ID# 1DB616-H1. 6 of the 25 complaint allegations resulted in deficiencies. Intake # 872868, 2671952, 2657171, 2662265, 2644434, 2596213, 2591729, 2581574, 2580726, 2562802.	F0000		12/11/2025
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by	F0552	F552 An informed consent was obtained for resident #45 for psychotropic medications on 11/24/2025 by the Director of Nursing Current psychotropic medications in use were audited by the Director of Nursing 12/15/2025 to ensure that informed consents had been obtained for the medication use. The Director of Nursing or designee will educate current licensed nurses including agency nurses to completed an informed consent in the electronic health record prior to administering any psychotropic medication. Education will be completed by 12/18/2025. Any licensed nurse, including agency not receiving this education will be educated by the Director of Nursing or designee prior to the start of their shift.	12/19/2025

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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F0552 SS = D	Continued from page 1 the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Nurse Practitioner, Psychiatric Nurse Practitioner, and staff interviews, the facility failed to obtain consent and inform the resident in advance of the risks and benefits of psychotropic medications prior to the initiation of the antianxiety medication clonazepam and the antidepressant medication venlafaxine for 1 of 5 residents reviewed for unnecessary medications (Resident #45). The findings included: Resident # 45 was admitted 11/01/2024 with diagnoses of chronic obstructive pulmonary disease (COPD), bipolar disorder, and depressive disorder. A Psychiatric Nurse Practitioner progress note dated 07/28/2025 indicated Resident #45 had experienced panic attacks 3 to 4 times weekly with symptoms that felt like he was having a heart attack. The plan indicated to start clonazepam twice a day. Resident #45's physician orders revealed an order dated 07/28/2025 for clonazepam 0.5 milligrams (mg) by mouth twice a day for anxiety. Resident #45's quarterly Minimum Data Set (MDS) dated 08/4/2025 revealed intact cognition and indicated Resident #45 received antianxiety and antidepressant medications on a routine basis during the 7-day look back period. Resident #45's physician orders revealed an order dated 08/12/2025 for the venlafaxine 75 mg by mouth daily for depression. A review of Resident # 45's medical record revealed no information whether Resident #45 was informed in advance of the risks and benefits of initiating clonazepam or venlafaxine and consented to the treatment.	F0552	Continued from page 1 Any new licensed nurses will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will review all psychotropic medication orders and changes and ensure informed consent has been obtained. This will be done during the morning clinical meeting 5x weekly x 12 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	

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F0552 SS = D	Continued from page 2 The Medication Administration Record (MAR) from 07/28/2025 to 11/18/2025 indicated Resident #45 was administered clonazepam and venlafaxine as ordered by the physician. An interview with Resident #45 on 11/17/2025 at 10:05 AM revealed Resident #45 was in good spirits, and he stated his anxiety and his depression were well controlled. An interview with the Nurse Practitioner on 11/19/2025 at 10:30 AM revealed she deferred Resident #45's psychotropic medication management to the Psychiatric Nurse Practitioner (NP) and she did not obtain consents for these medications. An interview with the Director of Nursing (DON) on 11/19/2025 at 2:00 PM revealed that the facility had not consistently been obtaining consents for psychotropic medications. The DON stated she thought that sometimes the psychiatric Nurse Practitioner obtained consents prior to starting the psychotropic medication. An interview with the Psychiatric Nurse Practitioner on 11/20/2025 at 9:00 AM indicated the nursing staff were supposed to notify the resident or the responsible party to discuss the treatment and the possible side effects when a psychotropic medication was initiated or the dosage had been increased. The Psychiatric Nurse Practitioner indicated that her discussion with Resident #45 consisted of asking the resident about mood fluctuations, anxiety episodes, and his degree of depression. An interview with Administrator on 11/20/2025 at 9:42 AM revealed that she was aware there was opportunity for improvement related to the use of psychotropics and informed consents. She stated that she expected informed consents including a discussion of the risks and benefits would be obtained prior to starting or changing a psychotropic medication.	F0552		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F0580	F580 The Nurse Practitioner was notified of the bruising on resident #23 on 11/17/2025 by the Director of Nursing.	12/19/2025

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F0580 SS = D	Continued from page 3 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that	F0580	Continued from page 3 The Nurse Practitioner for resident #63 was notified of tube feeding being disconnected by the Director of Nursing on 11/17/2025. The Director of Nursing and designee completed an audit to review the last 7 days of nursing notes to ensure any acute changes, abnormal labs, falls, changes in condition in the current residents' condition were noted and the physician had been notified. This was completed by the Director of nursing on 12/15/2025. The audit included a review of nursing notes and 24-hour shift to shift reports. Education started by the Director of Nursing to current licensed nurses including agency on 12/15/2025 for the change in condition and physician notification related to change in condition to include providing comprehensive assessments including any bruising or abnormal vital signs and abnormal blood sugars. Education also included not to turn off enteral feedings unless there is a provider order. If the enteral feeding is turned off the provider must be contacted. Any licensed nurse including agency not receiving education will receive education by the Director of Nursing or designee prior to the beginning of their shift. New licensed nurses will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will review the progress notes and the 24 hour shift to shift report of current residents 5x weekly x 12 weeks to ensure provider notification of any change in condition; abnormal labs; enteral feeding tubes turned off; abnormal vital signs Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of completion 12/19/2025	

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F0580 SS = D	Continued from page 4 comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to notify the physician immediately of abdominal bruising on a resident receiving Plavix and aspirin (antiplatelet medications) for 1 of 5 residents reviewed for unnecessary medications (Resident #23). The facility also failed to notify the physician before turning off a continuous enteral feeding (tube feeding) when a resident's blood sugar was elevated for 1 of 3 residents reviewed for tube feeding (Resident #63). The findings included: Resident #23 was admitted to the facility on 08/20/22 with diagnoses which included type-2 diabetes mellitus with chronic kidney disease, peripheral vascular disease (a condition of decreased blood flow in the lower extremities), and atherosclerotic heart disease (a heart condition caused by plaque buildup in the walls of arteries blocking blood flow to the heart). A review of Resident #23's physician orders revealed the following: · Plavix 75 milligrams by mouth daily for peripheral vascular disease · Aspirin 81 milligrams by mouth daily for atherosclerotic heart disease · Insulin Glargine (long-acting insulin) Pen-Injector (100 Unit/Milliliter) inject 15 unit subcutaneously (under skin) every 12 hours for type-2 diabetes · NovoLOG (Regular insulin) Solution Pen-Injector (100 Unit/Milliliter) inject subcutaneously before meals and at bedtime per sliding scale: if blood sugar 150-200 give 2 units; 201-250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-450 give 10 units; above 450 notify provider A progress note written by Nurse #1 dated 11/15/25 at 7:30 PM revealed the following: "A large bruise was noted on the left lower quadrant of abdomen. Bruise purple/blue in appearance".	F0580		

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F0580 SS = D	Continued from page 5 An interview with Nurse #1 was conducted on 11/17/25 at 10:33 AM. Nurse #1 revealed that on the morning of 11/15/25 at 6:00 AM, a skin assessment was performed on Resident #23 which revealed no injury. Nurse #1 further revealed when she arrived for her next shift on the evening of 11/15/25 at 7:30 PM, Resident #23 reported pain to abdominal area. Nurse #1 visualized the abdominal area and noted a purple bruise to Resident #23's left lower quadrant of abdomen. Nurse #1 stated she did not notify the provider. An interview with Unit Manager #1 was conducted on 11/16/25 at 1:42 PM. Unit Manager #1 revealed that she had come in at 3:00 PM on 11/15/25. Unit Manager #1 stated she assessed Resident #23 and noted a large bruise to the left lower quadrant of Resident #23's abdomen. Unit Manager #1 indicated that she did not notify the provider at that time. An interview of Resident #23 was performed on 11/16/25 at 11:16 AM. Resident #23 revealed a large bruise to left abdomen during the interview. A telephone interview with Unit Manager #2 was conducted on 11/17/25 at 6:16 PM. Unit Manager #2 reported on the night of 11/16/25, Resident #23 stopped to show her the bruising on her abdomen. Unit Manager #2 stated that she did not report it to the provider. An interview with the NP was conducted on 11/18/25 at 3:01 PM. The NP stated that she was not notified of the bruised area to Resident #23 until the AM of 11/17/25. The NP stated that when she became aware of the bruising, Resident #23 was seen by her in clinic. The NP stated the Plavix and aspirin are antiplatelet medication that Resident #23 received daily and could have contributed to bruising and Resident #23 received insulin injections which are commonly administered in the abdominal area. The NP indicated the provider should have been notified when the bruising was first assessed. 2. Resident #63 was admitted to the facility on 7/12/2016. Resident #63 had diagnoses that included diabetes mellitus (DM) type 2, encounter for attention to gastrostomy. Resident #63 had a physician's order dated 6/29/2024 for enteral feeding (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) for Nutren 2.0 (feeding formula) at 46 milliliters (ml)/hour (hr) administered continuously from 9:00 PM to 9:00 AM daily.	F0580		

