STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345343**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldsboro Rehabilitation and Healthcare Center	**1700 Wayne Memorial Drive , Goldsboro, North Carolina, 27534**

(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 The survey team entered the facility on 12/8/25 to conduct a recertification and complaint investigation survey and exited on 12/11/25. Additional information was obtained on 12/16/25 and 12/17/25. Therefore, the exit date was changed to 12/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DD739-H1.	E0000		01/01/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 12/8/25 to conduct a recertification and complaint investigation survey and exited on 12/11/25. Additional information was obtained on 12/16/25 and 12/17/25. Therefore, the exit date was changed to 12/17/25. Event ID #1DD739-H1. The following intakes were investigated: 2682329, 2651879, 2619712, 834801, 834849, 834848, and 834845. Intake 2682329 resulted in immediate jeopardy. 3 of the 11 complaint allegations resulted in deficiency. Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/11/25 and was removed on 10/12/25. An extended survey was conducted.	F0000		01/01/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689	"Past Noncompliance - no plan of correction required"	01/01/2026

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

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

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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with staff, Nurse Practitioner and Physician, the facility failed to provide the necessary supervision to prevent an avoidable accident for a resident who had severe cognitive impairment, was on a pureed diet, had a diagnosis of dysphagia (difficulty swallowing), and required staff assistance with eating due to his inability to control the speed and/or quantity of food that entered his mouth (Resident #132). On Saturday, 10/11/25 around 8:30 AM, Nurse Aide #8 left a meal tray in front of Resident #132 so she could pass the remaining meal trays. Shortly after meal trays were passed, Nurse Aide #1 found Resident #132 unresponsive and not breathing. Nurse Aide #1 called for help and code blue (life threatening medical emergency) was called. Cardiopulmonary Resuscitation (CPR) was performed by nursing staff until Emergency Medical Services (EMS) took over when they arrived at the facility. EMS was able to obtain the resident's pulse, and Resident #132 was transferred to the hospital. Resident #132 was intubated (a hollow, plastic tube placed into the windpipe to keep airways open) after he experienced a second cardiac arrest in the emergency department and was transitioned to the Intensive Care Unit (ICU). Hospitalists suspected the resident suffered a severe anoxic brain injury (occurs when the brain does not receive oxygen) and the decision was made on 10/16/25 to transition Resident #132 to comfort measures only. The resident was transferred to hospice care on 10/17/25 and expired on 10/18/25. His death certificate indicated the cause of death was occlusion of airway by bolus of food (when food blocks the throat). This deficient practice affected 1of 3 residents reviewed for accidents. Findings included: Resident #132 was readmitted to the facility on 8/4/22 with diagnoses including stroke, dementia, and dysphagia. A physician order dated 8/4/22 indicated Resident #132 was a full code status and required CPR during a medical emergency.	F0689		

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F0689 SS = SQC-J	Continued from page 2 A physician order dated 7/28/25 revealed that Resident #132 received a regular diet, puree texture, nectar thick liquids, double portions, and pudding at every meal. A quarterly Minimum Data Set (MDS) assessment dated 8/28/25 revealed that Resident #132 was severely cognitively impaired, did not have any swallowing difficulties coded, and required setup/clean up assistance with eating. A care plan last reviewed on 8/28/25 revealed that Resident #132 had an activities of daily living (ADL) self-care performance deficit related to decreased mobility. Interventions included that Resident #132 was dependent on staff for eating, and staff needed to observe intake during meals. The undated Kardex (a summary of resident's needs for nursing staff to review) for Resident #132 revealed that he was dependent on staff for eating and staff were instructed to observe his intake of meals. Speech Therapy notes were reviewed from August through October of 2025. The following details written by the Speech Therapist (ST) related to Resident #132's eating assistance/behaviors were as follows: - 9/3/25: A Nurse Aide was reminded to feed Resident #132 due to impulsive self-feeding. - 9/4/25: Training for Nurse Aides regarding swallowing recommendations was ongoing. Resident #132 remained at high risk of aspiration (when food or liquid goes into your airway and lungs) given the severity of cognitive deficits and extreme impulsiveness with self-feeding. - 9/5/25: Resident #132 continued to be extremely impulsive when feeding himself secondary to severe cognitive deficits. Ongoing training with nursing staff regarding swallowing recommendations included feeding Resident #132 to decrease aspiration risks, small bites, liquid wash following each bite, and nectar thick liquids with a cup only. Response to the training with Nurse Aides was good. - 9/11/25: Discussed Resident #132's status with nursing who reported improved adequacy of intake with decreased coughing by following the Speech Therapist's instructions with no overt signs or symptoms of aspiration. - 9/16/25: Nursing staff were aware of the need for	F0689		

