STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345273**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital East Greensboro	**2401 South Side Boulevard , Greensboro, North Carolina, 27406**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/15/25 through 12/19/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DD9D7-H1.	E0000		01/12/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/15/25 through 12/19/25. Event ID# 1DD9D7-H1. The following intakes were investigated 884142 and 884139. 1 of the 2 complaint allegations resulted in deficiency.	F0000		01/13/2026
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F0628		01/09/2026

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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F0628 SS = A	Continued from page 1 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F0628		

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F0628 SS = A	Continued from page 2 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F0628		

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F0628 SS = A	Continued from page 3 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F0628		

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F0628 SS = A	Continued from page 4 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of a resident discharge to another facility for 1 of 2 resident reviewed for discharge (Resident #24). The findings included: Resident #24 was admitted to the facility on 2/03/23. The discharge planning note dated 11/28/24 at 10:11 am by the Social Service Director revealed Resident #24 would be transferred to another skilled nursing facility on 12/03/24. The discharge planning note further revealed the physician was notified and a discharge summary was to be sent to the receiving facility. The nursing progress note dated 12/03/24 at 3:23 pm revealed Resident #24 was discharged from the facility at 3:00 pm. Review of the Ombudsman notification information sent for December 2024 revealed Resident #24's discharge from the facility on 12/03/24 was not included in the notification information sent. The Social Service Director was interviewed on 12/18/25 at 11:24 am who revealed she was unable to recall if she notified the Ombudsman of Resident #24's discharge on 12/03/24. The Social Service Director stated that the previous Unit Manager was normally the person responsible for the Ombudsman notification at that time but she was not sure if any information was sent.	F0628		

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F0628 SS = A	Continued from page 5 The previous Unit Manager was unable to be interviewed. A telephone interview was conducted with the Ombudsman on 12/18/25 at 1:44 pm who revealed she did not receive the notification that Resident #24 was discharged from the facility on 12/03/24. During an interview with the Administrator of 12/19/25 at 3:34 pm she revealed the previous Unit Manager would have been the staff member that notified the Ombudsman. She stated the previous Unit Manager would send the email to the Ombudsman on the date of discharge from the facility. The Administrator reported she was unable to find any documentation that Resident #24's discharge information was sent to the Ombudsman and she was unable to state why the information was not sent.	F0628		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for an evaluation for level II Preadmission Screening and Resident Review (PASRR) determination for a resident with serious mental health diagnoses. This deficient practice was for 1 of 1 resident reviewed for PASRR (Resident #6).	F0644	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 1/13/2026 a Level II PASARR was requested by Social Worker #1 on Resident #6. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 1/15/2026 Social Worker #1 completed an audit of any current residents that had a serious mental health diagnosis such as schizophrenia or bipolar disorder. No other residents were identified that would warrant a level II PASARR evaluation. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1/14/2026 the Administrator educated the Social Workers on the requirements for Level II PASARR related to any serious mental health diagnosis , when a diagnosis is added during a stay. The Administrator will educate any newly hired Social Worker going forward on the Level II PASARR requirements.	01/16/2026

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F0644 SS = D	Continued from page 6 The findings included: The PASRR history detail reported dated 5/16/11, provided by the facility, revealed Resident #6 had a PASRR Level 1 review only completed on 5/16/11 and the review did not meet level II criteria. The PASRR review revealed Resident #6 was noted to have no mental health diagnosis at the time of the review. Resident #6 was admitted to the facility on 6/05/15 with diagnoses which included major depressive disorder. A review of the active diagnosis list revealed Resident #6 had a diagnosis of bipolar disorder unspecified noted as active on 4/18/19 and a diagnosis of schizophrenia unspecified noted as active on 7/20/24. Review of Resident #6's electronic and paper medical record revealed no evidence a request was submitted for an evaluation for level II PASRR determination. The Minimum Data Set (MDS) annual assessment dated 2/20/25 revealed Resident #6 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A telephone interview was conducted with Social Worker #2 on 12/18/25 12:44 pm who confirmed she was responsible for requests for PASRR evaluations for the facility at the time of Resident #6's new serious mental health diagnoses. Social Worker #2 stated that she typically would only review a PASRR for new admissions or those residents that had an expiration date on a PASSR level I. Social Worker #2 confirmed that Resident #6's new serious mental health diagnoses of bipolar disorder and schizophrenia would be a significant change in her mental health but it was not her normal practice to submit a request for evaluation of PASRR level II. Social Worker #2 stated she understood the process of PASRR evaluations, but it was not something that was normally needed for the resident population at the facility and not part of her normal practice. An interview was conducted with the Administrator on	F0644	Continued from page 6 4) Social Worker #1 will complete audits starting on 1/15/2026 on all current residents with a serious mental health diagnosis and those admitted with a serious mental health diagnosis to ensure that a Level II PASARR evaluation was completed. The audits will be completed every week for 4 weeks and then every month for 3 months. The results of the audits will be taken to the Quality Assurance and Performance Improvement Committee by the Social Worker to ensure compliance. Corrective action completed 1/16/2026	