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F0580 SS = D	Continued from page 6 Resident #63 had a physician's order dated 6/29/2024 for blood sugar checks four times daily before meals and at bedtime for DM. An order dated 2/26/2025 for Lantus inject 20 units subcutaneously at bedtime for diabetes mellitus if CBG less than 65 only give 10 units. Notify provider if CBG is less than 60 or greater than 450. A progress note dated 8/1/2025 written by Nurse #3 revealed Resident #63's blood glucose was 335 milligram/deciliter mg/dl, tube feeding stopped early to help blood glucose stabilize. During a telephone interview on 11/17/2025 at 4:56 PM Nurse #3 revealed she worked at the facility on the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #3 confirmed she had turned off Resident #63's tube feeding early due to high blood sugar on the morning of 8/1/2025. Nurse #3 stated she didn't think she needed to get a doctor's order to turn off a tube feeding early and stated she thought it was nursing judgement. Nurse #3 stated she thought it was better to turn the tube feeding off early instead of calling a provider to try and get coverage orders when it would take a couple hours to hear back from the provider. Nurse #3 confirmed she did not notify the provider when she turned the tube feeding off early. An order for enteral feeding dated 10/4/2025 for Nutren 2.0 administer 65ml/hr continuously at 9:00 PM and off at 9:00 AM. During a telephone interview on 11/19/2025 at 8:20 AM Nurse #1 stated she worked at the facility since September 2025 and currently worked the 7:00 PM to 7:00 AM shift at the facility and was familiar with Resident #63. Nurse #1 stated one night in October 2025, she did not recall the specific date, she was worried about Resident #63 having a high blood sugar over 400, and no orders for sliding scale insulin coverage at that time. Nurse #1 stated she asked another nurse, she could not remember which one, what to do and the nurse told her to turn off the tube feeding. Nurse #1 stated she thought they had been turning off the tube feeding early due to high blood sugars, so Nurse #1 turned off Resident #63's tube feeding and did not notify the provider. During a telephone interview on 11/18/2025 at 7:05 AM Unit Manager #4 stated sometime around mid-October Nurse #1 reported to Unit Manager #4 that Resident #63's tube feeding had been held due to high blood	F0580		

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F0580 SS = D	Continued from page 7 sugar, that other nurses had done it since Resident #63 had no sliding scale insulin coverage for elevated blood sugars. Unit Manager #4 stated she told Nurse #1 that a tube feeding was not supposed to be turned off for elevated blood sugars, and a provider should have been notified. Unit Manager #4 stated she reported the information the NP #2 who gave new sliding scale insulin coverage orders, and to the Director of Nursing (DON). Review of a progress note from the NP #2 dated 10/13/2025 revealed in part, NP #2 had seen Resident #63 on 10/13/2025 regarding weight loss, with an additional note that revealed NP #2 had a telephone encounter 10/15/2025 and spoke with bedside nurse who stated that Resident #63 received before meals and a bedtime blood glucose checks without any sliding scale insulin coverage in place. Per nurse- tube feeding was stopped by night shift nurse due to blood sugar of 446. Per nursing reports tube feeding gets turned off frequently due to elevated blood sugars. Reviewed blood sugars and added sliding scale insulin coverage and would continue to monitor and adjust plan of care as needed. During a telephone interview on 11/17/2025 at 4:29 PM the Nurse Practitioner (NP) #2 stated she was notified by the facility that Resident #63's had weight loss in early October 2025 and Resident #63's tube feeding rate was reviewed by the RD and the tube feeding rate was increased. The NP #2 stated near the middle of October, Unit Manager #4 reported that when Resident #63 had elevated blood sugars the nurses had turned off Resident #63's tube feeding instead of calling the provider to get orders for insulin. NP #2 stated she expected nurses to administer tube feedings as ordered and should contact a provider to get an order for a tube feeding to be turned off early. During an interview on 11/19/2025 at 4:50 PM the Medical Director stated he expected tube feedings to be administered as ordered and to be contacted by the nurse to receive orders to turn a tube feeding off early, and for a provider to be notified for blood sugars over 400, if a resident did not have an order for coverage. During an interview on 11/18/2025 at 8:45 AM the DON stated a physician ordered tube feeding should not be turned off early unless the nurse contacted the provider and received orders to turn the feeding off early. During an interview on 11/20/2025 at 7:10 AM the	F0580		

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F0580 SS = D	Continued from page 8 Administrator stated she expected nurses to administer tube feedings as ordered, and to contact a provider for an order to turn a tube feeding off early.	F0580		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interviews, the facility failed to develop abuse policies and procedures that directed staff on how to immediately protect residents after an abuse allegation. The facility also failed to implement their abuse policy in the areas of reporting and training. An allegation of staff to resident physical abuse occurred on 11/15/25.	F0607	F607 Resident #23 was interviewed by the administrator on 11/16/2025. The administrator completed a Facility reported incident for the allegation of abuse on 11/16/2025. CNA that was noted to be in the room at the time of incident was removed from the schedule and sent home by the administrator on 11/16/2025. Interviews were completed by the social services department for unit 1 for residents BIMS 13-15. A skin observation was completed by the licensed nursing staff on residents on unit #1 on 11/16/2025 with no discolorations observed or concerns voiced. The Director of Nursing and administrator educated current staff including agency staff on reporting guidelines including timely reporting of allegations and sending named or involved staff home at the time of reporting. Education completed 12/18/2025. Any agency staff or facility staff not receiving education will receive education prior to the start of their shift by the Director of Nursing or designee New staff will receive education during the orientation process by the Director of Nursing, Administrator, or designee. Progress notes will be reviewed during morning clinical meeting by the nursing leadership team 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks, The RDCS or RVPO will review FRIs weekly x 12 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance : 12/19/2025	12/19/2025

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F0607 SS = D	Continued from page 9 The facility failed to immediately remove the alleged perpetrators from the facility, immediately notify the Administrator of the abuse allegation, and train staff on immediately reporting abuse allegations to administration. This deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #23). Findings included: Review of the facility's abuse policy titled "Patient Protection" dated 10/17/23 revealed "all employees are responsible for immediately (no later than 2 hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse of bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation, and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient". "Any and all suspected or witnessed incidents of patient abuse, neglect brought to the attention of Administration will result in internal investigation, appropriate and timely reporting to the State Agency and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary". The abuse policy did not direct staff to immediately protect all residents after an abuse allegation by removing alleged perpetrators from access to residents. Review of the facility's abuse policy titled "Prevention/Screening/Training" dated 02/05/23 revealed "all employees receive training in orientation and are routinely in-serviced regarding the definitions of abuse, neglect…and their responsibility for understanding and preserving patient rights, protecting patients from abuse and neglect, and their responsibility to immediately report any cases of suspected or witnessed abuse or neglect". Resident #23 was admitted to the facility on 08/20/22. A review of Resident #23's quarterly Minimum Data Set (MDS) dated 08/20/25 revealed that Resident #23 was cognitively intact. A telephone interview with Nursing Assistant (NA) #2 was conducted on 11/16/25 at 3:48 PM. NA #2 reported that she was assigned to Resident #23 the night of 11/15/25. At around 5:40 AM, NA #2 entered Resident #23's room for rounds where NA #1 was present providing care to Resident #23's roommate. Resident #23 refused	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0607 SS = D	Continued from page 10 incontinence care three times and NA #2 stated that there was a planned refusal form for Resident #23 to sign if she refused care due to frequent refusals. When NA #2 got the form, Resident #23 became agitated and began cursing. NA #1 then asked Resident #23 if she wanted to be changed to which Resident #23 agreed for NA #2 to complete incontinence care at that time. NA #2 had Resident #23 roll to her right side facing the window, then tapped her to roll over to her back. NA #2 stated that when Resident #23 rolled back onto her back, she began yelling “you are in my organs”. NA #2 stated that she was not touching Resident #23 at the time she began yelling. NA #2 stated that there was no bruising on Resident #23’s abdomen at that time. NA #2 reported the incident to Unit Manager #2. NA #2 indicated that Resident #23 was her last resident for rounds and she left at 7:00 AM. NA #2 reported that her assignment was not changed for the brief period left in her shift. NA #2 indicated she had been off since and had not returned due to previously scheduled time off. An interview with NA #1 was conducted on 11/16/25 at 3:19 PM. NA #1 revealed that she had arrived at work the 3:00 PM to 11:00 PM shift at the time of the interview. NA #1 stated that she was in Resident #23’s room providing incontinence care for Resident #23’s roommate on 11/15/25 at 5:40 AM. NA #2 entered the room to provide incontinence care for Resident #23. NA #1 stated she was not assigned to Resident #23 because she would not work with Resident #23. NA #1 stated that she would have another NA provide care to Resident #23. NA #2 worked with Resident #23 on the 11/15/25 7:00 PM to 7:00 AM shift. NA #1 observed NA #2 offer incontinence care to Resident #23 who refused 3 times. When NA #2 requested Resident #23 sign the planned refusal form, Resident #23 became upset and began cursing. NA #1 reported that she stated to Resident #23, “are you going to let her change you?” At that time, Resident #23 agreed to incontinence care by NA #2. NA #1 did not assist with care but observed Resident #23 had rolled to her right side facing the window when NA #2 tapped gently on Resident #23’s left hip to get her to turn over (Resident #23 is hard of hearing so this is how they indicate to her to turn). NA #1 observed Resident #23 roll over onto her back and NA #2 was at the bedside not touching Resident #23 when Resident #23 began yelling “you’re hurting my organs”. NA #1 reported that she told NA #2 to stop and told her to go get Nurse #1. NA #1 indicated that she left the room after completing care for the other resident. NA #1 stated that no one told her that she could not enter the room again or interviewed her about what happened. NA #1 stated her shift ended at 7:00 AM so Resident #23’s room was the last round of the shift.	F0607		

