STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	**9200 Glenwater Drive , Charlotte, North Carolina, 28262**

(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 from 7/21/25 through 7/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D102B-H1.	E0000		
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 7/21/25 through 7/24/25. Event ID # 1D102B-H1. The following intakes were investigated: 856144, 856377, 856373, 856372, and 856369. The statement of deficiency was amended to reflect F600 at past non compliance. 1 of the 8 complaint allegations resulted in deficiency.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to protect a resident's right to be free from abuse	F0600	A compliance date of 7/18/2025 for the corrective action plan was validated.. "Past Noncompliance - no plan of correction required"	07/18/2025

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F0600 SS = D	Continued from page 1 when Resident #23 hit Resident #96 in the face with a closed fist resulting in a slightly swollen area to the outer aspect of Resident #96's left eye. This affected 1 of 8 residents (Resident #96) reviewed for resident-to-resident abuse. The findings included: Resident #23 was admitted to the facility on 5/5/2023 with diagnoses which included mild vascular dementia without behavioral disturbance, psychotic disturbance or mood disturbance due to a previous cerebral infarction (a condition where brain tissue dies due to a lack of blood supply) and hypertensive heart disease with heart failure. A review of the quarterly Minimum Data Set (MDS) assessment dated 7/15/2025 revealed Resident #23 was cognitively intact. Resident #23 was able to ambulate 10 feet with a rolling walker unassisted but generally self-propelled in a wheelchair. A review of the care plan revised on 4/10/2025 revealed that Resident #23 had focus areas regarding ineffective coping which resulted in Resident #23 acting out in a verbally or physically aggressive manner and Resident #23 having some aggressive behaviors toward other residents. Goals included Resident #23 would display a decrease in aggressive and angry outbursts through the next review period and staff would recognize and avoid behaviors that provoked aggressive outbursts from Resident #23. Interventions included allowing Resident #23 time to respond to requests, approaching Resident #23 slowly and from the front, being aware not to invade Resident #23's personal space and being sure to have Resident #23's attention before speaking or touching the resident. Resident #96 was admitted to the facility on 3/7/1997 with diagnoses which included Alzheimer's dementia, heart failure, and aphasia (a language disorder that affects a person's ability to communicate). A review of the quarterly MDS dated 5/13/2025 indicated Resident #96 was moderately cognitively impaired. Resident #96 was not ambulatory and was mobile in a wheelchair for short distances. A review of the care plan dated 5/15/2025 revealed a focus area regarding refusal of care and showers but no aggressive behaviors noted. A review of a nursing note written by the Assistant Director of Nursing (ADON) on 7/16/2025 at 1:20 PM	F0600		

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F0600 SS = D	Continued from page 2 indicated nursing staff had entered the room shared by Resident #23 and Resident #96 and Resident #96 stated Resident #23 had hit her in the face. The residents were immediately separated and assessed for injury and pain. The Nurse Practitioner and Resident Representatives were notified. A review of a Wellness Nurse progress note dated 7/16/2025 indicated she assessed Resident #96 after the altercation and notified the Nurse Practitioner that Resident #96 had a slightly swollen area to the left outer eye. The note indicated an ice pack had been placed to the left outer eye area. The Nurse Practitioner ordered lab work, psychiatry and psychology referrals, and x-rays of Resident #96's face and hands. The Nurse Practitioner also ordered Resident #96's aspirin dose to be held for 3 days. The note indicated Resident #96 was angry and upset regarding the altercation with her roommate. A review of the Electronic Medical Record (EMR) for Resident #96 revealed a Nurse Practitioner order dated 7/16/2025 to hold the 81 milligram (mg) chewable aspirin tablet for 3 days. Resident #96 usually received one 81 mg chewable tablet once daily by mouth for antiplatelet therapy. A review of the initial allegation report dated 7/16/2025 at 2:15 PM stated the facility became aware of the incident on 7/16/2025 at 1:20 PM. Resident #23 hit Resident #96 in the face and both residents were placed on one to one supervision. Resident #96 had a bump on her cheek under the left eye. The initial report was signed by the Administrator. An interview on 7/24/2025 at 10:15 AM with Nurse #1 revealed she was walking down the hall on 7/16/2025 when she heard yelling and screaming coming from Resident #23's and Resident #96's room. She was the first staff member to enter the room within a few seconds of hearing the yelling and Resident #96 was screaming that Resident #23 hit her in the face. Nurse #1 observed Resident #23 standing up out of her wheelchair and leaning over Resident #96 who was seated in her wheelchair. Resident #23 was holding down Resident #96's arms by her wrists and pushing them down onto the wheelchair armrest. Resident #96 had both hands holding Resident #23's shirt which had been ripped on the side. Nurse #1 stated she had to physically removed Resident #96's hands from the shirt and asked Resident #23 to let go of Resident #96 which she did. She stated the residents were separated immediately. SW #1 had been notified and took Resident #96 out of the room to provide one to one supervision.	F0600		