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F0644 SS = D	Continued from page 7 12/19/25 at 3:38 pm who revealed the facility received Resident #6's PASRR level I information from the hospital and she was unsure who was responsible to resubmit when new mental health diagnoses were identified at the facility. The Administrator stated it was not the facility's normal practice to resubmit PASRR information after a resident was admitted to the facility and it was not something the facility was doing.	F0644		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, Consultant Pharmacist, and Physician interviews the facility failed to have clinical documentation to support a diagnosis of schizophrenia for 1of 5 residents reviewed for unnecessary medications (Resident #6). The findings included: Resident #6 was admitted to the facility on 6/05/15 with diagnoses which included major depressive disorder. Resident #6 was readmitted to the facility from a short-term hospital stay on 7/20/24. The hospital discharge summary dated 7/20/24 did not list a diagnosis of schizophrenia for Resident #6. The provider progress note dated 5/06/25 revealed Resident #6 was seen by Physician #2 related to reported visual hallucinations by the nursing staff. The provider's progress note did not list schizophrenia as a diagnosis for Resident #6. The assessment and plan for Resident #6, as noted by Physician #2, was to add haloperidol (an antipsychotic medication primary used to treat psychotic disorders like schizophrenia) one (1) milligram tablet by mouth every 6 hours as needed for the continued hallucinations.	F0658	1) Address how corrective action will be accomplished for those residents found to be affected by the deficient practice. On 1/13/2026 the diagnosis for resident #6 was discontinued by the Director of Nursing and the attending provider due to the lack of supporting clinical diagnosis. Resident #6 was referred for mental health services on 1/9/2026 by Social Worker #1. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. on 1/13/26 an audit was completed by the Director of Nursing for current residents with a diagnosis of schizophrenia to ensure that clinical documentation was in place to support the diagnosis. No other residents were identified during the audit as having an active diagnosis of schizophrenia 3) Address what measures will put in place or systemic changes made to ensure that deficient practice will not recur. On 1/3/2026 education by the Staff Development Coordinator was initiated and completed on 1/15/2026 for the Social Worker and Licensed Nurses on requirements of clinical documentation to support a diagnosis of schizophrenia. Any Social Worker or Licensed Nurse who have not completed the education will not be allowed to work until they compete the required education. The education has been added to orientation materials for any newly hired Social Worker and Licensed Nurse and will be educated by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its	01/16/2026

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F0658 SS = D	Continued from page 8 The active diagnosis list revealed Resident #6 had a diagnosis of schizophrenia, unspecified which was noted as an admitting diagnosis that was active as of 7/20/24 with no onset date listed, and with the clinical category of medical management. The diagnosis list further revealed Resident #6's schizophrenia diagnosis was added by Nurse #1 on 5/06/25. An interview was conducted with Nurse #1 on 12/19/25 at 11:11 am who added Resident #6's schizophrenia diagnosis to the medical record. Nurse #1 stated she recalled adding the schizophrenia diagnosis based on a medication that Resident #6 was taking that did not have a correct diagnosis. Nurse #1 stated she believed the diagnosis was given to her by a physician at the facility but she could not recall exactly who gave the information. Resident #6's care plan which was last revised on 11/04/25 revealed no care plan was in place for the diagnosis of schizophrenia. The Minimum Data Set (MDS) quarterly assessment dated 11/07/25 revealed Resident #6 was coded for the following psychiatric/mood disorders: anxiety, depression, and bipolar disorder. Resident #6 was not coded for a diagnosis of schizophrenia. Review of Resident #6's electronic and paper medical records revealed no clinical documentation supporting the schizophrenia diagnosis. Multiple attempts to conduct a telephone interview with the MDS Nurse on 12/19/25 were unsuccessful. A telephone interview was conducted on 12/19/25 at 11:16 am with the Consultant Pharmacist who revealed the pharmacy had not requested that the facility add a diagnosis of schizophrenia for Resident #6. A telephone interview was conducted on 12/19/25 at 3:09 pm with Physician #1 who revealed he had not written or given the facility a diagnosis of schizophrenia for Resident #6. Physician #1 stated to the best of his knowledge Resident #6 did not have a diagnosis of schizophrenia.	F0658	Continued from page 8 performance to make sure that solutions are sustained. Audits will be conducted by the Director of Nursing on current residents with a new diagnosis of schizophrenia , or any newly admitted resident with a diagnosis of schizophrenia , to ensure documentation is in place to support the diagnosis. The audits were started on on 1/15/26 by the Director of Nursing and will occur every week for 4 weeks and then every month for 3 months. The Director of Nursing will bring the audits to the Quality Assurance and Performance Improvement monthly as to ensure compliance. Date of Completion 1/16/2026	