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F0607 SS = D	Continued from page 11 A progress note written by Nurse #1 dated 11/15/25 at 6:09 AM revealed the following: “Patient reported to this nurse that she feels she was "being abused" by nightshift aides. Patient stated that aides were speaking to her harshly and handling her in a manner she perceived as rough. Patient was calm but appeared upset while reporting concerns. No signs of physical injury noted at the time”. An interview with Nurse #1 was conducted on 11/17/25 at 10:33 AM. Nurse #1 revealed that on the morning of 11/15/25 at 6:00 AM, Resident #23 reported to her she felt like she had been abused by the night shift NAs. Nurse #1 indicated that Resident #23 reported to her that the NAs had turned her roughly but did not report any specifics and could not name the NAs. Nurse #1 stated that she performed an assessment on Resident #23 at that time which was within normal limits. Nurse #1 reported that she told the two NAs on the floor that they needed to stay out of Resident #23’s room but that was their last round of their shift and Nurse #1 believed they left at 7:00 AM. Nurse #1 indicated she was not aware of what the NA’s names were as she was new. Nurse #1 stated she notified Unit Manager #2 but did not notify the Administrator and thought that Unit Manager #2 had. A telephone interview with Unit Manager #2 was conducted on 11/17/25 at 6:16 PM. Unit Manager #2 reported on the morning of 11/15/25 at 7:00 AM, Resident #23 approached her and reported that staff had “scolded” her during incontinence care at 5:45 AM that morning. Unit Manager #2 stated that Resident #23 did not report any physical abuse to her at that time, nor report any injury. Resident #23 could not name the NAs but described NA #1. Unit Manager #2 stated she did not instruct the NAs to leave the floor because she was unaware of the abuse allegation, and stated Nurse #1 did not report anything to her. Unit Manager #2 stated that she did not report the allegation to the Administrator. Unit Manager #2 stated she felt it was a minor incident and would discuss it with the Administrator on Monday. Unit Manager #2 stated that she was new to the role of Unit Manager and had not been educated in the supervisory reporting process of the Unit Manager role. Unit Manager #2 indicated she returned to work at 7:00 PM on 11/15/25 into 11/16/25. At 1:00 AM 11/16/25, Resident #23 approached Unit Manager #2 again and showed her a bruise to her left lower abdomen and reported it came from the NAs turning her the previous morning. Resident #23 did not report how the bruising occurred specifically and denied pain. Unit Manger #2 asked Resident #23 if she had reported	F0607		

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F0607 SS = D	Continued from page 12 it, and Resident #23 stated to her someone from administration had been there that day to see her. Unit Manager #2 indicated that Unit Manager #1 had come in the afternoon of 11/15/25 to assess Resident #23. And Resident #23 probably thought that was administration staff. An interview with Unit Manager #1 was conducted on 11/16/25 at 1:42 PM. Unit Manager #1 revealed that she had come in at 3:00 PM on 11/15/25 and Resident #23 reported to Unit Manager #1 that the night shift NAs were rough with her and “dug” their hand into her side during incontinence care. Unit Manager #1 revealed she did not know what NAs had worked with Resident #23 the night before. At that time, a bruise was noted to Resident #23’s left lower quadrant of her abdomen. Unit Manager #1 stated she did not notify the Administrator and assumed Unit Manager #2 had. Unit Manager #1 stated that she was new to the role of Unit Manager and had not been educated in the supervisory reporting process of the Unit Manager role. A review of the initial allegation report revealed an abuse allegation in which NA #1 and NA #2 were allegedly rough with Resident #23 while providing incontinent care at 5:45 AM on 11/15/25. The Administrator was notified of the allegation on 11/16/25 at 1:40 PM. The Administrator notified law enforcement and Adult Protective Services on 11/16/25 at 2:18 PM. The completed initial allegation report was submitted to the State Agency on 11/16/25 at 2:38 PM. A review of staffing schedules revealed the following: · NA #1 and NA #2 worked from 11:00 PM on 11/14/25 to 7:00 AM on 11/15/25. · NA #1 was scheduled to work from 3:00 PM on 11/1625 until 7:00 AM on 11/17/25. · NA #2 was not scheduled to work after 11/15/25 due to scheduled time off. A joint interview with the Regional Nurse Consultant and Administrator conducted on 11/16/25 at 3:32 PM revealed that the Administrator identified NA #3 (agency staff) as the alleged perpetrator of the staff to resident abuse. The agency had been contacted, and NA #3 had been terminated from the facility. This Surveyor revealed to the Administrator that NA #1 and NA #2 were the alleged perpetrators and worked with Resident #23 on 11/15/25 and not NA #3. The Administrator and Regional Nurse Consultant were notified by this Surveyor that NA #1 was in the	F0607		

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F0607 SS = D	Continued from page 13 building preparing to start her shift at that time. The Administrator stated they were not aware that NA #1 was one of the alleged perpetrators or that she was currently in the facility working and would be sent home immediately pending the investigation. The Administrator stated that NA #2 was not working due to scheduled time off and would remain out until the investigation was completed. A subsequent interview with the Administrator was conducted on 11/20/25 at 10:19 AM. The Administrator stated the staff did not inform her about the allegation of staff to resident abuse involving Resident #23 in a timely manner. The incident occurred on 11/15/25 at 5:45 AM and she was notified on 11/16/25 at 1:40 PM. The Administrator stated the staff should have notified her immediately of any suspected or witnessed allegation of abuse or neglect. The Administrator indicated that an investigation would have been immediately initiated had staff notified her when it occurred. The Administrator explained that abuse and neglect training were provided annually to all staff with additional training when needed. The Administrator further added one on one education was provided to staff who did not report the incident within the appropriate time frame. The Administrator indicated that NA #1 and NA #2 had been suspended during the investigation. NA #1 was an agency staff and was terminated from the facility. NA #2 was returning to work on her next scheduled day. The Administrator stated the allegation was unsubstantiated and investigation report had been submitted to the State Agency.	F0607		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, and staff	F0637	F637 Resident #73 admitted to Hospice 9/19/25 significant change with 10/16/25 assessment reference date was completed 10/22/2025. On 12/15/25, Regional Director of Clinical Reimbursement conducted a 100% audit to ensure there are no residents with a current late Hospice significant change assessment. All significant change assessments are now timely. Minimum Data Set (MDS) coordinators to be educated by Regional Director of Clinical Reimbursement 12/16/25 regarding timely completion of significant change assessments according to RAI manual guidelines for all Hospice admissions.	12/19/2025

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F0637 SS = D	Continued from page 14 interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days following hospice election for 1 of 1 resident reviewed for hospice (Resident #73). The findings included: Resident #73 was admitted to the facility on 02/19/21 with diagnoses which included Alzheimer's disease, unspecified dementia, and senile degeneration of the brain. A medical record review revealed Resident #73 was admitted to hospice on 09/19/25 with a primary hospice admission diagnoses of senile degeneration of the brain. A review of Resident #73's MDS assessments revealed a significant change in status MDS assessment was completed on 10/16/25 after the resident was admitted to hospice services. The MDS was coded for hospice care. An interview with the facility MDS Nurse was conducted on 11/20/25 at 10:04 AM. The MDS Nurse stated if a resident was admitted to hospice services, a significant change in status MDS assessment should be completed within 14 days. The MDS Nurse reported that no significant change in status MDS assessment was completed for Resident #73 within the required 14-day period. The MDS Nurse stated that several residents had been admitted to hospice services around the same time and she overlooked the significant change in status MDS for Resident #73. An interview was conducted with the Director of Nursing (DON) on 11/20/25 at 10:34 AM. The DON stated residents admitted to hospice services was considered a significant change and a significant change in status MDS assessment should have been completed within 14 days of hospice admission date. An interview with the Administrator was conducted on 11/20/25 at 11:19 AM. The Administrator stated that a significant change in status MDS should have been completed within 14 days after Resident #73 was admitted to hospice.	F0637	Continued from page 14 Any new MDS coordinator will receive education during the orientation process by the Regional Director of Clinical Reimbursement. Regional Director of Clinical Reimbursement will audit x5 Residents for timely completion of significant change assessments weekly for x4 weeks then biweekly x2, then monthly x1 Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance : 12/19/2025	

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F0637 SS = D F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and Medical Director, Nurse Practitioner (NP), staff, and resident interviews, the facility failed to complete and document thorough assessments of abdominal bruising on a resident that received Plavix (antiplatelet medication) and aspirin daily. The facility also failed to follow physician orders for daily scheduled treatment of surgical wounds. These practices occurred for 2 of 4 residents reviewed for providing care to maintain wellbeing (Resident #23 and Resident #105). Findings included: Resident #23 was admitted to the facility on 08/20/22 with diagnoses which included type-2 diabetes mellitus with chronic kidney disease, peripheral vascular disease (a condition of decreased blood flow in the lower extremities), and atherosclerotic heart disease (a heart condition caused by plaque buildup in the walls of arteries blocking blood flow to the heart). A review of Resident #23's physician orders revealed the following: · Plavix 75 milligrams by mouth daily for peripheral vascular disease · Aspirin 81 milligrams by mouth daily for atherosclerotic heart disease · Insulin Glargine (long-acting insulin) Pen-Injector (100 Unit/Milliliter) inject 15 unit subcutaneously (under skin) every 12 hours for type-2 diabetes · NovoLOG (Regular insulin) Solution Pen-Injector (100 Unit/Milliliter) inject subcutaneously before meals and	F0637 F0684	F684 Resident #23 bruise was assessed by the Nurse Practitioner on 11/17/2025 during her visit. Resident #23 and Resident #105 received treatment to their surgical sites on 11/17/2025. This was completed by the wound nurse. An audit was completed of the last 7 days of progress notes and the 24-hour shift to shift report by the Director of Nursing or designee to ensure that any new bruising or skin area was assessed by nursing. An audit was completed by the Director of Nursing or designee of the last 7 days of the ETAR to ensure that wound treatments were completed as ordered. The Director of Nursing or designee educated current licensed nurses including agency nurses on assessment of new skin area including bruising on 12/18/2025. The Director of Nursing or designee educated current licensed nurses including agency nurses on completing treatments as ordered and documentation on ETAR this was completed 12/18/2025. Any licensed nurse including agency not receiving the education will be educated by the Director of Nursing or designee prior to the beginning of their shift. New licensed nurses will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will review progress notes and the 24-hour shift to shift report during the morning clinical meeting to ensure that any new bruising or skin area has been assessed. This will be completed 5x weekly x 12 weeks. The Director of Nursing or designee will review the ETAR for completion during the morning clinical meeting to ensure all treatments have been completed 5x weekly x 12 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	12/19/2025