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F0600 SS = D	Continued from page 3 Nursing Aide (NA) #1 provided one to one supervision for Resident #23. The Wellness Nurse was in the facility and assessed both residents. Nurse #1 stated that Resident #96 had a slight swelling to the left side of her face below her eye. Resident #23 had no injuries. Resident #23 was moved across the building to another room the same afternoon and stayed on one to one supervision that day. Nurse #1 indicated there had never been any issues between the two residents until that altercation. Nurse #1 stated Resident #23 had been verbally aggressive to staff in the past regarding medication administration. Nurse #1 revealed Resident #23 had cursed at her in the past when the order required medications to be crushed in applesauce because Resident #23 had wanted to take her medications whole. An interview on 7/24/2025 at 2:48 PM with Nursing Aide (NA) #1 indicated she arrived at the room on 7/16/2025 just after Nurse #1 and the nurse had already separated the residents. NA #1 provided one to one supervision for Resident #23. She stated she stayed with Resident #23 while the Wellness Nurse and local law enforcement conducted their assessments. NA #1 stated Resident #23 was moved to a different room and hallway. As far as she knew there had not been any more behavioral issues with Resident #23 or Resident #96. NA #1 stated she never had any problems with either resident. An interview on 7/24/2025 at 10:58 AM with Social Worker (SW) #1 revealed she was called to the unit shortly after the altercation. Resident #96 was out in the hall in her wheelchair. SW #1 took Resident #96 into the activity room to provide one to one supervision and emotional support. SW #1 stated after Resident #96 told her about being hit by Resident #23, and talked through the incident, Resident #96 calmed down and returned to her baseline mood. Resident #96 and SW #1 sat together and watched television while arrangements for Resident #23 to move to another room were being made. SW #1 stated Resident #96 indicated she felt safe after the incident. SW #1 indicated Resident #96 had not displayed any behavioral changes since the altercation. A social services note dated 7/16/2025 indicated Resident #23 and the Resident Representative were advised of the room change and both agreed. A social services note dated 7/16/2025 revealed social services interviewed Resident #96 later in the day after the incident, and she expressed she felt safe and had no other concerns.	F0600		

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F0600 SS = D	Continued from page 4 A Nurse Practitioner note dated 7/17/2025 indicated she had been contacted on 7/16/2025 by the Wellness Nurse who had assessed Resident #23, and no injuries were noted. The Nurse Practitioner also noted no injuries, and the lab results were reviewed without any significant findings. Resident #23 appeared to be at her baseline regarding her mood and physical assessment. A Nurse Practitioner note dated 7/17/2025 indicated she examined Resident #96 and found less swelling to her face. Resident #96 complained of left sided rib pain, so x-rays were ordered. Lab results were reviewed without significant findings and Resident #96 appeared to be at her baseline regarding her mood. A nursing note dated 7/18/2025 revealed that Resident #96 was alert and pleasantly confused. Denied pain and no discomfort noted. The x-rays of Resident #96's ribs showed normal ribs. The nurse contacted the Resident Representative with the results. A review of a Physician progress note dated 7/18/2025 indicated Resident #23 was assessed due to the altercation with another resident. Resident #23's agitation on 7/16/2025 appeared to be situational. The Physician encouraged Resident #23 to do breathing exercises when she was annoyed. A review of the investigation report dated 7/18/2025 revealed the incident had been reported to the County Department of Social Services and to local law enforcement on 7/16/2025. The investigation report stated an altercation began between Resident #23 and Resident #96 when Resident #96 grabbed Resident #23's shirt and would not release her grip. Resident #23, in response, struck Resident #96 in the face. Staff heard yelling and immediately responded. Upon entering the room, Resident #23 was observed standing over Resident #96 and was holding Resident #23's wrists down against the arms of the wheelchair. Resident #96 had a grip on Resident #23's shirt with both hands and there was a tear down the right side of Resident #23's shirt. Resident #96 had a raised nickel-sized bump under her left eye. Staff separated the residents, and both were assessed and supervised. Resident #23 stated Resident #96 had been bumping her wheelchair into Resident #23's wheelchair and then grabbed her shirt from behind. Resident #23 admitted she struck Resident #96 with a closed fist under the left eye resulting in the bump. The report stated within a couple of hours there was no bump to Resident #96's cheek and no bruising noted. The investigation report stated both residents had cognitive impairment and diagnoses of dementia. There	F0600		

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F0600 SS = D	Continued from page 5 was no documented history of conflict or aggression between the residents prior to the incident. The report indicated Resident #23 remained on one to one supervision after the event. The report stated follow up x-rays, lab work and psychiatry and psychology referrals were completed as ordered by the Nurse Practitioner. The report revealed the abuse was not substantiated as there was no evidence of willful infliction of injury with an intent to harm. The investigation report was signed by the Administrator. An interview on 7/22/2025 at 11:15 AM with Resident #23 revealed she had moved to another room, and she reported all was going well with the new roommate. She stated she moved as she did not like the previous roommate. Resident #23 denied any altercation with the previous roommate. An interview on 7/23/2025 at 9:40 AM with Resident #96 revealed Resident #96 was alert, pleasant but was unable to provide information as she answered questions in a nonsensical manner. An interview on 7/23/2025 at 1:15 PM with the Assistant Director of Nursing (ADON) indicated she did not witness the altercation between Resident #23 and Resident #96. She stated she arrived at the room after the residents had been separated. Resident #23 had no injuries and admitted she hit Resident #96 in the face because Resident #96 had grabbed her shirt and would not let go. The ADON stated Resident #96 had a small, raised area on her left cheek. She stated the x-rays were negative. The ADON stated there had never been any issues between Resident #23 and Resident #96 and they had been roommates for several months. She indicated Resident #23 had behavioral issues around refusing medications and needed encouragement to take her medication, but the ADON had never witnessed any aggressive behavior. A follow up observation and interview on 7/24/2025 at 10:08 AM with Resident #96 revealed the resident resting in bed and that she remained pleasantly confused and unable to answer questions in an understandable way. A follow up interview on 7/24/2025 at 11:05 AM with Resident #23 revealed she admitted to hitting Resident #96 in the face. Resident #23 indicated both residents were up in their wheelchairs in their shared room. Resident #23 stated Resident #96 bumped her wheelchair into Resident #23's wheelchair and then grabbed Resident #23's shirt and would not let go. Resident #23 stood up, faced Resident #96 and yelled for Resident	F0600		