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F0658 SS = D	Continued from page 9 An attempt to conduct a telephone interview with Physician #2 on 12/19/25 at 3:19 pm was unsuccessful. An interview was conducted with the Director of Nursing (DON) on 12/19/25 at 3:29 pm who revealed she was unable to locate documentation from either Physician #1 or Physician #2 that noted Resident #6 to have a schizophrenia diagnosis. The DON stated she believed Physician #2 had reported that Resident #6 had a significant history of schizophrenia but she was not able to say why there was no clinical documentation regarding the diagnosis. The Administrator was interviewed on 12/19/25 at 3:42 pm. The Administrator revealed she was unable to recall if Resident #6 had a schizophrenia diagnosis but she stated she would discuss the diagnosis with the clinical team to confirm the diagnosis was correct.	F0658		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide tracheostomy (a hole surgeons make through the front of the neck and into the wind pipe, also known as the trachea) care consistent with professional standards of practice for 1 of 1 resident observed for tracheostomy care (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/03/25 with a diagnosis of metabolic encephalopathy and respiratory failure. The quarterly Minimum Data Set (MDS) dated 10/28/25 revealed Resident #2 was severely impaired cognitively. The MDS further revealed the Resident #2 was coded for	F0695	1) Address how corrective action will be accomplished for those residents found to be affected by the deficient practice. On 12/17/2025 the Staff Development Coordinator educated Respiratory Therapist #1 on the standards of practice for tracheostomy care . 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. on 1/14/2026 the Director of Nursing completed an observation audit with Respiratory Therapists identified in the deficient practice to ensure that tracheostomy care for current residents that required it be done was in accordance with professional standards of practice. No new issues were identified. 3) Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Education was initiated on 12/17/2025 and concluded on 1/15/2026 by the Staff Development Coordinator to the current Respiratory Therapist and Licensed Nurses on standards of practice for tracheostomy care. The education included appropriate hand hygiene, use of	01/16/2026

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F0695 SS = D	Continued from page 10 oxygen therapy, suctioning, respiratory services, and tracheostomy care. Resident #2 had a care plan with effective date of 12/12/25 that indicated a goal he would have no abnormal drainage around his tracheostomy site through the next review date. The care plan had interventions that included instructing the resident/caregiver in providing tracheostomy care/suctioning and signs/symptoms to report. An observation was conducted of tracheostomy care on 12/17/25 at 9:15am with Respiratory Therapist (RT) #1. RT #1 was observed performing hand hygiene and applying two pairs of clean disposable gloves. RT #1 opened the tracheostomy care tray on Resident #2's overbed table. RT #1 did not clean the overbed table before opening and setting up tracheostomy care supplies. RT #1 was observed pouring normal saline into the tracheostomy care tray and removing a clean gauze saturated with normal saline from the tracheostomy care tray. She then cleaned around Resident #2's tracheostomy site and placed the dirty gauze on a dressing package on Resident #2's overbed table. RT #1 was then observed removing another clean gauze from the tracheostomy care tray and cleaning around Resident #2's tracheostomy site and placing the soiled gauze in the clean tracheostomy care tray on top of the remaining clean gauze. RT #1 removed two cotton tip applicators saturated with normal saline from the tracheostomy care tray and cleaned around Resident #2's tracheostomy site. RT #1 was observed removing a clean gauze from under a used gauze to clean around the resident's tracheostomy site and placing the used gauze in the tracheostomy care tray. RT #1 removed the top pair of disposable gloves before opening the dressing to apply around Resident #2's tracheostomy site. RT #1 did not perform hand hygiene before applying the clean dressing to Resident #2's tracheostomy site. During an interview on 12/17/25 at 2:40pm RT #1 stated she was trained to work from the tracheostomy care tray, and she was not aware she needed to clean her work surface before setting up supplies. RT #1 confirmed she doubled gloved during the procedure and stated a third shift supervisor instructed her to use double gloves during tracheostomy care the morning of the observation. The RT #1 stated she normally wears the same gloves throughout tracheostomy care. She stated she was not aware she place the dirty gauze on top of the clean gauze. An interview was conducted over the phone on 12/18/25 at 11:41am with the Third Shift Supervisor who revealed	F0695	Continued from page 10 gloves , ensuring a clean surface for supplies, and placement of contaminated gauze pads. Any Respiratory Therapist or Licensed Nurse not having the education will not be permitted to work until they have receive the required education. The education has been added to the orientation process for any newly hired Respiratory Therapist and Licensed Nurses and will be completed by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its performance to make sure hat the solutions are sustained. Observation audits will be conducted by the Respiratory Supervisor, the Nurse Manager , the Staff Development Coordinator , and/or the Director of Nursing to ensure that residents that require tracheostomy care receive it in a manner that meets professional standards. The audits will be conducted on 4 residents with each audit . The residents observed will rotate until all residents tracheostomy care has been observed. The audits will begin 1/15/2026 and will occur every week for 4 weeks and then every month for 3 months. The results of the audits will be taken to the Quality Assurance and Performance Improvement Meeting by the Director of Nursing monthly to ensure ingoing compliance Date of completion 1/16/2026	