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F0684 SS = D	Continued from page 16 at bedtime per sliding scale. A progress note dated 11/15/25 at 7:30 PM written by Nurse #1 revealed the following: “A large bruise was noted on the left lower quadrant of abdomen. Bruise purple/blue in appearance”. An interview with Nurse #1 was conducted on 11/17/25 at 10:33 AM. Nurse #1 revealed that on the morning of 11/15/25 at 6:00 AM, a skin assessment was performed on Resident #23 which revealed no bruising. Nurse #1 stated she did not document that skin assessment in the electronic medical record. Nurse #1 further revealed when she arrived for her next shift on the evening of 11/15/25 at 7:30 PM, Resident #23 reported pain to abdominal area. Nurse #1 visualized the abdominal area and noted a large purple bruise to Resident #23’s left lower quadrant of abdomen. Nurse #1 stated she completed a progress note but did not complete measurements or documentation of the skin assessment in the electronic medical record. An interview with Unit Manager #1 was conducted on 11/16/25 at 1:42 PM. Unit Manager #1 revealed that she had come in at 3:00 PM on 11/15/25. Unit Manager #1 stated she assessed Resident #23 and noted a large bruise to the left lower quadrant of Resident #23’s left lower abdomen. Unit Manager #1 indicated that she did not complete measurements or documentation of the skin assessment in the electronic medical record. Unit Manager #1 did not complete a progress note. A telephone interview with Unit Manager #2 was conducted on 11/17/25 at 6:16 PM. Unit Manager #2 reported on the night of 11/16/25, Resident #23 stopped to show her the bruising on her abdomen. Unit Manager #2 stated that she did not document completion of the skin assessment in the electronic medical record or complete a progress note. An observation and interview with Resident #23 was performed on 11/16/25 at 11:16 AM. Resident #23 revealed a large area of diffuse (no defined shape) bluish purple bruising to left lower abdomen during the interview. Resident #23 stated that the area was painful and rated her pain level at an 8 out of 10 at that time (zero (0) meaning no pain and 10 meaning the worst pain). An interview with the NP was conducted on 11/18/25 at 3:01 PM. The NP stated that she was notified of the bruised area to Resident #23 on the morning of 11/17/25 and saw Resident #23 in clinic. The NP indicated that she assessed a hematoma (a collection of blood under	F0684		

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F0684 SS = D	Continued from page 17 the skin) to Resident #23's left lower quadrant of abdomen. The NP reported that area was tender per Resident #23 and appeared slightly swollen. The NP stated that the Plavix and aspirin that Resident #23 received daily placed her at risk for bleeding and could have contributed to the bruising. The NP stated Resident #23 also received insulin injections which are commonly administered in the abdominal area and may cause bruising to injection site areas. The NP indicated she ordered an abdominal x-ray and blood work to be performed STAT (immediately) on 11/17/25. The NP reported that labs were received and were within normal limits with no concerns about active bleeding. The abdominal ultrasound was still pending due to the ultrasound company's schedule. A review of laboratory results performed 11/17/25 at 3:00 PM revealed the following: · aPTT (activated partial thromboplastin time) (a blood test that measures how long it takes for blood to clot) within normal limits. · PT (prothrombin time) (a blood test that measures how long it takes for blood to clot) within normal limits. · INR (international normalized ratio) (a blood test that measures how long it takes for blood to clot) within normal limits. · CBC (completed blood count) (a routine blood test that measures the number of red blood cells, white blood cells, platelets, and hemoglobin and hematocrit levels) within normal limits. A review of Resident #23's abdominal ultrasound performed 11/19/25 at 8:00 AM revealed no subcutaneous (under the skin) fluid collection to left lower quadrant. An interview with the Director of Nursing (DON) was conducted on 11/19/25 at 11:22 AM. The DON reported that Resident #23 was administered Plavix and aspirin daily. Resident #23 had a large area of bruising noted to her left lower quadrant of abdomen initially noted on 11/15/25 by Unit Manager #1. Unit Manager #1 did not document measurements or assessment of the bruised area in Resident #23's electronic medical record. The NP was notified of the bruising and assessed Resident #23 in clinic on the morning of 11/17/25. The NP ordered blood work and an abdominal x-ray to be performed STAT on 11/17/25. The blood work had been performed and was within normal limits. The abdominal x-ray was performed the morning of 11/19/25 and the results were still	F0684		

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F0684 SS = D	Continued from page 18 pending at time of the interview. The DON stated that nurses should complete documentation of skin assessments when performed and complete a progress note in the electronic medical record. 2. Resident #105 was admitted to the facility on 10/24/25 with diagnoses which included trans-metatarsal amputation (surgical procedure to remove the forefoot including the metatarsal bone to preserve function of the foot) of the right foot, carbapenem resistant enterobacterales (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection), and type 2 diabetes. Review of surgical wound treatment order for Resident #105 written by the Nurse Practitioner (NP) dated 10/27/25 revealed clean open wound at right foot amputation site with Dakins 0.25% (solution used for cleaning infected and contaminated wounds), pack with Dakins 0.25% fluffed gauze (cotton roll used to cushion wound and secure dressing in place), cover with dry dressing (dry absorbent pad used to cover wound), abdominal pads (ABD)(pads used to absorb discharges from heavily draining wounds) and Kerlix (sterile bandage used to provide protection and manage wound drainage), perform daily and as needed. Review of the admission Minimum Data Set (MDS) assessment dated 10/30/25 revealed Resident #105 was cognitively intact and required minimal assistance with activities of daily living. The assessment also revealed Resident #105 had surgical wound to the foot, nutrition, and hydration interventions to manage skin problems, surgical wound care, application of medications and dressings, no behaviors or refusals of care. Review of revised care plan dated 11/06/25 revealed Resident #105 had a surgical wound to the right foot and was at risk for infection and complications. Interventions included keeping skin clean and dry as possible, complete treatment as ordered, observing the site for any signs or symptoms of infection, and enhanced barrier precautions per order. Review of November 2025 nursing schedule and daily assignment sheet revealed Nurse #12 was assigned to Resident #105 during first shift (7:00 AM to 7:00 PM) on Saturday 11/01/25 and Saturday 11/08/25. Nurse #2 was assigned during first shift on Saturday 11/15/25.	F0684		

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F0684 SS = D	Continued from page 19 Review of the November 2025 Treatment Administration Record (TAR) revealed Resident #105's daily scheduled surgical wound care was not documented on Saturday 11/01/25, Saturday 11/08/25, and Saturday 11/15/25 as completed. Nurse #12 who was scheduled to work first shift on Saturday 11/01/25 and Saturday 11/08/25, assigned on both dates to Resident #105 was unable to be reached for an interview. An interview was conducted with Resident #105 on (Sunday) 11/16/25 at 11:11 AM. He revealed that he had all of his right toes surgically removed, his right foot wound dressing was supposed to be changed daily, and the dressing had not been changed since Friday 11/14/25. He stated his wound was draining through his bandage and he needed his dressing changed. He revealed earlier this morning he had notified Nurse #2 that his wound was draining and he needed his dressing to be changed, and Nurse #2 had stated that she was not doing wound care and for him to find another nurse to do it. Resident #105 revealed that he currently had a bacterial infection and was afraid that his wound would become infected if his dressings were not changed daily. He stated that since he was admitted to the facility on 10/24/25, there had been times during the weekends when his wound dressing had not been changed and when he asked the nurse assigned to him (could not recall nurse's name) about changing his dressing they refused. Observation of Resident #105's wound dressing on his right foot revealed the top and bottom of the dressing covering the surgical wound to be soaked through with a wet brown discharge, areas of dried brown discharge, dated Friday 11/14/25, and initialed by the Wound Nurse. An interview with Nurse #2 on 11/16/25 at 11:20 AM revealed she had been assigned to Resident #105 yesterday 11/15/25 and today 11/16/25. She stated Resident #105 had asked her yesterday (11/15/25) and today (11/16/25) about changing his wound dressing but she was a contract nurse who had been working at the facility for one week and did not know anything about resident wound care orders or being responsible for providing wound care, had no plans to perform resident wound care, and any further questions regarding resident wound care could be directed to the Unit Manager.	F0684		