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F0600 SS = D	Continued from page 6 #96 to let go of her shirt. Resident #23 indicated she hit Resident #96 on the left side of her face with a right hand closed fist. Resident #23 stated she was holding Resident #96's wrists trying to push her arms down onto the wheelchair armrests to get her to release her grip. At that point, the nurse arrived and separated them. Resident #23 stated local law enforcement was called, and she provided the Officer with a statement. Resident #23 stated she moved rooms and was very happy with her new roommate. An interview on 7/24/2025 at 1:48 PM with Nursing Aide (NA) #2 revealed Resident #23 was doing great in the new room and loved being on the new hall. Resident #23 and her new roommate got along and interacted well. NA #2 indicated Resident #23 had not been upset at all and was doing fine. An interview on 7/24/2025 at 11:37 AM with the Nurse Practitioner indicated she saw both Resident #23 and Resident #96 on 7/17/2025. The Wellness Nurse had assessed both residents on 7/16/2025 and notified the Nurse Practitioner. She provided lab orders and psychiatry and psychology referrals for both residents. For Resident #96, the Nurse Practitioner ordered the aspirin dose to be held for 3 days and facial and hand x-rays. She stated both residents appeared to be back to their baseline for mood. Resident #23 seemed to be settling into the new room easily. The Nurse Practitioner stated she ordered bilateral rib x-rays for Resident #96 on 7/17/2025 due to pain complaints. The x-rays were negative for any abnormality. The Nurse Practitioner did not know of any issues between the residents previously and felt Resident #96's behavior (bumping into Resident #23's wheelchair and grabbing the shirt) was related to the progression of Resident #96's dementia. An interview on 7/24/2025 at 12:54 PM with the Director of Nursing (DON) indicated she was not working the day of the altercation and heard about it when she returned to work. An interview on 7/24/2025 at 1:23 PM with the Administrator indicated she conducted the investigation and did not believe resident to resident abuse occurred as Resident #23 did not intend to harm Resident #96 when she hit her. The Administrator stated Resident #23 was trying to get Resident #96 to release her grip on the shirt. She stated both residents had cognitive impairment, and the Brief Interview for Mental Status (BIMS) was not a good scale for the type of dementia Resident #23 had. The Administrator stated The Saint Louis University Mental Status Examination (SLUMS) was	F0600		

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F0600 SS = D	Continued from page 7 a more accurate assessment. A follow up interview on 7/24/2025 at 3:30 PM with the Administrator indicated she was requesting past noncompliance and provided the plan of correction. She also provided a SLUMS examination dated 7/24/2025 at 2:10 PM for Resident #23 which revealed a score of 11 which indicated dementia. The Administrator stated both Resident #23 and Resident #96 had skin checks after the altercation. She indicated all residents who were cognitively intact had been questioned about abuse with no concerns noted. All residents who were cognitively impaired had skin checks completed. The Administrator stated all staff had attended an abuse training. The facility provided the following corrective action plan: Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice: Problem Statement: On 7/16/2025, at 1:20pm, the aides on the unit heard yelling coming from the room while passing meal trays. Upon entering the room, resident #23 was observed standing over resident #96 holding resident #96's wrists down against the armrests of her wheelchair. The aides immediately separated the 2 residents and placed them on 1:1 supervision. Both residents were interviewed concerning the incident along with staff members present. Resident #23 stated that resident #96 rolled up behind her and grabbed the back of her shirt, bumping her wheelchair and then struck her in the face. Resident #23 stated that she struck resident #96 on the left side of the face. No injury was noted at the time of the incident; however, the nurse completed an assessment for latent injury and noted a bump under the left eye. On 7/16/2025, at the time of the incident, the nursing staff separated the residents immediately and placed them on 1:1 supervision. Resident #23 was moved to a different room in another area of the facility. Resident #23's family was notified of the room move. Skin checks were completed on resident #23 and resident #96. Medical services, Adult Protective Services (APS), police, and responsible party were notified. An initial report was placed with the division of health and human services. Medical services were completed for resident #23 on 7/16/2025 with labs and psych referral completed. Medical services were completed for resident #96 on	F0600		

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F0600 SS = D	Continued from page 8 7/16/2025 and 7/17/2025 with x-rays, labs and psych referral. No medication adjustments for either resident at the time of visits. How will the facility identify other residents having the potential to be affected by the same deficient practice: On 7/16/2025, skin checks were completed for 100% of all residents with a BIMS of 12 or below and interviews were completed for all residents with a BIMS of 13 or above. Any concerns were addressed immediately by the Administrator or Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur An in-service for abuse along with resident-to-resident physical interaction and behaviors was initiated with all staff to include agency and contract staff by the Administrator and the Administrator in Training on 7/16/2025 and was completed by 7/16/2025. The in-service education included an understanding of resident-to-resident interactions, causes and contributing factors, prevention strategies, documentation and reporting and promoting a culture of safety and respect. Any staff member to include agency and contract staff that had not completed the education as stated above by the completion date, received the education by their next scheduled shift. Any newly hired staff to include agency or contract staff received the above stated in-service education during orientation prior to their first shift. The training included: what is abuse and neglect, staff should intervene and protect the resident or residents by removing them from the situation if you feel abuse has occurred and who to report abuse to (immediate supervisor), and how the nurses should document and report a concern for abuse. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur: On 7/17/2025, the Director of Nursing or the Assistant Director of Nursing will review all progress notes 5x/week for 4 weeks during Cardinal Interdisciplinary Team (IDT) Meeting to identify any behaviors. Any concerns will be addressed immediately by the Administrator and the Director of Nursing, medical services and Responsible party will be notified as appropriate.	F0600		