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F0695 SS = D	Continued from page 11 he did not instruct RT #1 to double glove during tracheotomy care. The Third Shift Supervisor stated there was a discussion RT #1 on how care was performed in the past. He stated RT #1 must have misunderstood the conversation, because he never gave any directives for double gloving during tracheostomy care. The Third Shift Supervisor stated if he were performing tracheotomy care, he would perform hand hygiene and apply a clean pair of disposable gloves before applying a clean dressing. An interview was conducted on 12/18/25 at 10:10am with the Director of Respiratory Therapy who revealed they follow Lippincott's (digital resource) guidance for hand hygiene, which included removing gloves and performing hand hygiene between touching clean and dirty items during tracheostomy care. She stated that the Respiratory Department did not have an actual policy for tracheostomy care and that was a policy that may need to be added. She stated tracheostomy care was taught at the beside once the trainee was on the floor. The Director of Respiratory Therapy stated staff were not trained to double glove during tracheostomy care. She stated dirty items used should be disposed of to prevent cross contamination during tracheostomy care. She also stated she would expect staff to clean the work surface before setup, place wastebasket close by for disposal of dirty items, and she would expect hand hygiene to be performed before and after the procedure. When asked could there have been a negative outcome to Resident #2, the Director of Respiratory Therapy's response was "anything is possible". An interview was conducted on 12/18/25 at 3:30pm with the Infection Preventionist (IP) who revealed she was not responsible for training staff from the Respiratory Department. The IP stated tracheostomy care was taught by Respiratory Department. She also stated they follow Lippincott's guidance. When the IP was asked what the expectation of staff was working on the unit, she stated the expectation would be not to contaminate a clean area. When asked what the outcome could have been from Rt #1's actions, the IP stated it could have put Resident #2 at risk for infection. An interview was conducted on 12/18/25 at 2:55pm with the Director of Nursing (DON) who revealed she was not aware of any training for staff that involved wearing double gloves. The DON stated her expectation during tracheostomy care would be for staff to perform hand hygiene and apply clean gloves, before applying a clean dressing. She also stated she would not expect staff to go from dirty to clean when providing care and she would expect staff to clean their work surface before	F0695		

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F0695 SS = D	Continued from page 12 and after performing care. When the DON was asked if she thought RT #1's actions could have had a negative impact on Resident #2, she stated it was possible. An interview was conducted on 12/19/25 at 3:00pm with Physician #2 who revealed he would expect RT #1 to apply clean gloves between dirty and clean when providing care. He also stated double gloves were not the appropriate Personal Protective Equipment (PPE) and staff should not take short cuts with hand hygiene. When asked if the actions of RT #1 could have had an negative effect on Resident #2, he indicated it could have caused additional problems.	F0695		
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, and physician interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents reviewed for unnecessary medications (Resident #6). The findings included: Resident #6 was admitted to the facility on 6/05/15. Resident #6 was noted with diagnoses which included major depressive disorder, bipolar disorder, general anxiety disorder, and schizophrenia. The Minimum Data Set (MDS) quarterly assessment dated 11/07/25 revealed that Resident #6 was cognitively intact and was not coded for hallucinations or behavioral symptoms during the assessment reference period. The MDS further indicated that Resident #6	F0740	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility has obtained a mental health provider and on 1/9/2026 and resident # 6 was referred to them by the Social Worker. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was was conducted by the Social Worker on 1/14/26 to determine if behavioral health services were warranted. There were 3 additional residents that could benefit from mental health services. The Social Worker sent those 3 additional residents for referral of mental health services on 1/14/2026 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recure. On 1/15/2026 the Administrator educated the Social Worker on the requirements for having behavioral health services available for residents. The education was added to the orientation material for any newly hired Social Worker going forward and will be provided by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	01/16/2026

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F0740 SS = D	Continued from page 13 reported feeling down, depressed, or hopeless for 2-6 days (several days) during the assessment reference period. The MDS quarterly assessment noted that Resident #6 was coded for the following psychiatric/mood disorders: anxiety, depression, and bipolar disorder. Resident #6 was coded for the use of antipsychotic and antidepressant medications. Review of the active physician orders dated December 2025 revealed that Resident #6 was prescribed the following medications: venlafaxine (antidepressant medication) 75 milligram (mg) capsule extended release 24-hour one capsule every day for bipolar disorder, unspecified; cariprazine (antipsychotic medication) 4.5 mg capsule daily for bipolar disorder unspecified; and fluoxetine (antidepressant medication) 20 mg capsule every day for major depressive disorder recurrent. The facility was unable to provide any documentation regarding mental health provider visits for Resident #6 since the last recertification survey of 9/18/24. The Facility Assessment that was last revised on 11/26/25, revealed the facility did not have behavioral or mental health providers which included psychiatrist, psychologist, or licensed counselors. The Facility Assessment further noted that the facility provided mental health and behavior services which were performed by the attending physician and the Social Worker. The Facility Matrix for Providers (a tool used to track resident's specific medical conditions and services needed) provided by the Administrator was reviewed and revealed that 16 of the 20 residents that resided at the facility were prescribed psychotropic (medications used to treat mental health conditions) medications which included antianxiety, antidepressants, and antipsychotic medications. An interview was conducted with Resident #6 on 12/19/25 at 11:16 am. Resident #6 reported that she was unable to recall the last time she was able to talk to a doctor about her mental health issues. The resident stated she used to see a mental health provider in the past before living at the facility. Resident #6 stated that she does talk to the staff, but she would like to be able to talk to a doctor when she begins to feel down.	F0740	Continued from page 13 Audits will be conducted by the Social Worker to determine if there are residents that would benefit from behavioral health services. The determination will be made by auditing the most current MDS, assessment for residents that are coded as feeling down, depressed , or hopelessness during the assessment reference period. In addition, the audit will include residents interviews for the desire to speak to a behavioral health specialist. The audits will begin on 1/15/2026 and occur every week for 4 weeks then every month for 3 months. The results of the audits will be taken to the Quality Assurance and Performance Improvement Committee monthly by the Social Worker to ensure ongoing compliance. Date of correction 1/16/2026	