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F0689 SS = SQC-J	Continued from page 3 supervision during eating due to Resident #132's impulsivity. An interview was conducted with the Speech Therapist on 12/10/25 at 12:40 PM. She revealed that Resident #132 was referred to her services on 8/19/25 due to coughing and congestion with meals. She performed an assessment and determined that pureed foods with nectar thick liquids were most appropriate. Resident #132 needed to be positioned upright while eating and for 20 minutes after. The Speech Therapist stated that Resident #132 needed a slowed eating rate due to cognition and an impulsive very rapid eating pattern. He also required a drink between each bite to slow down the eating process. From 8/19/25 through 9/16/25, the Speech Therapist stated she educated every Nurse Aide that she could during lunch and supper meals about Resident #132 needing supervision during meals due to his impulsivity and high risk of aspiration/choking. They all expressed understanding. If staff were not present with the meal tray in front of Resident #132, he would eat rapidly and not stop coughing a lot. If he was left unsupervised, the Speech Therapist stated that there was a risk of aspiration, and he could choke on pureed foods. She indicated Resident #132 had no impairment of his upper extremities. A nursing progress note dated 10/11/25 at 9:54 AM written by the Weekend Nurse Supervisor revealed that she responded to a code blue announcement for Resident #132's room. When she entered the room, Nurse #2 and Nurse #3 were in the process of performing CPR on Resident #132. The Weekend Nurse Supervisor called 911. CPR continued as the nurses took turns performing compressions. EMS arrived approximately 10 minutes or less after the call. They took over the situation. After working on Resident #132 for approximately 20 minutes, EMS stated he had a pulse, and they transported him via stretcher to the Emergency Department (ED). Resident #132's family member was contacted and updated of Resident #132's condition. Nurse Aide #8's witness statement dated 10/11/25 at 9:46 AM indicated on 10/11/25 around 8:00/8:30 AM, she (Nurse Aide #8) was passing out meal trays to her assigned rooms, including Resident #132's room. She looked at Resident #132's meal ticket to make sure it was for the correct resident. She recalled Resident #132 received puree consistency with nectar thickened liquids. Nurse Aide #8 made sure Resident #132 was sitting up in bed at a 90-degree angle. She set up his tray and placed it in front of him. Resident #132 was alert with his eyes open and was able to eat the meal tray that was given. She then left the room to pass the	F0689		