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F0600 SS = D	Continued from page 9 On 7/17/2025, the social workers will complete interviews with 5 residents a week for 12 weeks who have a BIMS of 13 or >. These interviews included the following questions: 1. How do you usually respond when another resident upsets or bothers you? 2. Are there any residents you don't get along with, or who make you feel uncomfortable? 3. If someone is bothering you or touches your things, who can you talk to about it before it becomes a problem? On 7/17/2025, licensed nurses will complete 5 staff interviews weekly for 12 weeks with direct care staff to ensure understanding of prevention for resident-to-resident altercations. The questions will include: 1. How do you identify when a resident with cognitive impairment is becoming agitated or overstimulated, and what steps do you take to de-escalate the situation. 2. Can you give an example of how you've successfully intervened to prevent a conflict between two residents? 3. How do you monitor and manage interactions between residents with different cognitive levels or behavioral triggers? 4. What communication strategies do you use when redirecting a resident with dementia who is entering another resident's space or becoming intrusive? The Nursing Home Administrator will review the responses weekly for 12 weeks. Any areas of concern will be addressed immediately by the Administrator or Director of Nursing. The Administrator or Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will meet monthly for 3 months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. QAPI meetings were held on 7/17/2025. Date of Compliance: 7/18/2025 The corrective action plan was validated onsite on 7/24/2025. The validation included review of the initial and follow up assessments of Resident #23 and Resident #96, the immediate separation of both residents, both residents placed on one-to-one supervision, Resident #23 being moved to another room and hallway. All skin checks were reviewed for completeness and all resident interviews regarding abuse were reviewed with no additional findings noted. The initial report and the investigation report were sent to the State Agency, local Law Enforcement and	F0600		

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F0600 SS = D	Continued from page 10 Adult Protective Services were notified on 7/16/2025. The Resident Representatives and MD/NP were notified of the incident on 7/16/2025. The handout regarding resident-to-resident abuse provided during the abuse training was reviewed. Interviews with staff revealed that they had received recent education on abuse and were able to verbalize types of abuse and the procedure for reporting. Signature sheets were reviewed to confirm all staff were educated. Social worker interviews with 5 residents regarding abuse concerns were reviewed with no concerns noted. Nursing staff interviews regarding understanding of resident-to-resident abuse were reviewed with no concerns noted. A compliance date of 7/18/2025 for the corrective action plan was validated.	F0600		
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. §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 observations, staff interviews, and record reviews the facility failed to remove expired	F0761	Plan of Correction Tag: F761 – Label/Store Drugs and Biologicals Properly Deficient Practice: The facility failed to remove expired medications stored in the Garden City medication cart. 1. Corrective Actions for Resident(s) Affected: The Licensed Nursing Home Administrator is responsible for implementing the plan of correction. On 7/23/2025 The expired medications were immediately removed from Garden City medication cart and returned to pharmacy by the Director of Nursing (DON). The Garden City medication cart was then audited by the Director of Nursing and the Unit Manager in its entirety to ensure no other expired medications were present. 2. Identification of Other Residents Who Could Be Affected: On 7/23/2025, a 100% audit was conducted of all medication carts and medication storage areas by the Director of Nursing and Unit Managers to ensure no other expired medications were present. No additional expired medications were noted during this audit. 3. Systemic Changes to Prevent Recurrence: On 7/24/2025 in-service education was initiated for all Licensed nurses and Certified Medication Aides (CMA) to include agency and contract staff by the Staff	08/21/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing and Rehabilitation Center	**9200 Glenwater Drive , Charlotte, North Carolina, 28262**

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F0761 SS = D	Continued from page 11 medications stored in 1 of 4 medication carts (Garden City). The findings included: An observation of the Garden City medication cart was conducted on 7/22/25 at 1:30 PM in the presence of Nurse #1. The following expired medications were found in the Garden City medication cart, a pack of Catapres 0.1 micrograms (medication to lower blood pressure) with an expiration date of 7/18/25 in the second drawer from the top; and a pack of Atarax 25 milligrams (treat anxiety and itching) with an expiration date 2/27/25 were in the second drawer from the top. An interview with Nurse #1 was completed on 7/23/25 at 1:50 PM. The Nurse stated that all staff who administer medication were responsible for checking medication expiration dates. The night shift had more down time and was expected to check the medication carts to restock and get rid of expired medications. An interview with the Unit Manager was completed on 7/23/2025 at 1:54 PM. The Unit Manager reported that expired medications were placed in a gray box, then scanned by the night shift nurse and returned to pharmacy daily. The interview with the Director of Nursing (DON) on 7/24/25 at 12.35 PM revealed that the nurses on the medication carts should check the medication cart and get rid of expired medication each shift. The DON stated that staff should follow the medication administration policy that included checking the medication expiration date prior to administration. An interview with the Administrator was completed on 7/24/25 at 1:23 PM. The Administrator stated that she expected the staff who administered medications to follow the medication administration policy and remove expired medication from the medication carts.	F0761	Continued from page 11 Development Coordinator (SDC), Director of Nursing, Assistant Director of Nursing, Nursing Home Administrator (NHA) and Unit Managers on the facility's policy for medication storage, to include routinely checking for and removing expired medications from the medication carts. Any licensed nurses or Certified Medication Aides to include agency or contract staff who have not completed the in-service education by 8/20/2025 will complete it on their next scheduled shift. All newly hired licensed nurses and certified medication aides to include agency and contract staff will receive this education during their orientation. 4. Monitoring to Ensure Sustained Compliance: The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit 100% of all medication carts and medication storage areas weekly for 4 weeks to ensure no expired medications are noted on the medication carts. The Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 1 month. The Quality Assurance Performance Improvement Committee will meet monthly for 1 month and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 8/21/2025	
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.	F0812	Plan of Correction – F812: Food Procurement, Store/Prepare/Serve – Sanitary On 7/21/25 the facility failed to remove a dented can of food located on a shelf ready for use in the kitchen in the dry storage area. The facility also failed to reseal, label, and date leftover food items stored for use in the walk-in freezer of the kitchen. 1. Corrective actions for those residents who were affected by the deficient practice:	08/21/2025