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F0740 SS = D	Continued from page 14 An interview was conducted with Nurse Aide (NA) #1 on 12/19/25 at 11:06 am who revealed she provided care to Resident #6 frequently. NA #1 reported that Resident #6 often had hallucinations which included seeing cats, dogs, rats, and people that were not there, as well as episodes of crying. NA #1 stated that when these things happened, she attempted to calm Resident #6 by trying to convince the resident that what she was seeing was not there. NA #1 stated she also would also spend time with Resident #6 until the resident was calm. During an interview on 12/19/25 at 11:11 am with Nurse #1 she revealed that Resident #6 had a history of hallucinations but reported the resident was easily settled by talking with the resident. The Social Worker was interviewed on 12/18/25 at 11:43 am who confirmed that the facility did not have a mental health provider that met with the residents. The Social Worker reported that Resident #6 had periods of hallucinations that were worsening and she was not sure how to engage with the resident when that happened. The Social Worker stated the nursing staff was very engaged with Resident #6 and talked with the resident often to help support Resident #6 when the hallucinations were occurring. The Social Worker stated she was able to provide Resident #6 with emotional and psychosocial support but stated that Resident #6 would benefit from talking to a mental health provider. The Social Worker reported that she had attempted to obtain a mental health provider for the facility by reaching out to providers and community organizations but she had not been successful. The Social Worker stated the need for a mental health provider had been discussed during the facility's IDT (interdisciplinary team) meetings but the facility was still without the services. A telephone interview was conducted with Physician #1 on 12/19/25 at 3:29 pm who was the provider for the residents of the facility along with Physician #2. Physician #1 stated that he and Physician #2 were Internists (physicians specialized in adult care) which afforded them the ability to manage all areas of care needed by the residents. Physician #1 reported that he and Physician #2 manage the mental health medications and immediate needs of the residents. He stated that the facility had a mental health provider in the past but they have not had anyone recently to provide those services. Physician #1 stated that the discussion	F0740		

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F0740 SS = D	Continued from page 15 regarding the need for a mental health provider in the facility has been discussed with Administration during the IDT meetings. An attempt to conduct a telephone interview with Physician #2 on 12/19/25 was unsuccessful. The Director of Nursing (DON) was interviewed on 12/18/25 at 2:57 pm who revealed the facility did not have a mental health provider but the facility relied on the physicians to mange the mental health care. The DON stated that Resident #6 did have periods of hallucinations but she was not able to say when she was last seen by a mental health provider. An interview was conducted on 12/19/25 at 3:09 pm with the Administrator who revealed the facility had a mental health provider that would come to the facility in the past, but they no longer came to see the residents. The Administrator stated the attending physicians were responsible for managing the mental health needs and medications of the residents. The Administrator confirmed the need for a mental health provider had been discussed during the quarterly IDT meetings but she had not been able to secure a mental health provider for the facility.	F0740		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F0757	1) Address how corrective action will be accomplished for those residents found to been affected by the deficient practice. Resident # 19 had a TSH level completed on 12/18/2025. The results were reported to the Provider by the Licensed Nurse on 12/22/25. There were no new orders given at the time related to the TSH level. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. on 12/17 2026 current residents were reviewed by the Consulting Pharmacist for any necessary blood work needed. No other residents were identified needing blood work that was not already current. 3) Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.	01/16/2026

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F0757 SS = D	Continued from page 16 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Consultant Pharmacist, and Physician interviews, the facility failed to monitor a TSH (thyroid stimulating hormone) level for a resident prescribed amiodarone (a medication used to treat life-threatening irregular heartbeats). This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #19). The findings included: Resident #19 was admitted to the facility on 10/14/25 with diagnoses which included paroxysmal atrial fibrillation (an irregular heartbeat). Resident #19 had a physician order dated 10/14/25 for amiodarone 200 milligram tablet once a day for paroxysmal atrial fibrillation. The Consultant Pharmacist Recommendation to Physician report dated 10/27/25 revealed Resident #19 received the medication amiodarone but did not have a TSH blood test documented in the medical record for the last six months. The Consultant Pharmacist recommendation was to please monitor TSH on the next convenient laboratory day and every six months thereafter. Resident #19 was noted to have a physician order dated 11/06/25 for a TSH level blood test. The order was discontinued on 11/07/25. Resident #19's electronic and paper medical records were reviewed and revealed no TSH laboratory results from the 11/06/25 physician order. A telephone interview was conducted on 12/18/25 at 2:13 pm with the Consultant Pharmacist who revealed he reviewed Resident #19's medications upon admission and	F0757	Continued from page 16 On 12/18/2025 the Staff Development Coordinator initiated education for the Licensed Nurse on the requirements for addressing the Consultant Pharmacist recommendations. The education was concluded on 1/15/2026 by the Staff Development Coordinator. Any licensed Nurse not having the required education will not be allowed to work until it is completed. The education was added to the orientation process for any newly hired Licensed Nurse and will be completed by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by the Director of Nursing to ensure that recommendations from the Consulting Pharmacist are addressed. The audits will begin on 1/15/2026 and will be be completed every week for 4 weeks then monthly for 3 months. The results of the audits will be taken to the Quality Assurance and Performance Improvement Meeting Committee monthly by the Director of Nursing to ensure compliance. Corrective action completed 1/16/2026	