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F0689 SS = SQC-J	Continued from page 4 rest of her assigned breakfast trays. A telephone interview was conducted with Nurse Aide #8 on 12/09/25 at 3:02 PM. She revealed that she was assigned to Resident #132 on 10/11/25 during the day shift. Before she passed the breakfast meal tray to Resident #132, she made sure she gave him the correct meal tray and that he was sitting up at 90 degrees. Nurse Aide #8 was verbally told by other nurse aides (names unknown) that Resident #132 could feed himself while seated at a 90-degree angle and did not require assistance with eating. She never worked with Resident #132 prior to 10/11/25. She was hired around 9/22/25 and finished her orientation with another Nurse Aide (name unknown) on 10/9/25. A follow up telephone interview was conducted with Nurse Aide #8 on 12/16/25 at 3:02 PM. She clarified that on the morning of 10/11/25 when she served Resident #132 his meal tray, she took the lid off his meal and set up the meal tray, so it was ready for the resident to eat. She stated that she checked the meal ticket and ensured the meal tray she served to Resident #132 had his name on the meal ticket. She could not recall what was on the meal tray. An interview was conducted with Nurse Aide #1 on 12/09/25 at 1:51 PM., She revealed that she was assigned to some of the rooms on Resident #132's hall on 10/11/25 during the day shift. Nurse Aide #1 indicated that she was the one who found Resident #132 unresponsive in his room around 8:30 AM. She noticed the meal trays were put in front of Resident #132 and his roommate, and both residents required assistance with eating. Nurse Aide #1 indicated she noticed that Resident #132 ate some of the food on his plate and was unresponsive but warm to touch. She yelled for Nurse #2 to help and stayed with Resident #132. Nurse #2 entered the room, called for help from Nurse #3, who was in the hallway, and called out for someone to call 911. Code blue was then announced, and Nurse Aide #1 stepped out of the room. Nurse Aide #1 stated she did not see who passed the meal trays for Resident #132 and his roommate. She revealed that if a meal tray was left in front of Resident #132, he would "shovel food in his mouth" and as a result he needed assistance with eating. Nurse #2 was interviewed on 12/09/25 at 12:59 PM. He revealed that Nurse Aide #1 called him into Resident #132's room on 10/11/25 around 8:30 AM and told him that Resident #132 was not breathing. He then assessed the resident, and he was not breathing and had food in his mouth. Nurse #2 stated that Resident #132 had	F0689		

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F0689 SS = SQC-J	Continued from page 5 choked and was not responsive. He could not recall the consistency of the food in his mouth. However, he suctioned out whatever was in Resident #132's mouth during CPR. Nurse #2 explained that he announced code blue for help. He stated he was the first nurse in the room. All nurses responded, and Nurse #3 took charge. CPR was initiated, and someone called 911. EMS arrived shortly after and took over CPR on Resident #132. Nurse #2 stated he was unsure what happened after that. Nurse #2 added that he could not recall the details of the meal tray or meal ticket in Resident #132's room. An interview was conducted with Nurse #3 on 12/10/25 at 4:36 PM. She revealed that on 10/11/25 Nurse #2 yelled out code blue from the room of Resident #132. She was in the hallway and immediately responded. She observed Resident #132 was sitting up. Nurse #3 stated she laid Resident #132 flat to start CPR because he did not have a pulse and was not breathing. She was the only nurse in the room at the time because Nurse #2 went to get the crash cart and make the announcement for code blue. Nurse #3 stated she hollered for suctioning due to food debris in his mouth. As she was performing compressions, more food came up and she removed it by suctioning the resident. EMS arrived and they took over. They were able to get a pulse and Resident #132 was breathing when he left the facility. Nurse #3 stated that Resident #132 was to be supervised while eating because he ate very fast and "shoveled food into his mouth." The resident was able to eat without assistance, but in her opinion he should not because he ate too fast and was at risk for aspiration or choking. Nurse #3 reported she did not get a chance to observe Resident #132's meal tray in the room. The Weekend Nurse Supervisor was interviewed on 12/10/25 at 11:26 AM. She revealed that for residents who were diagnosed with dementia, nursing staff should look at the Kardex to identify the photographic picture of the resident in question. Prior to the incident on 10/11/25, nursing staff were instructed to not put the meal tray in front of residents who needed assistance with eating until staff were ready to help. This was due to the risk of aspiration or choking if the residents attempted to eat without supervision, including Resident #132. The Weekend Nurse Supervisor indicated on 10/11/25 around 8:30 AM, she was taking care of another resident when she heard the code blue announcement and saw nurses running toward Resident #132's room. She heard Nurse Aide #1 say, "he is not breathing." Nurse #2 and Nurse #3 were performing CPR on Resident #132. Nurse #3 yelled for someone to call 911. Nurse #2 was assigned to Resident #132 that morning. The Weekend Nurse Supervisor indicated she ran	F0689		