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F0684 SS = D	Continued from page 20 An interview was conducted with Unit Manager #1 on 11/16/25 at 11:25 AM. She stated the facility Wound Nurse performed resident wound care Monday through Friday and nursing staff were responsible for performing wound care scheduled for the evenings and on weekends. She revealed she was not aware of nursing staff refusing to perform wound care or resident wound care not being performed as ordered. UM #1 stated she would investigate why Resident #105's wound care had not been performed as ordered on the weekends and would speak with nursing staff immediately to ensure Resident #105's wound dressing was changed as soon as possible. An interview was conducted with the Nurse Practitioner (NP) on 11/18/25 at 1:29 PM. The NP revealed that she expected the facility nursing staff to follow her wound care orders as written. She stated she also expected the nursing staff to notify her with any questions or concerns regarding any resident's wound care orders and to inform her of any issues involving resident's wounds. The NP revealed Resident #105's wound care should be provided daily and as needed especially if the wound was draining to keep the wound from becoming infected. An interview on 11/19/25 at 9:31 AM with the Director of Nursing (DON). The DON stated she expected the wound treatments to be done as ordered. She stated she also expected that if nursing staff were not able to complete a wound treatment that they notify their nursing supervisor immediately. The DON revealed Resident #105 should have received his wound treatments daily and as needed per his wound orders. An interview was conducted with the facility's Medical Director on 11/19/25 at 4:53 PM. The Medical Director stated that he expected the nursing staff to follow physician orders for dressing changes and wound care. An interview was conducted with the Administrator on 11/20/25 at 11:01 AM. The Administrator revealed that she expected nursing staff to follow all orders, procedures, and protocols for providing resident wound care and should have provided Resident # wound care as ordered. She stated if nursing staff had questions regarding wound care orders or were not able to provide a resident's wound care as ordered then she expected them to inform their supervisor immediately.	F0684		

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F0684 SS = D F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Guardian, staff, Registered Dietician, Nurse Practitioner and Medical Director interviews, the facility failed to provide enteral feedings (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) per the physician orders for 1 of 3 residents reviewed for nutrition (Resident #63). The findings included: Resident #63 was admitted to the facility on 7/12/2016. Resident #63 had diagnoses that included diabetes mellitus (DM) type 2, anxiety, major depressive disorder, encounter for attention to gastrostomy (artificial opening in the stomach). Resident #63 had a physician's order dated 6/29/2024 for enteral feeding (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) for nutren 2.0 (feeding formula) at 46 milliliters (ml)/hour (hr) administered continuously from 9:00 PM to 9:00 AM daily.	F0684 F0693	F693 Resident #63 is receiving enteral feeding through a gastrostomy tube as ordered. The last 7 days of current residents with gastrostomy feeding tubes were reviewed by the Director of Nursing that enteral feedings were given as ordered. Review was completed on 12/15/2025. The Director of Nursing or designee educated current licensed nurses including agency regarding following provider orders for enteral tube feedings including to not turn tube feeding off without obtaining a provider order. This education was completed 12/18/2025. Any nurse, including agency nurse not receiving the education will receive education prior to the beginning of their shift by the Director of Nursing or designee. New licensed nurses will receive education by the Director of Nursing or designee during the orientation process. The Director of Nursing or designee will review progress notes and EMAR and ETAR of enteral gastrostomy tube feeding residents to ensure tube feedings completed as ordered 5x weekly x 12 weeks. The Director of Nursing or designee will random check resident who receive tube feeding 3x weekly x 12 weeks to ensure tube feeding is infusing as ordered. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	12/19/2025

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F0693 SS = D	Continued from page 22 Resident #63 had a physician's order dated 6/29/2024 for blood sugar checks four times daily before meals and at bedtime for DM. Resident #63 had a physician order dated 2/26/2025 for Lantus (long-acting insulin) inject 20 units subcutaneously at bedtime for diabetes mellitus if Capillary Blood Glucose (CBG) less than 65 only give 10 units. Notify provider if Capillary Blood Glucose (CBG) is less than 60 or greater than 450. This order was discontinued on 10/15/2025 and a new order was written. Review of Resident #63's care plans last revised on 2/27/2025 revealed: Resident was at risk for complications related to the need for an enteral tube feeding secondary to dysphagia and poor po intake with interventions that included check for residual prior to feeding administration, if greater than 120 milliliters (ml) hold feeding for 1 hour and recheck. If residual amount remains over 120ml call provider for further instruction. Review of the annual Minimum Data Set (MDS) dated 7/30/2025 revealed Resident #63 had severe cognitive impairment, indicated Resident #63 had a feeding tube, and received a mechanically altered and therapeutic diet and received 51% or more of diet and 501 cubic centimeters (cc)/day or more of fluid through a feeding tube, and weighed 95 lbs. A progress note dated 8/1/2025 written by Nurse #3 revealed Resident #63's blood glucose was 335 milligram/deciliter (mg/dl), tube feeding stopped early to help blood glucose stabilize. During a telephone interview on 11/17/2025 at 4:56 PM Nurse #3 revealed she worked at the facility on the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #3 confirmed she had turned off Resident #63's tube feeding early due to high blood sugar on the morning of 8/1/2025. Nurse #3 stated she thought it was nursing judgement. Nurse #3 stated she thought it would be better for the resident to have the tube feeding stopped than have an elevated blood sugar. Nurse #3 would not verify if this was the only time she turned Resident #63's tube feeding off early.	F0693		

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On 10/3/2025 Resident #63's had a new physicians order for enteral feeding nutren to increase flow rate by 10ml every 24 hours to a goal rate of 65ml/hr from 9:00 PM to 9:00 AM.

During an interview on 11/19/2025 at 8:20 AM Nurse #1 stated she had worked at the facility since September 2025 and currently worked the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #1 stated one night in October 2025, she did not recall the specific date, she was concerned about Resident #63 having a high blood sugar over 400, and that it would continue to get higher, and no orders for insulin sliding scale coverage. Nurse #1 stated she asked another nurse, she could not remember which one, what to do and the nurse told her to turn off the tube feeding. Nurse #1 stated she thought the nurse that had told her to turn off the tube feeding, had been turning off the tube feeding early due to high blood sugars, so Nurse #1 turned off Resident #63's tube feeding. Nurse #1 stated she did not document in the electronic medical record or on the MAR that Resident #63's tube feeding had been turned off early. Nurse #1 stated she had reported it to Unit Manager #4 who told her not to turn a resident's tube feeding off early, and no one else talked to her about it. Nurse #1 stated at the time she was more worried that the elevated blood sugar could cause a seizure.

During a telephone interview on 11/17/2025 at 10:00 AM, Resident #63's Guardian stated she had concerns that Resident #63's tube feeding was not running the full length of time it was ordered and discussed weight loss Resident #63 experienced. Resident #63's Guardian stated on several visits to Resident #63 around 9:00 AM in morning, the tube feeding was not running. Resident #63's Guardian stated she spoke to the Director of Nursing (DON), a unit manager and the Nurse Practitioner (NP #2) regarding her concerns and did not feel Resident #63's tube feeding had been monitored until she spoke to the facility after Resident #63 experienced weight loss.

During a telephone interview on 11/18/2025 at 7:05 AM Unit Manager #4 stated sometime around mid-October Nurse #1 reported to Unit Manager #4 that Resident #63's tube feeding had been held due to high blood sugar, and that other nurses had done it since Resident #63 had no insulin orders for sliding scale coverage for elevated blood sugars. Unit Manager #4 stated she

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F0693 SS = D	Continued from page 24 told Nurse #1 that a tube feeding was not supposed to be turned off for elevated blood sugars. Unit Manager #4 stated she reported the information to NP #2 who gave new insulin orders, and she reported the information to the Director of Nursing (DON). Review of Resident #63 clinical note written by NP #2 dated 10/15/2025 read in part: the NP #2 spoke with the DON regarding weight loss concerns from Resident #63's guardian. NP #2 noted it was unclear if tube feeding was not actually running for full 12 hours and that staff would be educated on appropriate administration of tube feeding. The NP #2's clinical note also read in part: "Telephone encounter 10/15: Per nurse- TF (tube feeding) was stopped by night shift nurse due to BS 446. Per nursing reports TF gets turned off frequently due to hyperglycemia. Reviewed blood sugars and added SSI. Will continue to monitor blood sugars and adjust plan of care based on changing condition. Will update guardian on new orders." During a telephone interview on 11/17/2025 at 4:29 PM NP #2 stated around the middle of October 2025 the Unit Manager #4 reported that when Resident #63 had elevated blood sugars the nurses had turned off Resident #63's tube feeding instead of calling the provider to get orders for insulin. NP #2 stated she had discussed Resident #63's weight loss with the DON and concerns regarding tube feeding being administered as ordered, and NP #2 thought the nurses had been educated by the DON. NP #2 stated she expected nurses to administer tube feedings as ordered and to notify the provider if a resident had elevated blood sugars. During a telephone interview on 11/17/2025 at 4:13 PM the Registered Dietician (RD) stated she was not made aware Resident #63's tube feeding had been turned off early by nurses but could not say for sure if that alone could contribute to the weight loss. The RD stated if Resident #63's tube feeding was turned off early she would not have received her minimal nutritional needs. The RD stated due to Resident #63's inconsistent intake of pleasure foods and supplements, her nightly tube feeding was determined to provide the minimal nutrition Resident #63 required. During an interview on 11/19/2025 at 4:50 PM the Medical Director (MD) stated having tube feeding cut off early for a short period of time could cause weight loss. The MD stated if the tube feeding had been turned	F0693		