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F0757 SS = D	Continued from page 17 identified that a TSH level was not in the record. The Consultant Pharmacist stated that it was important to monitor TSH when taking the medication amiodarone because the medication had large amounts of iodine which can interfere with the normal thyroid function. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 3:00 pm who revealed the order for Resident #19's TSH level was entered as a one-time order (completed once) in the electronic record to be performed on 11/06/25 but it was not drawn by the lab. The DON stated that when an order was entered as a one-time order, the order automatically discontinued 24 hours after the order was entered because it was expected to be completed within the 24-hour period. The DON stated she did not know why the TSH lab was not obtained as ordered for Resident #19 and stated that when the TSH level was not drawn on 11/06/25 it should have been re-ordered to be drawn on the next day. The DON stated that she did not follow up to confirm that the TSH level was drawn as ordered on 11/06/25 and she was unable to locate any previous TSH results from the hospital discharge record. A telephone interview was conducted with the Physician on 12/19/25 at 3:09 pm who confirmed he was notified by the facility on 12/18/25 that Resident #19's TSH order was not completed as ordered. The Physician stated he did not have a concern that Resident #19's TSH level was not drawn when first ordered because it was just for monitoring purposes.	F0757		
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	F0842	1) Address how corrective action will be accomplished for those residents found to be affected by the deficient practice. The medical record for Resident #14 was corrected on 12/17/25 by the the Licensed Nurse as the location of the wounds. 2) Address how the facility will identify other residents found to be affected by the same deficient practice. on 12/22/25 the Director of Nursing reviewed the current residents with skin injury to ensure that the medical record was accurate regarding the location of the wound being treated. No other issues were identified during the audit.	01/16/2026

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F0842 SS = B	Continued from page 18 medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §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-	F0842	Continued from page 18 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Staff Development Coordinator ,the Licensed Nurse Manager, and/or the Director of Nursing initiated education on 1/13/2026 and completed on 1/15/2026 with the Licensed Nurses on the requirements of the accurate medical record , including the location of any new skin injury being treated . Any Licensed Nurse not having the education by 1/15/2026 will not be permitted to work until they complete the required training. The education has been added to the orientation process for newly hired Licensed Nurses going forward and will be educated by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by the Licensed Nurse Manager and or the Director of Nursing to ensure that the residents medical records regarding the location of any skin injury being treated were accurate to the location of the injury. The audits will begin 1/15/2026 and occur every week for 4 weeks and every month for 3 months. The results of the audits will be taken to the Quality Assurance and Performance Improvement Meeting every month by the Director of Nursing to ensure ongoing compliance. Corrective action completed 1/16/2026	

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F0842 SS = B	Continued from page 19 (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 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 observation, record review, and staff interviews, the facility failed to ensure the medical record was accurate related to pressure ulcer documentation and pressure ulcer treatment orders for 1 of 8 residents reviewed for accuracy of resident records (Resident #14). The findings included: Resident #14 was admitted to the facility on 11/03/25. Review of Resident #14's Weekly Wound Assessments dated 11/03/25, 11/11/25, 11/18/25, and 11/25/25, and 12/02/25 revealed documentation of Resident #14's multiple wounds including a pressure ulcer to the right buttock, but there was no documentation for a wound to the left buttock. The assessments were completed by Nurse #3. Review of the December Treatment Administration Record (TAR) for Resident #14 revealed the following order for treatment to the right buttock wound, for the period of 12/2/25 through 12/10/25, to clean the right buttock wound with the wound cleanser, apply collagenase to the wound bed, pack the wound with saline soaked gauze, and apply foam dressing once daily and if soiled. This treatment was signed off as administered from 12/2/25 through 12/10/25. Nurse #3 signed off as administering the treatment on 12/9/25 and 12/10/25. For the period of 12/11/25 through 12/17/25 the treatment ordered was to clean the right buttock wound with wound cleanser, pack calcium alginate to wound bed, apply foam dressing once daily and as needed. Nurse #3 signed off the treatments as administered on 12/11/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, and 1217/25. There was no	F0842		