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F0689 SS = SQC-J	Continued from page 6 out of the room and called 911. She indicated EMS came down the hall 5 to 7 minutes after she called 911. EMS took over CPR when they arrived and were able to obtain a pulse. The hospital discharge summary for Resident #132 dated 10/17/25 revealed that he was admitted on 10/11/25 after he experienced cardiac arrest (heart stopped beating) from choking on food. Resident #132 was intubated after a second cardiac arrest in the emergency department and was transitioned to the Intensive Care Unit (ICU) for further management. Severe anoxic brain injury (occurs when the brain does not receive oxygen) was suspected by the hospitalists, and the decision was made on 10/16/25 to transition Resident #132 to comfort measures only. He was discharged to hospice care on 10/17/25. A Certificate of Death dated 10/18/25 revealed that Resident #132's cause of death was "occlusion of airway by bolus of food." Director of Nursing (DON) #1 was interviewed on 12/10/25 at 11:46 AM. She revealed that she was the previous DON and she trained DON #2 after she (DON #2) started in the DON position on 9/22/25. DON #1 stated that nursing staff should pass out all meal trays for residents who ate independently and leave the meal trays for those who needed assistance with eating on the meal cart, including Resident #132. Staff should only pass meal trays to those who needed assistance with eating when they were ready to provide assistance. DON #1 indicated nursing staff should be present in the room for those who needed assistance, and meal trays should not be left by staff in the room. An interview was conducted with DON #2, the current DON, on 12/11/25 at 3:22 PM. She stated she did not feel comfortable speaking on the incident with Resident #132 that occurred on 10/11/25 because DON #1 was still training her at that time. However, she stated that residents who needed to be supervised during meals should not have access to the meal tray without staff present. The Administrator was interviewed on 12/09/25 at 2:10 PM. She indicated on 10/11/25, she received a phone call from DON #2. She said there was an incident, and Resident #132 was sent to the hospital after being found unresponsive. After the incident on 10/11/25 the Administrator spoke to Nurse Aide #8 who stated that she gave Resident #132 the correct meal tray. The Administrator revealed that Resident #132 had the ability to eat independently but needed to be closely	F0689		

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F0689 SS = SQC-J	Continued from page 7 supervised; however, Nurse Aide #8 did not remain in the room on 10/11/25 to supervise Resident #132. The Administrator indicated Nurse Aide #8 was sent home pending an investigation of the choking incident. A follow-up interview was conducted with the Administrator on 12/11/25 at 4:07 PM. She revealed that Nurse Aide #8 should have remained in the room with the meal tray for Resident #132, which was conveyed in the resident's Kardex for nursing staff to review. An interview was conducted with the Nurse Practitioner on 12/11/25 at 9:28 AM. She revealed that Resident #132 was supposed to be supervised during meals. Also, recommendations made by Speech Therapy were important to implement for Resident #132's safety such as, nursing supervision during meals, sitting up straight during and after meals, and slowing down his eating by having the resident take a sip of liquid between each bite. The aspiration risk for Resident #132 was attributed to stroke and cognitive decline. The Nurse Practitioner stated that a meal tray should not have been left with Resident #132 without supervision, and she agreed with Speech Therapy's recommendations/education for nursing staff. A telephone interview was conducted with the Medical Director on 12/11/25 at 9:35 AM. She revealed that she was notified that Resident #132 was left unattended during the meal on 10/11/25. She stated that Resident #132 had the habit of "shoveling food into his mouth," causing him to choke and put him at risk of aspiration. The Medical Director stated that Resident #132 should not have been left alone with the meal tray in front of him. The Administrator was notified of Immediate Jeopardy on 12/10/25 at 9:53 AM. The facility provided the following corrective action plan with a completion date of 10/12/25: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #132 was provided with his breakfast tray by Nurse Aide (NA) #8. Nurse Aide #8 walked out of the resident's room. Shortly after the resident was observed by another NA to be unresponsive. This NA notified the hall nurse, and the hall nurse cleared the patient's airway and suctioned the resident. The hall nurse immediately called 911. The resident was breathing with a pulse and was transferred to the	F0689		