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F0693 SS = D	Continued from page 25 off early long term it had the possibility to cause malnutrition and further damage. During an interview on 11/18/2025 at 8:45 AM the DON stated, she did not recall the specific day that Unit Manager #4 reported that Nurse #1 had turned off Resident #63's tube feeding at 6:00 AM because there were no orders for insulin coverage. The DON stated she went to the NP #2 and the RD when she was made aware and asked why Resident #63 was not on a diabetic tube feeding and got orders for insulin coverage, at this time the amount of nondiabetic tube feeding had been increased due to weight loss. The DON stated she educated Nurse #1 that Resident #63's tube feeding needed to run for the full 12 hours as it was ordered. The DON stated Nurse #1 was a new nurse and the DON was not sure that Nurse #1 knew you can't turn off the feeding early without an order. The DON stated she did not talk to any other nurses regarding tube feeding running the complete time it was ordered because she thought it was only Nurse #1 that had turned it off early. The DON stated she had not been told other nurses had also turned off Resident #63's tube feeding early. The DON was not aware of the progress note from 8/1/2025 that documented Resident #63's tube feeding was turned off early. The DON stated she expected nurses to follow orders and administer tube feedings as ordered. During an interview on 11/20/2025 at 7:10 AM the Administrator stated she expected the nurses to follow orders and administer tube feeding to residents as ordered.	F0693		
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, record reviews, and Nurse Practitioner and staff interviews, the facility failed	F0695	F695 Resident #126 received orders for oxygen administration and the oxygen in use sign was placed on the doorway frame of resident #126. This was completed 11/20/2025 by the charge nurse. An audit was completed on current residents to ensure that residents requiring oxygen had orders for oxygen and oxygen in use signage on their doorframe. This was completed 12/16/2025 by the Director of Nursing or designee. The Director of Nursing or designee educated current licensed nursing staff including agency staff on entering orders for oxygen when oxygen is in use and placing a oxygen in use signage on the door frame when	12/19/2025

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F0695 SS = D	Continued from page 26 to obtain a physician's order for a resident who was admitted from the hospital on continuous oxygen (Resident #126). The facility also failed to post cautionary signage outside of resident rooms that indicated the use of oxygen for 1 of 5 residents reviewed for respiratory care (Resident #126). Findings included: Resident #126 was admitted on 11/13/25 with diagnoses that included pneumonia. A review of Resident #126's admission orders revealed that Unit Manager #2 completed the admission. Resident #126's physician orders revealed no order for oxygen use. Resident #126's admission Minimum Data Set (MDS) dated 11/13/25 revealed that Resident #126 was admitted 11/13/25 and MDS was in progress at time of review. No oxygen or respiratory information was complete. A review of Resident #126's care plan updated on 11/14/25 revealed a plan for risk of respiratory complications. The stated goal was that Resident #126 would be free from respiratory complications. Interventions included administer oxygen as ordered, monitor for signs of respiratory distress, and check vital signs as needed. a. An observation of Resident #126 in her room on 11/16/25 at 12:41 PM revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. A second observation of Resident #126 in her room on 11/17/25 7:54 AM revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. A third observation of Resident #126 in her room on 11/18/25 7:42 AM revealed the oxygen concentrator in use via nasal cannula at 2 liters per minute. b. An observation of Resident #126 in her room on 11/16/25 at 12:41 PM revealed no cautionary oxygen in use signage was noted outside of Resident #126's room indicating oxygen was in use. A second observation of Resident #126 in her room on 11/17/25 7:54 AM revealed no cautionary oxygen in use signage outside of Resident #126's room indicating oxygen was in use. A third observation of Resident #126 in her room on	F0695	Continued from page 26 oxygen is in use in the resident room. This education was completed on 12/18/2025. Any licensed nurse including agency not receiving education will receive education by the Director of Nursing or designee prior to the beginning of their shift. New licensed nurses will receive education by the Director of Nursing or designee during the orientation process. The central supply clerk will make facility rounds 5x weekly x 4 weeks, then 3xweekly x 4 weeks, then weekly x 4 weeks to determine resident who are utilizing oxygen. The Director of Nursing or designee will audit resident oxygen list to ensure orders are in place and signage is on door. This will be completed 5x weekly x 4 weeks, 3x week x 4 weeks, weekly x 4 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	

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F0695 SS = D	Continued from page 27 11/18/25 7:42 AM revealed no cautionary oxygen in use signage outside of Resident #126's room indicating oxygen was in use. An interview with Medication Aide #1 was conducted on 11/18/25 at 1:08 PM. Medication Aide #1 stated Resident #126 received oxygen continuously. Medication Aide #1 indicated, she did not see an order for oxygen on the medication administration record and indicated she did not know who was responsible for applying the oxygen in use cautionary signs to resident rooms. Medication Aide #1 verbalized she had not noticed that Resident #126 did not have an oxygen in use sign on door. An interview was completed with Unit Manager #2 on 11/20/25 at 7:47 AM. Unit Manager #2 revealed that she could not recall if she completed the admission orders for Resident #126. Unit Manger #2 stated that orders were received from the hospital via discharge paperwork and entered into facility electronic medical record. Unit Manger #2 stated there were many admissions that day, and she could not remember if she initiated Resident #126's oxygen or not. Unit Manager #2 stated whoever initiated the oxygen should have placed the cautionary signage on Resident #126's door. An interview with the Nurse Practitioner (NP) was completed on 11/18/25 at 2:28 PM. The NP stated that Resident #126 was admitted from the hospital, and any orders on discharge paperwork would be entered by the nurse admitting the resident. The NP stated that she assessed Resident #126 on Monday 11/17/25 and stated that she was on oxygen via nasal cannula at time of assessment. The NP stated that Resident #126 had no respiratory difficulty or shortness of breath on assessment. The NP stated she did not know how the order for oxygen got overlooked. An interview was conducted with the Director of Nursing (DON) on 11/20/25 at 10:19 AM. The DON stated that oxygen orders should have been in place for oxygen use for Resident #126 prior to initiating oxygen. The DON further stated that oxygen-in-use cautionary signage should be posted outside the doors of all residents' rooms who used continuous oxygen.	F0695		
F0732 SS = B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis:	F0732	F732 Registered Nurse hours were added to the Daily staff posting for 09/08/2025, 09/09/2025, 09/15/2025, 09/17/2025, 9/19/2025, 10/27/2025, 11/07/2025,	12/19/2025

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(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
F0732 SS = B	Continued from page 28 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing information for 10 of 79 days reviewed for posted nurse staffing (09/08/2025, 09/09/2025, 09/15/2025, 09/17/2025, 09/19/2025, 10/27/2025, 11/07/2025, 11/14/2025, 11/17/2025, and 11/18/2025).	F0732	Continued from page 28 11/14/2025, 11/17/2025, and 11/18/2025 No residents were affected by this practice. The scheduler and service ambassadors were educated by the Administrator or designee on ensuring the staffing hours information is filled out on the daily staffing sheet each day with corrections following staffing changes. Education occurred on 12/16/2025. Any scheduler or service ambassador not receiving education will receive by the administrator or designee before the start of their shift. Any new scheduler and service ambassador will be educated during the orientation process by the administrator. The Administrator or designee will audit the daily staffing sheet for staffing hours 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345138**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/24/2025**

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F0732 SS = B	Continued from page 29 The findings included: The daily posted nurse staffing sheets were reviewed for the period of 09/01/2025 through 11/18/2025 and revealed the following: September 2025 did not have any RN documented as working for all 3 shifts on the following days: 09/08/2025, 09/09/2025, 09/15/2025, 09/17/2025, and 09/19/2025. October 2025 did not have an RN documented as working for all 3 shifts on the following day: 10/27/2025. November 2025 did not have any RN documented as working for all 3 shifts on the following days: 11/07/2025, 11/14/2025, 11/17/2025, and 11/18/2025. Review of employee timecard punches provided by the Administrator verified there had been RN coverage in the building for all the above dates and the RN staffing information posted was incorrect. During an interview on 11/19/2025 at 8:40 AM with the Scheduler, she stated she was responsible for the staff posting and she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing. During an interview on 11/19/2025 at 9:52 AM with the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being done, and the Scheduler did not know the posted staffing information should be updated with the actual staff on each shift.	F0732		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F0761	F761 Expired medication and flu vaccine not stored correctly were discarded. A new temperature log was placed on both medication refrigerators. The Director of Nursing or designee performed a med cart and med room audit and removed any expired medication and any medication not stored correctly. This was completed on 12/16/2025. The medication	12/19/2025

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F0761 SS = D	Continued from page 30 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, Consultant Pharmacist, and staff interviews, the facility failed to discard expired medications in 1 of 1 medication room, failed to store influenza vaccine per manufacturer recommendations, and failed to maintain a refrigerator temperature log for 2 of 2 refrigerators housing medications that required refrigeration. The findings included: 1. An observation of the medication room was conducted on 11/19/2025 at 1:45 PM with the Director of Nursing (DON). The observation revealed one medication room that contained 2 small refrigerators. One on the “upper” counter and one on the “lower” counter. The observation revealed 8 unopened, expired bottles of magnesium citrate. The expired bottles of magnesium citrate were located on the bottom shelf in the medication storage room. A review of the manufacture’s label affixed to the bottles of Magnesium Citrate indicated the expiration date was 10/9/2025 on all 8 bottles. During the observation the DON confirmed the expiration date and stated there should be no expired medications in the medication storage room or in the medication carts. She also stated the bottles of magnesium citrate should have been discarded. The DON further explained that all nursing staff were responsible for checking the medication rooms weekly for expired medications and the bottles of Magnesium Citrate should have been discarded.	F0761	Continued from page 30 storage refigerators had new temperature logs placed. The DON or designee to provided current licensed nurses and medication aides including agency licensed nurses and medication aides with education on the labeling and storage of drugs and process for checking the medication room refrigerators daily. This education completed on 12/18/2025. Any licensed nurse or medication aide not receiving the education will receive education by the Director of Nursing prior to the beginning of their shift. New licensed nurses and medication aides will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing and Nursing administration will conduct reviews of medications in the facility storage rooms, medication rooms, and medication carts for expired medications 3 times a week for 8 weeks, 1 time a week x 4 weeks. The Director of Nursing or designee will audit to ensure the refrigerator temperatures are documented on the medication refrigerators 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025 .	