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F0842 SS = B	Continued from page 20 documentation for wound treatment provided to the left buttock. During an observation on 12/17/25 at 8:46 am Nurse #3 provided treatment to a wound on Resident #14's left buttock and there was no wound observed on the resident's right buttock. An interview was conducted on 12/17/25 at 1:51 pm with Nurse #3. During the interview Nurse #3 identified he had been documenting the location of Residents #14's left buttock wound incorrectly on his weekly wound assessments and Treatment Medication Record since the resident was admitted on 11/03/25. He stated when Resident #14 was admitted to the facility he had conducted a wound assessment, then obtained an order for treatment for the wound from the physician and entered the order in the medical record. Nurse #3 stated he should have put the order in for the left buttock and not the right buttock. He also stated he should have documented the wound location as the left buttock not the right buttock on the weekly wound assessment sheet. Nurse #3 indicated he never noticed he was signing off the TAR for treatment to a right buttock wound after he provided the treatment to the left buttock. An interview was conducted on 12/17/25 at 2:55 pm with the Director of Nursing (DON). The DON stated Nurse #3 had informed her about Resident #14's wound documentation and wound orders being incorrect. During a follow up interview on 12/19/25 the DON stated she had not done rounds with Nurse #3, but a process needed to be put in place.	F0842		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Staff Development Coordinator , Nurse Manager , and/or Director of Nursing educated the Licensed Nurse #2 , the Licensed Nurse #3 and the Nursing Assistant #2 on 1/13/2026 . The education completed covered residents on contact precautions , hand hygiene , wound care and PPE. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	01/16/2026

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F0880 SS = E	Continued from page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 21 An audit was completed on 1/14/2026 by the Director of Nursing for current residents who receive wound care as well as current residents that are on contact precautions The observation was to ensure that that staff adhered to the appropriate infection control procedures for wound care , contact precautions and hand hygiene. No issues were identified during the audit. 3) Address what measures will be put into place or systemic changes to ensure that the deficient practice will not recur. Education was initiated on 12/17/25 and completed 1/15/2026 with all Staff by the Staff Development Coordinator ,the Nurse Manager, and/or the Director Nursing on requirements of infection control during wound care , using appropriate PPE before touching an open wound , contact precautions and performing hand hygiene when changing gloves. Staff will not be allowed to work until required education is completed. The education was added to the orientation process for all newly hired staff and will be completed by the Staff Development Coordinator. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be conducted by the Licensed Nurse Manager, the Staff Development Coordinator, and /or the Director of Nursing to ensure that wound care is being performed in accordance with infection control practices, employees entering the residents rooms on contact precautions apply appropriate PPE and hand hygiene. The audits will involve 4 residents and a rotating roster. The audits will begin on 1/15/2026 and will occur every week for 4 weeks and then monthly for 3 months. The Licensed Nurse Manager will bring the audit results to the Quality Assurance and Performance Improvement Meeting every month to ensure ongoing compliance . Corrective action completed 1/16/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0880 SS = E	Continued from page 22 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 infection control policy and procedures when Nurse #3 failed to perform wound cleansing and treatments for several wounds separately and failed to remove gloves and perform hand hygiene between cleansing each wound and providing the treatment for each wound. Nurse #3 also touched a new wound observed on the resident's right leg wearing a soiled glove (Resident #14). In addition, Nurse #2 failed to wear a gown when entering the room for a resident on contact precautions (Resident #13). The deficient practice occurred for 2 of 2 staff members observed for infection control practices (Nurse #3 and Nurse #2). The findings included: 1. The facility's Hand Hygiene policy last released in November 2022, stated to practice good hygiene to prevent the spread of disease or cross-contamination between patients, staff and food. The policy indicated hand hygiene should be performed: before having direct contact with patient/patients, before a clean/aseptic procedure, after touching a patient, after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, after touching a patient's surroundings/environment, with additional opportunities being: before donning and after removal of gloves. The facility's Clean Dressing Change policy last released in October 2022, stated to perform clean aseptic technique while performing dressing changes to open wounds to protect from contamination and absorb drainage. The policy indicated to place plastic bag near foot of bed to receive soiled dressing, perform hand hygiene, create clean field with paper towels or drape, put on first pair of gloves, remove old adhesive, remove soiled dressing and discard one layer at a time, remove gloves and dispose, perform hand hygiene and put on second pair of gloves, clean wound with prescribed solution, remove gloves and perform hand hygiene, open dressing pack, and put on gloves.	F0880		