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F0689 SS = SQC-J	Continued from page 8	F0689		

hospital. The resident can feed himself but supervision by staff was recommended by the Speech Language Pathologist (SLP). The SLP provided this education to nursing staff on 9/8/25 related to the high risk of aspiration/choking due to Resident #132's impulsiveness of feeding himself at a rapid rate. The required feeding assistance was noted on the resident's Kardex. The charge nurse completed a Risk Management and Situation Background Assessment Recommendation (SBAR). The SBAR indicated the resident was found unresponsive during breakfast. The Administrator, Director of Nursing, Medical Director, and Responsible Party were all notified by the hall nurse on 10/11/25. Resident #132's diet consistency, supervision needs, and feeding requirements were reviewed by the Director of Nursing and Administrator on 10/11/25. The Registered Dietician confirmed that Resident #132 was appropriate for a puree diet with thickened liquids, with staff supervision required during meals. The root cause analysis was determined by the Administrator, Director of Nursing, and Eastern Regional Administrator on 10/11/25 that Nurse Aide #8 did not provide resident supervision during meal. Nurse Aide #8 was suspended pending investigation. The resident remained in the hospital until transferred to another facility where he expired.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents that require supervision during feeding have the potential to be at risk. Nurse Management/designee reviewed all residents' kardex and audited the assistance level required while feeding, completed 10/11/25. It was concluded that 9 residents were dependent on staff for feeding and 7 residents required supervision of staff. DON #1/designee completed observation rounds during lunch and dinner meals on the identified residents that needed feeding assistance on 10/11/25 with no other concerns identified.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 10/11/25, Nurse Management initiated a facility-wide education for all licensed nurses/NAs on meal delivery and feeding assistance, focusing on proper resident identification, verification of correct diet orders, and adherence to required supervision levels during meals. Licensed nurses/NAs were educated on utilizing the kardex to locate information needed to determine

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F0689 SS = SQC-J	Continued from page 9 supervision required with feeding. No licensed nurses/NAs are permitted to work after 10/11/25 without education in meal tray delivery until they have completed this required education. All licensed nurses/NAs were educated by Nurse Management or the Administrator via phone or with one-on-one in-service. The only staff that pass resident meal trays are NAs/licensed nurses. The Nurse Manager confirmed this education was completed prior to staff being scheduled and if staff were not scheduled, they were contacted via phone. This training has been added to the orientation program for all licensed nurses/NAs effective 10/11/25. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing, Nurse Manager, and Administrator will conduct audits of resident meal tray delivery beginning on 10/11/25. These audits include validation of accurate meal tickets, correct resident identification, and confirmation that residents receive the correct diet with the required level of assistance as indicated on the resident Kardex and diet order. Audits began on 10/11/25. The decision to monitor and take to Quality Assurance Performance Improvement (QAPI) was made on 10/11/25 by the Regional Clinical, Regional Administrator, Administrator, Medical Director, Nurse Management, and Director of Nursing. The audits were completed by observation and occurred on weekdays and weekends for varying meals with all three meals incorporated into the audit. The audits were done two meals per day, five days per week for six weeks. Any concerns identified will be addressed and corrected immediately. Results of these audits will be reviewed during the October QAPI meeting to determine whether additional monitoring is needed. Attendees on 10/22/25 at the QAPI meeting were Medical Director, Administrator, Pharmacist, Social Services, Nursing Management, Environmental Services Manager, Maintenance Director, Infection Preventionist, Therapy Manager, Admissions, and Treatment Nurse. Results were discussed to determine what additional monitoring was needed. The Administrator is responsible for ensuring completion and oversight of this Plan of Correction. Alleged Date of Immediate Jeopardy Removal and Compliance: 10/12/25 The facility's corrective action plan was validated on 12/11/25. The validation process included staff interviews, record reviews, review of education provided to nursing staff, and review of initial	F0689		