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F0812 SS = E	Continued from page 12 (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 remove a dented can located on shelf ready for use and failed to reseal and label and date leftover food items stored for use. These practices occurred in 1 of 1 walk-in freezer and 1 of 1 dry storage room and had the potential to affect food served to residents. The findings included: An initial tour of the kitchen occurred on 7/21/25 at 10:09 AM. The following concerns were identified: a. Items in the walk-in freezer that were open to air and not resealed but labeled included: -one 15.33 pound (lb.) box of Texas Toast bread, dated 7/11/25 -one 7.93lb box of churros, dated 10/24/25 Items in the walk-in freezer that were open to air, not resealed, and not labeled included: -one18.9lb box of colby cheese omelets -one 20lb box of cookie dough balls b. Items in the dry storage area that were opened and resealed but not dated included: -one bag of brown sugar -one 22.6-ounce (oz) bag of brown gravy mix	F0812	Continued from page 12 The Licensed Nursing Home Administrator is ultimately responsible for implementing this plan of correction. On 07/21/2025, the Certified Dietary Manager (CDM) immediately discarded all food items found to be improperly stored and cans that were dented from the walk-in freezer and dry storage areas. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice: On 7/21/2025 the Certified Dietary Manager and the Nutritional Consultant conducted a 100% inspection of all food storage areas within the facility to identify any additional dented cans or improperly stored food items that may pose a risk to other residents. All additional items identified were discarded immediately. 3. What measures will be put into place or systemic changes made to ensure the deficient practice does not recur: In-service education was initiated by the Certified Dietary Manager and the Nursing Home Administrator on 7/25/2025 for all dietary staff to include contract and agency staff regarding Food Procurement, Storage, and Sanitation. This training emphasized the proper procedures for resealing, labeling, and dating all food items once opened. Any dietary staff to include agency and contract staff who have not completed the in-service by 8/20/2025 will complete it on their next scheduled shift. All newly hired dietary staff to include contract and agency staff will receive this education during their orientation. 4. How the facility will monitor its corrective actions to ensure the deficient practice does not recur: On 7/28/2025 the Dietary Manager or Assistant Administrator will conduct audits three (3) times a week for 4 weeks, using the Food Procurement Audit Tool. This audit is to verify compliance with resealing, labeling, and dating of all open food items in the walk-in freezer as well as identification of any dented cans in the dry storage located in the kitchen. During these audits, all concerns identified will be addressed immediately, including ensuring all opened foods are sealed and stored appropriately and any dented cans removed from dry storage immediately. The Administrator will forward the audit results to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI	

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F0812 SS = E	Continued from page 13 -one 31oz bag of white sugar -one 160oz bag of elbow macaroni -one 57oz box of complete mashed potatoes d. One 105oz can of pears on the rack in the dry storage area for use was dented on the bottom seal An interview with the Dietary Manager (DM) on 7/24/25 at 11:11 AM was conducted. She explained kitchen staff were instructed to rewrap items in the dry storage area after use and date them with a seven-day expiration date. The DM stated the food items in the freezer followed a guide with use by dates specific to the food. She stated the staff forgot to reseal and date the items. The DM stated the dented can was removed and sent back to the distributor for credit. An interview with the Administrator on 7/24/25 at 1:26 PM was conducted. She stated she had the expectation that kitchen staff follow the policies and procedures for proper food storage.	F0812	Continued from page 13 Committee will evaluate audit findings to identify trends or ongoing issues and determine if additional corrective actions or continued monitoring are needed to ensure sustained compliance. Date of Compliance: 8/21/2025	
F0842 SS = B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	Plan of Correction – F842: Resident Records – Complete/Accurate/Accessible Incomplete Documentation of Physician Communication Deficient Practice: The facility failed to maintain accurate medical records related to the documentation of treatment to a pressure ulcer for Resident # 110. 1. Corrective Actions for the Resident Affected: The Licensed Nursing Home Administrator is ultimately responsible for implementing this plan of care. On 7/24/2025 Resident #110 medical record was reviewed and updated by the Director of Nursing (DON) to reflect the communication that occurred between the wound nurse and the wound clinic. On 7/24/2025 a late entry was added to by the Director of Nursing to Resident #110s medical record to clarify the order was discussed and intentionally discontinued by the physician. No interruption in Resident #110s care occurred; the treatment remained consistent with current clinical needs.	08/21/2025

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F0842 SS = B	Continued from page 14 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 14 2. Identification of Other Residents Potentially Affected: On 7/31/2025 the DON conducted a 100% audit of the wound treatment documentation, orders, and the progress notes of all residents with wounds for the previous 3 months to ensure physician communications are reflected in the resident's current order for treatment of the wound. All documentation was accurately reflected in the medical records after completion of this audit. 3. Measures and Systemic Changes to Prevent Recurrence: On 7/24/2025 an in-service education was initiated for all licensed nurses to include wound care staff and contract and agency staff by the Staff Development Coordinator (SDC), the Director of Nursing, Assistant Director of Nursing, Nursing Home Administrator or the Unit Managers on the requirements of documentation for all physician communications, including verbal orders, clarifications, or treatment decisions, in the resident's medical record. Any licensed nurses and wound care staff to include contract and agency staff who have not completed the in-service by 8/20/2025 will complete it on their next scheduled shift. All newly hired licensed nurses to include contract and agency staff will receive this education during their orientation. 4. Monitoring to Ensure Ongoing Compliance: Effective 7/28/2025 the wound nurse, Director of Nursing, Assistant Director, and Unit Managers will conduct an audit of 5 resident a week for 4 weeks residents with a focus on wound care patients and documentation. The Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 1 month. The Quality Assurance Performance Improvement Committee will meet monthly for 1 month and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 8/21/2025	