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F0880 SS = E	Continued from page 23 The Clean Dressing Change policy further noted if patient has multiple wounds to wash hands in between wounds and cleanse the least contaminated to the most contaminated wound. During an observation of wound care on 12/17/25 at 8:46am Nurse #3 was observed with supplies placed on a drape on top of Resident #14's overbed table. Nurse Aide #2 was also present to help position Resident #14 during wound care. Once Resident #14's was placed on his right side Nurse #3 loosened the edges of the dressings dated 12/16/25 from a wound to the sacrum (triangular bone at the base of the spine), a wound to the right ischium (curved bone that forms the lower and back portion of the pelvis), and wound to the left buttock. Nurse #3 performed hand hygiene and applied a clean pair of gloves. Nurse #3 was then observed removing the old dressing from the wound to the sacrum and rolling the old dressing down to the right ischial wound and rolling both old dressings from both wounds together and discarded both old dressings into a wastebasket at the bedside. Nurse #3 then removed the old dressing from the wound to the left buttock and discarded the old dressing into the wastebasket at the beside. Nurse #3 performed hand hygiene and applied a clean pair of gloves. Nurse #3 then began cleaning the wound to the sacrum, the wound at the right ischium and the wound at the left buttock. He used multiple gauze to clean all three wounds. Nurse #3 did not perform hand hygiene or apply clean gloves between each wound. While wearing the same pair of gloves Nurse #3 began packing an absorbent dressing in the wound to the sacrum, the wound to the right ischium and the wound to the left buttock. Nurse #3 did not perform hand hygiene or apply clean gloves between packing each wound or after she had packed the wounds. Nurse #3 opened three separate dressings onto the overbed table and proceeded to apply clean dressings to the wound to the sacrum, right ischium, and the left buttock. Nurse #3 was then observed performing hand hygiene and applying clean gloves before starting treatment to Resident #14's left heel. Nurse #3 applied the wipe that forms a protective barrier to the left heel. Nurse #3 then cut the soiled bandage from the right foot and placed the scissors onto the overbed table and applied the wipe that forms a protective barrier to Resident #14's right heel. Nurse #3 did not perform hand hygiene or apply clean gloves between performing the treatment between the wound on the left heel and the right heel. While still wearing the same pair of gloves Nurse #3 wrapped the right heel with a clean bandage. During the observation Nurse Aide #2 identified a new wound on Resident #14's outer right leg and Nurse #3 touched the new wound with his right index finger wearing the soiled gloves.	F0880		

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F0880 SS = E	Continued from page 24 Resident #14 was repositioned by Nurse #3 and Nurse #3 removed his gloves and performed hand hygiene. Nurse #3 did not remove his gloves or perform hand hygiene before repositioning Resident #14. Nurse #3 then discarded his supplies, removed his gloves and performed hand hygiene. Nurse #3 did not clean the overbed table that was used during Resident #14's treatment before leaving the room. During an interview on 12/17/25 at 1:51pm Nurse #3 stated he was not aware that he had touched the newly identified wound on Resident #14's outer right lower leg with soiled gloves he wore during the treatment for the left and right heel. Nurse #3 confirmed he did not perform hand hygiene or apply clean gloves between each wound. He confirmed he did not follow the dressing change policy, nor did he complete the dressing changes as he was trained. Nurse #3 stated he felt like he could have done better. An interview was conducted on 12/18/25 at 3:30pm with the Infection Preventionist (IP) who revealed she was responsible for training Nurse #3. The IP stated that the policy for dressing change does indicate staff should change gloves in between wounds during a dressing change. She then stated the expectation for staff would be to not cross contaminate between wounds and perform wound care for one wound before moving on to the next wound. When the IP was asked what the outcome could have been from Nurse #3's actions, the IP stated Resident #14 could have been put at risk for cross contamination if there was infection in any of the wounds. She also indicated she did not believe any of Resident 14's wounds were infected at that time. An interview was conducted on 12/18/25 at 2:55pm with the Director of Nursing (DON) revealed she would expect staff to perform hand hygiene and apply cleans gloves in between dressing changes for each wound. The DON also stated she would expect staff to clean the work surface before and after performing a treatment. When the DON was asked if she thought the actions of Nurse #3 could have had a negative impact on Resident #14, she stated it was possible. An interview was conducted on 12/19/25 at 3:00pm with Physician #2 who revealed he would expect staff to perform hand hygiene and apply clean gloves between wounds. Physician #2 stated that the actions of Nurse #3 were not appropriate and could have moved "microbes" (microorganism) from one area to another. 2. The facility's Personal Protective Equipment (PPE) policy last released in October 2022 revealed that PPE	F0880		

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F0880 SS = E	Continued from page 25 will be utilized to reduce the risk of transmission and prevent the transmission of pathogenic organisms from patient to health care worker and from health care worker to patient. The policy further noted that contact precautions were intended to prevent the transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. The policy stated that contact precautions required the use of gown and gloves on every entry into a patient's room or the patient's environment. On 12/17/25 at 9:33 am Resident #13 had signage posted at the entrance of the room that alerted staff that Resident #13 was on contact precautions. The signage noted that all healthcare personnel must wear gloves and gown when entering the room. A supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves. A continuous observation was conducted on 12/17/25 at 9:33 am through 9:35 am of Nurse #2 who was observed in Resident #13's room without a gown in place. Nurse #2 was observed to pick up enteral feeding supplies from the overbed table and walk towards the sink before returning the supplies to the overbed table. Nurse #2 was then observed to remove the disposable gloves, perform hand hygiene and exit the room. An immediate interview was conducted with Nurse #2 on 12/17/25 at 9:35 am. Nurse #2 confirmed that Resident #13 was on contact isolation for multiple drug-resistant organism (MDRO) related to pneumonia and she should have donned a disposable gown before entering the room, but it slipped her mind. An interview was conducted with the Infection Preventionist on 12/18/25 at 3:27 pm who revealed Nurse #2 was required to wear PPE, which included a disposable gown, for the entire time she was in a resident room that was on contact precaution isolation.	F0880		