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F0761 SS = D	Continued from page 31 An interview was conducted with the Administrator on 11/19/2025 at 3:30 PM. The Administrator stated that she expected all expired medications to be discarded and not available for use. 2. Review of the manufacture's storage recommendations that were undated for Seqirus Influenza vaccines (the brand in both refrigerators) indicated that vaccines should be refrigerated between 36-46 degrees Fahrenheit and should not be frozen, any vaccine that is frozen should be discarded immediately. It was recommended that temperatures be checked and recorded in the storage units twice a day. An observation of the “upper” refrigerator and temperature logs for September 2025 was conducted on 11/19/25 at 1:45 PM revealed a temperature was recorded once daily for 10 out of 30 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 20 out of 30 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. Further observation of the “lower” refrigerator and review of the logs for September 2025 revealed a temperature was recorded once daily for 10 out of 30 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 20 out of 30 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. An observation of the “upper” refrigerator and temperature logs for October 2025 on 11/19/25 at 1:45 PM revealed a temperature was recorded once daily for 18 out of 31 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 13 out of 31 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. Further observation of the “lower” refrigerator and review of logs for October 2025 revealed a temperature was recorded once daily for 18 out of 31 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 13 out of 31 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded	F0761		

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F0761 SS = D	Continued from page 32 twice daily as recommended. An observation of the “upper” refrigerator and temperature logs for November 2025 on 11/19/25 at 1:45 PM revealed temperatures had been recorded once a day for 2 out of 19 days on 11/10/25 and 11/11/25 and was at 32 degrees Fahrenheit on both days. No temperatures were recorded for 17 out of 19 days. The refrigerator contained Seqirus influenza vaccines. These temperature readings were outside of the manufacture’s recommendations for storing these medications. Recommended temperature recordings of twice daily were also not being followed for the month of November. Further observation of the “lower” refrigerator and review of November 2025 logs revealed temperatures had been recorded once a day for 2 out of 19 days on 11/10/25 and 11/11/25 and was at 32 degrees Fahrenheit on both days. No temperatures were recorded for 17 of 19 days. The refrigerator contained Seqirus influenza vaccines. These temperature readings were outside of the manufacture’s recommendations for storing these medications. Recommended temperature recordings of twice daily were also not being followed for the month of November. Observation of the Seqirus influenza vaccine vials revealed vials with clear liquid that had no free-floating particles and no evidence that the liquid had been frozen. An interview was conducted with the Director of Nursing (DON) 11/19/25 at 1:45 PM that indicated she expected staff to record temperatures twice a day, for both refrigerators and report to her or the administrator if temperatures were out of range. She reported all nursing staff were responsible for doing this and she was not aware of the temperature log having holes or temperatures being out of range. An interview with the Administrator on 11/19/25 at 3:30 PM indicated she expected staff to record temperatures for both refrigerators and report any out-of-range temperatures. She reported she was unsure why this was not being done correctly. An interview with facility Consultant pharmacist on 11/20/25 at 10:25 AM. He reported that vaccines were only good for 12 days when not being stored between 36-46 degrees Fahrenheit. He stated that a temperature reading of 32 degrees Fahrenheit would only be a concern if any of the medication had frozen. He reported that the pharmacy expected the facility to	F0761		

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F0761 SS = D	Continued from page 33 keep logs of temperature recordings of all refrigerators twice a day and any temperature outside of the 36-46 degrees Fahrenheit should be reported to pharmacy. He reported that if the vaccine did not freeze during the days the temperature was recorded to be 32 degrees Fahrenheit, then it would still be ok to administer for another four days, since the last known temperature was on 11/11/25.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to clean 1 of 2 ice machines (the dining room ice machine). This practice had the potential to affect beverages served to residents. The findings included: During the initial tour of the kitchen on 11/16/2025 at 9:40 AM an observation of the dining room ice machine was conducted with the Dietary Manager (DM). The observation revealed a black substance located on the plastic splash guard above the ice. The substance was not in contact with the ice in the ice machine.	F0812	F812 The ice machine was cleaned by the maintenance department on 11/16/2025. The ice machine received a deep clean from a service provider on 12/01/2025. An audit of all ice machines was conducted by the Maintenance Department on 12/16/2025. Education was provided to the maintenance department on ice machine sanitation by the administrator on 12/16/2025. Any new maintenance employees will receive education from the administrator during the orientation process. The Maintenance Director or designee will audit ice machine sanitation 3x weekly x 4weeks, weekly x 4 weeks and monthly x 1. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of compliance: 12/19/2025	12/19/2025

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F0812 SS = E	Continued from page 34 During an interview with the DM on 11/16/2025 at 10:15 AM, the DM stated the ice machine was less than six months old was still under warranty and the first full deep clean was scheduled for 12/01/2025 and then would be completed every 6 months. The DM stated maintenance was responsible for completing a wipe down cleaning of the ice machines monthly, but a new Maintenance Supervisor just recently started at the facility. The DM stated she expected the ice machine to be free of any black substances. The Maintenance Supervisor was in training and not available for interview. During an interview on 11/20/2025 at 6:45 AM the Administrator stated a new Maintenance Supervisor had been recently hired and the ice machines may not have been cleaned on schedule prior to the recent hire. The Administrator stated she expected the ice machine to be cleaned routinely.	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	F880 Resident #105 was placed on contact precautions on 11/24/2025 by the Director of Nursing. The Director of Nursing contacted the state health department on 11/24/2025 and initiated the process of resident testing. Testing was completed by local health department and facility staff on 12/11/2025. The Director of Nursing completed a review of current residents to determine if transmission-based precautions should be implemented. This was completed on 11/25/2025. The local health department recommended lab testing for a sample of current residents. This was completed by the nursing leadership team and sent to the state lab for testing. This was completed on 12/11/2025. The results were obtained on 12/17/2025 with no further abnormalities. The Director of Nursing educated current licensed nurses including agency licensed nurses. on the infection control policy regarding transmission-based precautions and enhanced barrier precautions and when to place residents on precautions. This education was completed on 12/18/2025. Any licensed nurse, including agency nurse not receiving education will receive education prior to the beginning of their shift by the Director of Nursing or designee.	12/19/2025

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F0880 SS = E	Continued from page 35 (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 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and Nurse Practitioner (NP), Local Health Department Nurse, State Health Department, staff and resident interviews, the	F0880	Continued from page 35 New licensed nurses will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will audit orders and lab results 5x weekly x 12 weeks to determine if transmission based or enhanced barrier precautions are indicated. This will occur as part of the morning clinical meeting. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of completion: 12/19/2025	

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F0880 SS = E	Continued from page 36 facility failed to implement their infection control policy and procedures for enhanced barrier precaution (EBP) for a resident who was positive for Carbapenem Resistant Enterobacterial (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection). In addition, the facility failed to immediately implement health department recommendations to initiate the process to test other residents for CRE. This deficient practice was identified for 1 of 6 residents observed for infection control practices and had the potential to affect other residents (Resident #105). The findings included: Review of revised facility “enhanced barrier precautions” (EBP) policy dated 3/26/24 revealed this policy might be indicated for residents known to be colonized or infected with bacterial organisms to include carbapenem resistant enterobacterial (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection), surgical wounds, and indwelling medical devices. The policy also revealed the EBP policy required the use of personal protective equipment (PPE), hand hygiene, and EBP signage to be placed on the wall or door outside of resident’s room. Resident #105 was admitted to the facility on 10/24/25. Review of Resident #105’s preliminary lab results for right foot wound culture dated 10/31/25 revealed the culture obtained on 10/27/25 was positive for carbapenem resistant enterobacterial (CRE). Review of NP order dated 10/31/25 received by the Director of Nursing (DON) for Resident #105 to be placed on enhanced barrier precautions for wound infection. Review of Resident 105’s final lab results received from the local county health department dated 11/13/25 revealed Resident #105’s right foot wound culture obtained on 10/27/25 was positive for CRE. Recommendations included immediate placement of resident on enhanced barrier precautions and further screening of residents to ensure no colonization. Review of nursing note dated 11/13/25 written by Nurse	F0880		