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F0842 SS = B	Continued from page 15 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate records related to documentation of treatment to a pressure ulcer for 1 of 3 residents reviewed for accurate medical records (Resident #110). The findings included: A review of Resident #110's physician orders dated May 2025 revealed the following: - - Treatment to sacral wound: cleanse with sodium hypochlorite (wound cleaner), apply Drawtex (wound dressing) to wound bed, secure with 4-inch by 4-inch bordered foam daily and as needed until resolved. The order was dated 05/01/25. A review of Resident #110's May 2025 Treatment Administration Record (TAR) revealed the following order: - -Treatment to sacral wound: cleanse with sodium hypochlorite (wound cleaner), apply Drawtex (wound dressing) to wound bed, secure with bordered foam daily and as needed until resolved. The order was dated 05/01/25. The order was documented as completed and signed off by a nurse daily. A review of Resident #110's June 2025 Treatment Administration Record (TAR) revealed the following order: - - Treatment to sacral wound: cleanse with sodium hypochlorite (wound cleaner), apply Drawtex (wound dressing) to wound bed, secure with 4 inch by 4 inch bordered foam daily and as needed until resolved. The order was dated 05/01/25. The order was documented as completed and signed off by a nurse daily from 06/01/25 through 06/24/25. A wound care consultation report dated 06/25/25 revealed the wound care physician had ordered for Resident #110's dressing to be changed to the following:	F0842		

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F0842 SS = B	Continued from page 16 - -Cleanse the wound with wound cleanser. Apply calcium alginate with silver, apply a 2-inch by 2-inch gauze border foam dressing and change daily. A review of Resident #110's June 2025 Treatment Administration Record (TAR) revealed the following order: - -Treatment to sacral wound: cleanse with sodium hypochlorite (wound cleaner), apply Drawtex (wound dressing) to wound bed, secure with 4-inch by 4-inch bordered foam daily and as needed until resolved. The order was dated 05/01/25. The order was documented as completed and signed off by a nurse daily from 06/25/25 through 06/30/25. There was no documentation of the application of the calcium alginate with silver, apply a 2-inch by 2-inch gauze border foam dressing in the June TAR. A review of Resident #110's July 2025 Treatment Administration Record (TAR) revealed the following order: - - Treatment to sacral wound: cleanse with sodium hypochlorite (wound cleaner), apply Drawtex (wound dressing) to wound bed, secure with 4-inch by 4-inch bordered foam daily and as needed until resolved. The order was dated 05/01/25. The order was documented as completed and signed off by a nurse daily until 07/23/25. There was no documentation of the application of the calcium alginate with silver, apply a 2-inch by 2-inch gauze border foam dressing in the July TAR for the period of 07/01/25 through 07/23/25. On 07/24/25 at 10:13 AM an interview was conducted with Wound Nurse #1. During the interview Wound Nurse #1 stated she was the facility's weekend wound nurse and had worked in the facility for 2 years. She stated she completed all wound care on the weekends and would often look back through resident's charts from the previous week to ensure orders were placed into the electronic medical record (EMR). She stated she had not seen Resident #110's wound care consultation report from 06/25/25 or realized there was a different order on the consultation than what she had been completing for Resident #110. Wound Nurse #1 confirmed she had been treating the sacral pressure ulcer with the order dated 05/01/25. Wound Nurse #1 stated she would have to talk to Wound Nurse #2 about the order because she felt like it was just a documentation issue. Wound Nurse #1 stated Resident #110's wound was improving in size and appearance.	F0842		

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F0842 SS = B	Continued from page 17 On 07/24/25 at 10:37 AM an interview was conducted with Wound Nurse #2 via telephone. During the interview she stated she was out of town but typically completed all wound care during the week and Wound Nurse #1 completed the wound care on the weekends. During the interview she stated she had received the wound care consultation order on 06/25/25. However, she asked the Medical Director if they could keep Resident #110's treatment order the same as ordered on 05/01/25 because the wound was improving. The Medical Director told her it was fine to do so however she did not put a note into the EMR or a new physician order on the resident's Treatment Administration Record. On 07/24/25 at 10:50 AM an interview was conducted with the Medical Director. During the interview he stated any resident with a stage three or greater pressure ulcer was sent out to the wound care clinic. He stated the wound care clinic made recommendations for dressing changes and would send consultation reports back with the resident to the facility. The Medical Director stated he ultimately approved or denied them. He stated Wound Nurse #2 was good about coming to him about orders and if she felt an order was working better than the recommendation then he would have kept the treatment order the same. He stated he felt like he remembered Wound Nurse #2 coming to him about the new order on 06/25/25 and he told her it was okay to keep the treatment regimen the same. The Medical Director stated he just didn't write a note about it or an order for it. The interview revealed Resident #110's wound was improving in size and appearance. On 07/24/25 at 11:46 AM an interview was conducted with the Wound Care Clinic Staff Member #1. During the interview she stated they had received a call from the facility on 06/25/25 and they gave a verbal order that it was okay to continue with the treatment order from 05/01/25. She stated Resident #110 had been evaluated in the wound care clinic on 07/23/25 and her wound was improving. On 07/24/25 at 12:43 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Wound Nurse #2 should have written a note into the resident's EMR and there should have been documentation to show the consultation report from 06/25/25 was not missed. The DON stated the physician order should have been updated to reflect a new date and that it was appropriate to use sodium hypochlorite (wound cleaner), and Drawtex (wound dressing) to wound bed, instead of the calcium alginate with silver order from 06/25/25.	F0842		