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F0689 SS = SQC-J	Continued from page 10 auditing and monitoring audits. The education for staff included meal delivery and eating assistance, focusing on proper resident identification, verification of correct diet orders, and adherence to required supervision levels during meals. Observations of meal tray service during the investigation were conducted with no concerns. The immediate jeopardy removal date and compliance date was verified as 10/12/25.	F0689		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an	F0756	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #4 had a medication regimen review completed for October 2025 on 12/11/2025 by Consultant Pharmacist. Director of Clinical Operations for Pharmacy Provider has provided re-training and education to Pharmacist #2 on 12/15/25 regarding the monthly medication review processes and the policy and procedure from the Pharmacy Policy and Procedure Manual. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. A 100% audit was completed for the October 2025 Drug Regimen Reviews. This audit was completed by Pharmacist #2 Supervisor on 12/11/2025 and no other concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Clinical Operations will provide education to all North Carolina Consultant Pharmacists and to all new hires regarding the monthly medication review processes and the policy and procedure from the Pharmacy Policy and Procedure Manual, Medication Monitoring – Medication Regimen Review & Reporting by January 5, 2026 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	01/07/2026

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F0756 SS = D	Continued from page 11 irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Pharmacist interviews, the facility failed to have a copy of a monthly medication regimen review (MRR) available for review for 1 of 5 residents reviewed for unnecessary medications (Resident #4). Findings included: Resident #4 was readmitted to the facility on 6/23/25 with diagnoses that included hypertension, hyperlipidemia, stroke, peripheral vascular disease, chronic kidney disease, depression and insomnia. Review of Resident #4's medical record revealed that a monthly pharmacist medication regimen review was missing for the month of October 2025. An interview was conducted with the Pharmacist #1 on 12/11/25 at 2:03 PM. She revealed that Pharmacist #2 was traveling out of state and unavailable for interview. Resident #4's pharmacy documentation for October 2025 could not be found. Pharmacist #1 stated that Pharmacist #2 told her she had paper notes related to the October 2025 medication regimen review (MRR) for Resident #4; however, Pharmacist #1 could not locate any documentation to confirm the October MRR was completed. The Director of Nursing (DON) was interviewed on 12/11/25 at 3:24 PM and revealed she received monthly MRRs and recommendations from Pharmacist #2. Residents without any recommendations were included in a general list, and specific recommendations for residents were written out on a separate communication form. The DON stated that the October MRR provided to her by Pharmacist #2 did not have Resident #4's name included on the list. The DON stated that an MRR should be completed by a licensed Pharmacist at least monthly for all residents in the facility. The Administrator was interviewed on 12/11/25 at 4:08 PM. She revealed that the October 2025 MRR for Resident #4 should have been completed in a timely manner by the Pharmacy representative.	F0756	Continued from page 11 The Director of Clinical Operations or Lead Consultant Pharmacist will complete an audit of the "Current Resident Listing with Medication Regimen Review Activity" report monthly for 3 months, or until 100% compliance is noted for 3 consecutive months. Consultant Pharmacist, or designee, will bring any concerns identified to the QAPI committee monthly for 3 months. Alleged date of compliance: 1/07/2026	

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F0756 SS = D F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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.	F0756 F0880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurses Aide (NA) #4 and NA #5 performed Resident #109 urinary catheter care without the required gown in place. NA #4 and NA#5 were immediately educated on following Enhanced Barrier Precautions (EBP). Resident #109 was assessed by a Licensed Nurse (LN) to determine if any adverse outcomes resulted from the failure to follow EBP during urinary catheter care. No signs or symptoms of infection of injury were identified at the time of the assessment. The resident was monitored for any delayed signs of infections by LN. The care plan was reviewed and reflects continued adherence to EBP requirements. Resident #109 continues to receive catheter care in accordance with EBP, with staff utilizing required personal protective equipment (PPE), including gowns and gloves for all high contact care activities. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility identified that all residents requiring Enhanced Barrier Precautions (EBP) had the potential to be affected by the deficient practice. The facility management/designee completed a 100% audit of all residents to determine which residents met criteria for EBP and that NA/LPN and Therapy Staff were observed during care to ensure they were donning and doffing PPE in accordance with EBP. The audit verified that residents requiring EBP were correctly identified, had appropriate signage posted at the entrance to the resident room, and that EBP requirements were reflected in the resident's care plan. Any discrepancies identified during the audit were immediately corrected to ensure staff awareness and compliance with Enhanced Barrier Precautions. All new admissions will be evaluated by the Director of Nursing (DON) or designee to determine if they meet the criteria for EBP and appropriate signage will be placed at their door. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/11/25 the facility initiated a facility wide	01/07/2026