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F0880 SS = E	Continued from page 37 #3 indicated a return phone call was made to the communicable disease nurse from the local county health department and was informed Resident #105's right foot wound sample came back positive for CRE. NP was made aware. An interview was conducted with Nurse #3 on 11/18/25 at 4:00 PM. Nurse # revealed that she was working first shift on Thursday 11/13/25 and had received a telephone call from the nurse at the local health department stating Resident #105's final wound culture was available and had been faxed over to the facility and that he was positive for CRE. She stated she made a note in Resident #105's electronic medical record, retrieved the paper copy of the results off the fax, made copies of the results, and placed the copies of the results in the DON and the NP's box for review. Nurse #3 stated she did not review the results herself and was not aware of the recommendations. She revealed she had not been made aware of Resident #105's precautions status and that typically nursing staff were not notified of a resident's precautions status unless they had received the order for the resident to be placed on precaution or happened to see the order in the chart. She stated typically the only way staff are made aware of when a resident was placed on precautions for whatever reason was by the precaution signage placed on their door and if a resident did not have precautions signage on their door, then it was assumed they were not on any type of precautions. An interview and observation were conducted with Resident #105 inside of his room on 11/16/25 at 11:11 AM. He revealed that he recently had all his toes on his right foot surgically removed, his wound was currently draining and required daily wound care and was positive for a bacterial infection from his wound. Observation of Resident #105's wound dressing on his right foot revealed the top and bottom of the dressing covering the surgical wound to be soaked through with a wet brown discharge and areas of dried brown discharge. There was no barrier precaution signage located on or outside of Resident #105 door and no PPE present. An interview was conducted with Unit Manager #1 on 11/16/25 at 11:25 AM. Unit Manager #1 stated Resident #105 should have already been placed on enhanced barrier precautions, he was admitted with a surgical wound that required wound care, had an order for enhanced precautions from the NP, and was also positive for a bacterial wound infection. She revealed she was	F0880		

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NAME OF PROVIDER OR SUPPLIER: Lenoir Health and Rehabilitation Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 322 Nuway Circle , Lenoir, North Carolina, 28645		

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F0880 SS = E	Continued from page 38 on her way to place the enhanced precautions on Resident #105 door and that it was nursing staff responsibility to make sure all residents' orders were followed, residents were placed on the correct precautions, and that all staff were informed of resident's precaution status. An interview was conducted with Wound Nurse on 11/17/25 at 10:45 AM. The Wound Nurse stated that to her knowledge all residents requiring wound care were on enhanced barrier precautions to help prevent the spread of any bacteria and reduce infections. She revealed she was not aware and had not even noticed that Resident #105 was not on enhanced barrier precaution or that he did not have any precautions posted on his door. The Wound Nurse stated that she practices enhanced barrier precautions automatically with all her residents. She revealed the decision on whether a resident was placed on transmission based or enhanced barrier precautions was decided by the physician or the NP and they were responsible for writing the order for the precaution and nursing staff were responsible for making sure the order was being followed, precaution signage was placed on the door, and all staff were alerted to resident's precautions status. An interview on 11/19/25 at 9:31 AM with the Director of Nursing (DON). The DON stated she was not aware Resident #105 was not on enhanced barrier precaution, and no precaution signage had been placed on his door to alert staff of his precaution status. She revealed that per facility policy all residents requiring wound care should be placed on enhanced barrier precautions and their precaution signage placed on their door to inform staff of what type of precautions and protective equipment they should be using when providing care. She stated in reviewing Resident #105's electronic medical record she saw that she had signed off as receiving the verbal order from the NP on 10/31/25 for enhanced barrier precautions but did not recall why Resident #105 was not placed on enhanced barrier precautions at that time or why no precautions signage was placed on his door. The DON revealed that she had been out of the facility the previous week on vacation, had not checked her emails while on vacation, and did not have anyone designated to cover for her while she was gone so she did not receive Resident #105's final wound culture results dated 11/13/25 until she returned to work on Monday 11/17/25. She stated that she had also received what appeared to be some kind of infection control kit she believed was from the local health department, telephone messages and emails from both the local	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345138**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenoir Health and Rehabilitation Center	**322 Nuway Circle , Lenoir, North Carolina, 28645**

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F0880 SS = E	Continued from page 39 health department nurse and the state health department regarding the final wound culture results for Resident #105 but had not had the time to review the toolkit, return their calls, or respond to their emails. She revealed that as far as the testing of other residents for CRE she would have to speak with the Administrator to see how testing needed to be handled. The DON stated enhanced barrier precautions should be followed as ordered for all residents, precautions signage should be placed on doors to identify precautions status, and all staff should be made aware of any resident placed on barrier precautions to help in preventing the spread of infections. A telephone interview was conducted with the local health department nurse on 11/19/25 at 11:41 AM. The local health department nurse stated that on 11/13/25 he received the final results from the right foot wound culture obtained on 10/27/25 for Resident #105. He revealed once he received the final results, he contacted the facility and spoke with Nurse #3 to notify Resident #105 was positive for CRE, they would be receiving a copy of the results by fax, and that he would be dropping off a toolkit on 11/14/25 to assist the facility with making sure precautions were in place and explaining the testing of other residents to prevent the spread of the bacteria. He stated he also left a telephone message and sent an email to the DON explaining the final results and requested a return call to discuss the recommendations to prevent the spread of the bacteria. The local health department nurse revealed he dropped off the toolkit on the morning of Friday 11/14/25 to what he assumed was a facility nurse although he did not receive the nurse's name who stated they would leave the toolkit for the DON. He stated he had left a message and emailed the DON again on 11/16/25 requesting a return call to discuss the positive results for Resident #105 and at this time he had not received a returned telephone call or email response back from the DON or the facility. He revealed the state health department had also been trying to contact the DON regarding Resident #105's positive results for CRE and had also not received a response back. The local health department nurse stated it was highly important for someone from the facility to either return his or the state health department's telephone call so they could discuss Resident #105's results, importance of making sure enhanced barrier precautions were being followed, provide instruction and assistance with the testing of other residents at the facility, and assist with the ordering of the testing kits. He revealed this type of organism could easily be spread to other residents especially those	F0880		

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F0880 SS = E	Continued from page 40 with wounds and that was why it is so important for the facility to be educated on the bacteria, how the bacteria can be spread, precautions needed in place, and actions the facility needs to take to ensure all residents are safe and prevent the bacteria from spreading. A telephone interview was conducted with the state health department on 11/19/25 at 4:05 PM. The state health department stated they were notified on 11/13/25 of the final results from Resident #105's right foot wound culture showing positive for CRE. He revealed he contacted the local health department nurse on 11/13/25 and notified them of the results. He stated that he also left a telephone message and sent an email for the facility DON on 11/14/25 and 11/16/25 requesting a return call to discuss Resident #105's positive results and the recommendations on how the facility should proceed moving forward to prevent further spread of the bacteria to include the importance of Resident #105 being placed on enhanced barrier precaution and the testing of other residents in the facility to ensure the bacteria had not spread. He stated he had not received a return telephone call or an email response from the facility at this time. He revealed it was of high importance that someone from the facility reach out to him so they could discuss Resident #105's results, receive education on this particular bacterium and how it can be spread, importance of barrier precautions especially since can easily spread through wound care, identifying residents and obtaining sample size for further testing, and assist with ordering test kits. An interview was conducted with the Nurse Practitioner (NP) on 11/18/25 at 1:29 PM. The NP stated Resident #105 was admitted to the facility on 10/24/25 with a surgical wound to his right foot that required wound care treatment. She revealed during her first encounter with Resident #105 on 10/27/25 she noticed that his wound had a smell and could possibly be infected, so she ordered his wound treatments and a wound culture to be completed. She stated she received the preliminary results back from the culture on 10/31/25, gave a verbal order for Resident #105's antibiotic and for him to be placed on enhanced barrier precautions. The NP revealed she felt that enhanced barrier precautions were appropriate for Resident #105 and did not realize that he had not been placed on enhanced barrier precautions at that time. She stated she received a copy from the local county health department of Resident #105's final results from his wound culture on 11/14/25 which included recommendations for enhanced	F0880		

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F0880 SS = E	Continued from page 41 barrier precautions and testing of other residents to ensure the bacteria had not spread. She stated since she had already written an order for enhanced barrier precautions on 10/31/25 she did not write another order for precautions and that she did not have any input on the testing of other residents that would be a decision made by the DON and the Administrator. She revealed she assumed Resident #105 had been placed on enhanced barrier precautions from her order on 10/31/25 and was not aware that he had not been placed on barrier precautions or that all staff had not been made aware of his precaution status. The NP stated that she herself used barrier precautions with all of her residents and that it was of high importance that the facility followed precaution orders for all residents, all staff were made aware of residents' precaution status and were implementing the correct precautions to prevent the spread of infections. An interview was conducted with the Administrator on 11/20/25 at 11:01 AM. The Administrator revealed that she was not aware that Resident #105 had not been placed on enhanced barrier precautions prior to Sunday 11/16/25. She stated according to facility policy, any resident requiring wound care should have been placed on enhanced barrier precautions upon their admission. She revealed once Resident #105 received an order from the NP for enhanced barrier precautions on 10/31/25 the nursing staff including the DON should have made sure Resident #105 had been placed on enhanced barrier precautions, precautions signage was placed on door, and all staff were made aware of precaution status. The Administrator stated that she was not made aware until yesterday 11/19/25 of Resident #105's final results showing he was positive for CRE, that the local and state health department had left telephone messages and emails for the DON regarding the positive test results and those had gone unreturned, or of the recommendations for further resident testing. She revealed they had spoken with state health department this morning regarding Resident #105's positive results, had identified a sample size of 48 residents that would require further testing, and the state health department would be mailing them the test kits.	F0880		