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F0842 SS = B	Continued from page 18 On 07/24/25 at 3:35 PM an interview was conducted with the Administrator. During the interview she stated Wound Nurse #2 should have documented in Resident #110's EMR if an order was not followed or changed for Resident #110's wound care.	F0842		
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:	F0880	Plan of Correction – F880: Infection Control and Prevention Deficient Practice: The facility failed to implement the policy on hand hygiene after Nurse #3 failed to perform hand hygiene after handling medication packaging and then dispensing medications into her bare hand before placing them into the medication cup. The facility failed to implement their policy on enhance barrier precautions when Nurse Aide #3 and Nurse Aide #4 failed to wear personal protective equipment during a high contact care activity that included transferring Resident #122 and Resident #117 who have a culmination indwelling urinary catheter and/or a chronic wound. 1. Corrective Action Taken for Those Found Affected: On 7/22/2025 the Nurse Aide #3 and Nurse Aide #4 were immediately re-educated by the Staff Development Coordinator (SDC) on the Enhanced Barrier Precautions protocol, to include proper donning and doffing of Personal Protective Equipment , specifically the use of gowns during transfers of residents who meet the criteria for Enhanced Barrier Precautions. On 7/25/2025 The licensed nurse #3 was re-educated by the Staff Development Coordinator (SDC) on infection control during mediation administration to include performing hand hygiene during the medication pass, and not placing medications directly into the hand. Beginning 7/25/25, Resident #117 and Resident #122 were assessed by the licensed nurse for any signs or symptoms of infection; no adverse outcomes were identified. 2. Identification of Other Residents Who Could Be Affected: On 7/25/2025 a 100% facility-wide audit was conducted by the Director of Nursing and the Assistant Director of Nursing to identify other residents currently on Enhanced Barrier Precautions.	08/21/2025

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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
F0880 SS = D	Continued from page 19 (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 staff interviews, the facility failed to implement their policy for hand hygiene when Nurse #3 failed to perform hand hygiene during medication administration after handling medication bottles and dispensed pills into her bare hand before placing the pills in a medicine cup. In addition, the facility failed to implement their policy for enhanced barrier precautions (EPB) when Nurse Aide (NA) #3 failed to wear personal protective equipment (PPE) during a high contact care activity that included transferring Resident #122 who had a chronic wound and an indwelling urinary catheter and when NA #3 and NA #4 transferred Resident #117 who had an indwelling urinary catheter. This was for 3 of 5 staff members observed for infection control practices (Nurse #3, NA #3 and NA #4). The findings included:	F0880	Continued from page 19 On 7/25/2025, the Director of Nursing and the Assistant Director of Nursing completed random observations for staff providing care to those residents (nurse aides, therapy staff, licensed nurses) to include contract and agency staff, who are on Enhanced Barrier Precautions to ensure usage and compliance with Personal Protective Equipment. All concerns were addressed immediately by the Director of Nursing and Assistant Director of Nursing with re-education completed. On 7/25/2025, the Director of Nursing and the Assistant Director of Nursing completed and audit of 100% of all licensed nurses and medication aides to include agency and contract staff who are working on medication carts to ensure they are knowledgeable on the proper hand hygiene during medication administration. Any concerns were addressed immediately with re-education by the Director of Nursing or the Assistant Director of Nursing. 3. Systemic Changes to Prevent Recurrence: On 7/24/2025 education was initiated by the Director of Nursing, Nursing Home Administrator (NHA) and the Assistant Director of Nursing for 100% of all licensed nurses, Medication Aides, Nurse Aides, and therapy staff to include contract and agency staff on Enhanced Barrier Precautions protocols, including when and how to use gowns, gloves, and infection control related to hand hygiene and medication administration. The in-service will be completed by 07/31/2025. Any licensed nurse, Medication Aide, Nurse Aide or therapy staff member to include contract or agency who have not completed the in-service by 8/20/25 will complete by their next scheduled shift. All newly hired licensed nurses, Medication Aides, Nurse Aides, and therapy staff to include contract and agency staff will receive this education during their orientation. On 7/24/25, the Director of Nursing, the Assistant Director of Nursing (ADON) and the Nursing Home Administrator (NHA) initiated in-service education for all licensed nurses and medication aides to include contract and agency staff on infection control with a special focus on hand hygiene during medication administration. Any licensed nurses or Medication Aides to include contract and agency staff who have not completed the in-service by 8/20/2025 will complete it on their next scheduled shift. All newly hired licensed nurses and medication aides to include contract and agency staff will receive this education during their orientation. 4. Monitoring to Ensure Sustained Compliance:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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F0880 SS = D	Continued from page 20 1. A review of the facility's policy titled "Medication Administration – Person Centered Care" dated last revised on 6/2021 revealed in part the following: If breaking tablets was necessary to administer the proper dose, hands are washed with soap and water or alcohol gel prior to handling tablets. On 7/23/2025 at 8:41 AM a continuous observation for medication administration was conducted for Resident #18 with Nurse #3. Nurse #3 used hand sanitizer for both hands, opened the medication cart drawer with right hand. She then held a medication bottle with her left hand and removed the top with her right hand. Nurse #3 then poured one (1) pill from the medication bottle into her left hand and placed the pill in a clear medication cup. Nurse #3 then touched other medication bottles in the medication cart drawer looking for the next medication. Nurse #3 did not perform hand hygiene and proceeded to pour a second pill into her left hand and then placed the pill in the clear medication cup. The surveyor stopped Nurse #3 before dispensing further medications. On 7/23/2025 at 8:50 AM an interview with Nurse #3 was conducted outside of Resident #18's room. Nurse #3 stated that she thought that she could dispense pills in her hand if she used hand sanitizer prior to dispensing all medications. Nurse #3 indicated she was not aware that she was contaminating her hands when touching various unclean surfaces prior to dispensing the pills in her hand. An interview with the Director of Nursing (DON) was completed on 7/24/25 at 12:35 PM. The DON stated Nurse #3 should not dispense medications in her hands to prevent the spread of bacteria. The DON reported Nurse #3 should have followed the medication administration policy to wash hands with soap and water or alcohol gel prior to handling tablets/medications. She did use hand sanitizer prior to handling pills. The DON stated she would have dispensed the pill in the lid of the medication bottle and then into the medication cup. On 07/24/2025 at 1:23 PM an interview with the Administrator indicated Nurse #3 should have followed the medication administration policy as it pertained to hand washing. 2. A review of the facility's policy titled "Enhanced Barrier Precautions" dated last revised on 6/13/24 revealed in part the following: "Enhanced Barrier Precautions are used in conjunction with standard precautions to reduce the risk of MDRO transmission during high-contact resident care activities. It	F0880	Continued from page 20 Effective 7/28/2025 The Assistant Director of Nursing (ADON) or Unit Managers will conduct Weekly audits of 5 residents for 4 weeks who are on Enhanced Barrier Precautions and receiving care to ensure compliance is met with the guidelines for residents who are on Enhanced Barriers Precautions. Effective 7/28/2025 The Assistant Director of Nursing (ADON) Unit Managers will conduct Weekly medication administration audits for 5 nurses or Medication Aides to include contract or agency staff for 4 weeks to ensure compliance is met for proper infection control practices related to hand hygiene and safe handling of medications related to medications not being placed in bare hands. The ADON will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 1 month. The Quality Assurance Performance Improvement Committee will meet monthly for 1 month and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 8/21/2025	