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F0880 SS = D	Continued from page 13 (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 observation, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse Aide (NA) #4 and NA #5 failed to apply personal protective equipment (PPE) during urinary catheter care for a resident on Enhanced Barrier Precautions (EBP). This deficient practice was for 2 of 2 staff members observed for infection control practices (NA #4 and NA #5). The findings included: The facility's Infection Prevention and Control Program (IPCP) policy last revised 10/2018 indicated that the facility was responsible for establishing and maintaining an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The policy further noted the importance of infection prevention, which included education of staff to ensure they adhere to proper techniques and procedures. The facility's Enhanced Barrier Precautions (EBP) policy last revised 7/26/22 revealed EBP was to be	F0880	Continued from page 13 education for all LN/NA and therapy Staff on correct donning and doffing of PPE when performing high contact care activities with a resident identified as requiring EBP. This education included the requirement for all LN/NA and therapy staff to check for EBP signage to verify status prior to initiating care. This education was completed by 1/5/26 and no LN/NA or therapy staff will be permitted to work after 1/5/26 without receiving this required education from the Director of Nursing (DON) or designee. This training has been added to the orientation program for all LN/NA and therapy staff effective 1/5/2026 to be provided by DON or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON, Nurse Manager, or designee will conduct audits of correct donning and doffing of PPE for patients that have met the criteria for EBP beginning on 1/2/2026. These audits include staff correct donning and doffing of PPE when providing high contact activities with residents on EBP. The audits will observe 3 staff members randomly, 3 days per week for 12 weeks. Any concerns identified will be addressed and corrected immediately. Results of these audits will be brought to QAPI by the DON or designee and will be reviewed for 3 months to determine what changes and additional monitoring is needed. The Administrator is responsible for ensuring completion and oversight of this Plan of Correction. Alleged Date of Compliance: 1/7/2026	

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F0880 SS = D	Continued from page 14 utilized for all residents with an indwelling medical device which included a urinary catheter. The policy further noted that personal protective equipment (PPE) for EBP was necessary when performing high-contact care activities which included urinary catheter care and required staff to wear gloves and gown when the care was provided. On 12/11/25 at 10:39 am Resident #109 had signage posted at the entrance of the room that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gowns for the following high-contact resident care activities which included urinary catheter care. A clear plastic supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves. A continuous observation of urinary catheter care was conducted on 12/11/25 from 10:40 am through 10:47 am for Resident #109. NA #4 and NA #5 were observed to perform hand hygiene, don clean gloves, and began to perform urinary catheter care for Resident #109. NA #4 and NA #5 performed Resident #109's urinary catheter care without the required gown in place. An immediate interview was conducted with NA #5 on 12/11/25 at 10:48 am who revealed she had been educated on EBP and the need to use PPE when performing urinary catheter care. NA #5 stated she just forgot to use the gown when she assisted NA #4 with Resident 109's urinary catheter care. During an interview with NA #4 on 12/11/25 at 10:49 am she revealed a gown was supposed to have been worn when she provided urinary catheter care to Resident #109. NA #4 stated she was nervous and forgot to put on the gown when the care was provided. An interview was conducted with the Infection Preventionist, who was also the facility's Director of Nursing, on 12/11/25 at 1:34 pm. The Infection Preventionist stated that all facility staff, including NA #4 and NA #5, had received education regarding EBP and the use of PPE when specific tasks were performed. The Infection Preventionist stated the staff were responsible for looking at every resident room entered for signage to see if the resident was on EBP and to use the appropriate PPE as noted. The Administrator was interviewed on 12/11/25 at 4:10 pm and revealed that NA #4 and NA #5 should have donned and doffed the required PPE according to the signage on the door for Resident #109 when they provided the	F0880		

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F0880 SS = D	Continued from page 15 urinary catheter care.	F0880		