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F0880 SS = D	Continued from page 21 includes the use of both gowns and gloves. Enhanced Barrier Precautions apply to residents with any of the following: Presence of an indwelling medical device with or without the presence of an MDRO infection or colonization. Example of indwelling device included urine drainage device. Resident care activities that are considered high contact included transferring a resident. An observation on 7/23/25 at 1:24 PM revealed NA #3 entered Resident #117's room. Signage for EBP was posted on the outside of Resident #117's door and indicated that staff performing high contact care that included transferring residents should wear a gown and gloves. PPE was observed hanging the door that included gowns, gloves and masks. NA #3 then exited the room and returned with a mechanical lift to transfer Resident #117. NA #3 entered Resident #117's room without donning a gown and gloves and began to place lift pad under Resident #117. The Surveyor intervened and inquired about the reason Resident #117 required EPB. NA #3 stated that Resident #117 had a chronic wound and indwelling urinary catheter and then donned a gown and gloves. An interview with NA#3 on 7/23/2025 at 2:44 PM was completed outside of Resident #117's door. NA #3 stated that she knew that she should wear PPE in Resident #117's room and was going to put on the gown and gloves after someone arrived to assist her with the transfer. b. An observation on 7/24/25 at 2:30 PM revealed EBP signage was posted on the outside of Resident #122's door that indicated staff performing high contact care that included transferring residents should wear gown and gloves. NA #4 was observed entering Resident #122's room without PPE and closed the door. The Surveyor knocked on Resident #122's door, then entered Resident #122's room. NA #3 and NA #4 had not donned a gown or gloves and were transferring the resident from the bed to the wheelchair using the mechanical lift. NA #3 was observed holding Resident #122's legs and NA #4 had her hands under Resident #122's armpits, while Resident #122 hovered over a wheelchair. Resident #122 had an indwelling urinary catheter. An interview with NA#3 on 7/23/2025 at 2:44 PM revealed she had completed the online computer training and hands on training for EBP during her employment orientation. NA #3 reported she was aware that Resident #122 required PPE; however, was focused on getting Resident #122 up in wheelchair and out to wound appointment on time.	F0880		

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F0880 SS = D	Continued from page 22 An interview was completed on 7/23/2025 at 2:35 PM with NA #4. NA #4 reported she saw NA #3 having a hard time preparing Resident #122 for a mechanical lift transfer and “jumped in” to assist NA #3. NA #4 stated that she knew to put on PPE for EBP rooms; however, she was rushing to assist NA #3 and forgot to don PPE. NA #4 reported she was more concerned about transferring Resident #122 safely and assisting Resident #122 to wound appointment. NA #4 confirmed that NA #3 was not wearing PPE. On 7/24/25 at 12:35 PM an interview with the Director of Nursing (DON) stated NA #3 had previously received education on the use of EBP precautions with online computer training and hands on training during new employee orientation. The DON reported that NA #3 and NA #4 should have been wearing the appropriate PPE listed on the EBP sign posted on Resident #117 and Resident #122’s doors when providing high contact care for residents with chronic wounds and indwelling urinary catheters. On 07/24/2025 at 1:23 PM an interview with the Administrator indicated NA #3 should have followed EBP which included wearing a gown while performing high contact activity, such as transferring residents to prevent the potential spread of microorganisms.	F0880		